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CUMBERLAND COUNTY COUNCIL

THE HEALTH OF CUMBERLAND 1971

REPORT OF THE COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON

THE HEALTH OF THE COUNTY
FOR THE YEAR 1971

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

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PREFACE

To the Chairman and Members of the County Council,

This report on the health of the County for the year 1971 shows clearly that there has been a continued and rapid further development of services, so that by the time of the re-organisation of the National Health Service outside local government we will have obtained a virtual functional unity of these health services in Cumberland.

Such advances include the implementation of the computer call up procedure for immunisation of infants at general practitioners' surgeries, which will have the practical effect of increasing the protection rate from 70% to 90%. A useful "spin off" from this work has been the ability to call forward three year old children for dental examination, and the results from these examinations are such that there is clear proof of the beneficial effect of the adjustment of the fluoride content of the water supply to a dental optimum of one part per million.

Another advance on another front has been the welcome and increased involvement of general practitioners in the treatment of road traffic accidents and medical emergencies involving the ambulance service. From early beginnings is growing a great sense of common medical purpose in these matters. Such a team approach of hospital and community doctors, nurses, midwives and ambulance drivers and attendants, and indeed the other emergency services, leads clearly to a higher standard of service more fitted for today's conditions.

The implementation of the Mayston report on nurse management in this County has underlined the development of this profession to take its place under its own management in the community health teams now so well established in this area. The unification of the nursing services of hospital and community is imminent and it is well that management structures for both have been determined so that this unification can take place with ease and effect.

The last advance I wish to note is the further evolution of even more effective health care teams in association with family doctors, to include registered and enrolled nurses, health visitors, domiciliary midwives and lay attendants. In addition one can now see the necessity of adding members of the professions supplementary to medicine to these

teams. It appears clear that all medical treatment and care that can be given at a group practice centre will be given there and only those cases where it is necessary will in future attend the district general hospital either as an in or out patient.

In all these advances, the basic thought has been the strengthening of the team — already in this County it is accepted that team work has taken over from the relative ineffectiveness and inefficiency of individual effort.

Turning now to the new pattern of clinical activities by doctors and nurses in the local government service, I am glad to say that there has been significant advance in developmental paediatrics, whilst family doctors have also become more involved in the care of the school child. It is quite clear to me that the essential steps have now been taken to make an easy transition to integrated care schemes for a variety of patient groups.

Domiciliary midwifery in Cumberland is now only at a rate of 3% and there is a movement towards agreement by all the professional people concerned, and the mothers and their families, that hospital confinement is the general rule, coupled where necessary with planned early discharge. In about half of the county area home confinements are not taking place, but should any occur hospital teams are available to deal with the situation.

In a rural area, at the present time, there is much anxiety about the curtailment of public transport services and the associated difficulties. However it is clear that there is no such anxiety about the Ambulance Service which meets medical needs in a commendable way with great efficiency and devotion to duty. The reorganisation of this service during the year was far reaching and far exceeded the relatively small matter of the location of stations.

The year has produced difficulties and disappointments. I find that the public reaction to health centres is completely out of date. These are places in which modern medicine may be practised in many of its facets — preventative, diagnostic and curative. Some of the premises from which family health teams are now practising simply do not match up to reasonable contemporary needs.

Another difficulty is the lack of active comprehensive health and welfare planning in particular for the main community care groups and a lot more must be done about this in the near future.

The health hazards of cigarette smoking have not yet been accepted by the community. Can it be again plainly said that cigarette smoking plays a major part in the development of many diseases, causes widespread and distressing disability from chest and heart diseases, and increases morbidity and mortality from several conditions. Furthermore smoking during pregnancy diminishes the chances of a mother being delivered of a normal child. Indeed I look forward to the day when it is generally agreed that it is normal not to smoke.

Turning to vital and health statistics, it can be said that the figures show a steady overall improvement, the main community disease being associated with degenerative processes due to ageing. There is a low birth rate, a steady death rate and a declining population.

A tribute to the work of the voluntary services is one that is both necessary and pleasant to record in a report of this kind. It is to be expected that with the forthcoming reorganisation of the National Health Service the great work of the voluntary organisations in hospital and the community will receive the full recognition they so richly deserve.

The staff of the department have all worked excellently during the year, although there has clearly been anxieties which cannot easily be dispelled about the forthcoming reorganisation. I have on many occasions met the staff and dispelled as far as I can their fears for the future. A time of change does however carry these personal difficulties, at times of an irrational nature, and only the completion of the change can dispel them. There is no doubt in my mind that the skills and experience of every member of the staff will be necessary in the immediate integrated service, and the need for more of their kind will be clear. The new service must not be hospital dominated and more resources must be made available for prevention of disease, and supportive community care of cases which need not be in hospital.

My thanks thus go out to my medical and nursing colleagues for their help and advice, and to the administrators and clerical officers in the Health Department for their loyal

co-operation and great efficiency — tangible evidence of this latter being the early production of this report. To the Clerk of the County Council, the County Treasurer and to my fellow chief officers I am indebted for their helpful co-operation. To my Deputy, Dr. J. D. Terrell and the Principal Administrative Officer, Mr. J. J. Pattinson, my admiration and thanks for their professional advice which has been fundamental to the smooth running of such a changing department.

To the Chairman of the Health Committee go my thanks for her continued support and wise advice during the year.

I have the honour to be, Sir,

Your obedient Servant,

John Leiper.

County Medical Officer of Health.

County Health Department,
11 Portland Square,
Carlisle. CA1 1QB.

STAFF

County Medical Officer of Health :

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

Deputy County Medical Officer of Health :

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

Area Medical Officers :

J. Connolly, M.D., D.P.H., Northern Area Medical Officer; Medical Officer of Health to the Penrith Urban District Council and the Border, Wigton and Penrith Rural District Councils.

A. Hargreaves, M.B., Ch.B., D.P.H., Western Area Medical Officer; Medical Officer of Health to Workington Borough and Port, Cockermouth Rural District and Cockermouth, Keswick and Maryport Urban District Councils.

H. M. Marks, B.A., M.B., B.Ch., D.P.H., Southern Area Medical Officer; Medical Officer of Health to Whitehaven Borough and to the Ennerdale and Millom Rural District Councils.

Medical Officers in Senior Posts :

J. E. Ainsworth, M.B., Ch.B.
J. E. M. Garland, M.B., Ch.B., D.P.H.
M. P. McMillan, M.B., Ch.B.

Medical Officers in Department :

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

K. R. Walker, M.B., Ch.B.

Chief Dental Officer :

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

Western Area Dental Officer :

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

Dental Officers :

D. Allan, B.D.S.
K. M. Burnett, B.D.S.
J. Colvin, L.D.S.R.F.P.S.
Miss A. Corkhill, B.D.S.
A. B. Gibson, B.D.S.
F. H. Jacobs, L.D.S.
A. R. Peck, L.D.S.
A. M. Scott, L.D.S.
Mrs. S. M. Wallace, B.D.S.

Consultant Psychiatrist seconded from Newcastle upon Tyne Regional Hospital Board :

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

Chief Nursing Officer :

Miss K. J. Hayes, S.R.N., S.C.M., D.N. Cert., H.V. Cert., N. Admin. Cert. (P.H.).

Area Nursing Officers :

Miss J. M. Crossfield, S.R.N., Q.N., H.V. Cert., N.Admin. Cert. (P.H.), Western Area.

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

Mrs. J. M. Roberts, S.R.N., S.C.M., H.V. Cert., Q.N., Northern Area.

Chief Chiropodist :

G. H. Thomas, M.Ch.S., S.R.Ch.

Chiropodists :

Miss P. A. Fisher, M.Ch.S., S.R.Ch.
Mrs. G. Garrett, M.Ch.S., S.R.Ch.
W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N.
F. J. McCourt, M.Ch.S., S.R.Ch.
Mrs. D. E. Smart, M.Ch.S., S.R.Ch.
W. S. Storie, M.Ch.S., S.R.Ch.

Orthoptists :

Mrs. J. A. M. Payne, D.B.O.
Mrs. J. Scott, D.B.O.
Mrs. J. E. Wilson, D.B.O.

Physiotherapists :

Mrs. P. P. Bratt, M.C.S.P.
Miss M. Sivewright, M.C.S.P.

Screening Assistants :

Mrs. L. Crossley.
Miss D. Kidd.
Miss L. Mayell.

Senior Speech Therapist :

Mrs. E. M. Blacklock, L.C.S.T.

Speech Therapists :

Miss A. Bainbridge, L.C.S.T.
Mrs. J. Lahiff, B.Sc. (Speech).
Miss E. B. Moon, L.C.S.T.
Mrs. M. E. Ogram, L.C.S.T.
Miss A. M. Ross, L.C.S.T.

County Ambulance Officer :

M. F. Smith, F.I.A.O.

Principal Administrative Assistant :

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

NORTHERN AREA
FAMILY HEALTH CARE TEAMS

DECEMBER 1971

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. R. Hassan Dr. A. M. Brown, Alston	Mrs. E. M. Walton Mrs. P. White (Relief) Mrs. A. Davidson (Aux.)	Mrs. E. M. Walton	Mrs. A. Gallacher
Dr. A. K. Rankin Dr. A. M. Rankin, Aspatria Dr. A. C. Beeby, Aspatria Dr. J. R. Rose, Aspatria	Miss S. West Mrs. J. Dickinson (Relief) Mrs. S. Wilkinson (Relief)	Miss S. West	Miss C. M. Bannan (Group Adviser) Mrs. J. Eelbeck (H.V. Assist.)
	(FOR ALL ASPATRIA PRACTICES)		
Dr. H. P. Nelson Dr. W. J. Lush Dr. R. E. D. Nelson Dr. J. C. Burn Dr. I. J. Clark Dr. H. Bell, Brampton	Mrs. M. Dobson Miss M. Lowes Mrs. F. Gaskin (Relief) Mrs. K. M. Bell (Relief) Mrs. T. Wight (Relief) Mrs. D. Pearson (Relief) Mrs. P. Alexander (Aux.)	Mrs. M. Dobson Miss M. Lowes	Miss B. Knibbs (Group Adviser) Mrs. H. G. Watson Mrs. M. Dobson Mrs. A. Gallacher

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. M. I. Cox Dr. A. G. MacKenzie, Caldbeck	Miss E. Henderson Mrs. E. A. Strickland (Relief)	Miss E. Henderson	Miss E. Henderson
Dr. H. J. Bradley Dr. D. Dickenson Dr. G. McInroy, Dalston	Mrs. M. E. Wilde Miss K. Winter Mrs. M. Faulder (Relief)	Mrs. M. E. Wilde Miss K. Winter	Miss P. B. Simpson
Dr. N. W. Cameron, Hesket	Mrs. J. R. N. Pickering Mrs. P. I. Rae	Mrs. J. R. N. Pickering	Mrs. D. Edmondson
Dr. N. C. F. Milne, Kirkoswald	Mrs. J. R. N. Pickering Mrs. P. I. Rae	Mrs. J. R. N. Pickering	Mrs. M. McCredie
Dr. D. A. McDonald Dr. R. A. Maxwell, Kirkbride	Miss A. A. Cockton Mrs. M. Thom (Relief)	Miss A. A. Cockton	Mrs. D. Lancaster (Group Adviser)
Dr. R. A. Forrester, Longtown	Mrs. M. Ashbridge Mrs. J. M. Armitage (Relief) Mrs. A. Nixon (Relief)	Mrs. M. Ashbridge	Miss M. Butler (Group Adviser) Mrs. B. Buchanan (H.V. Assist.)
Dr. G. M. Ingall, Longtown	(FOR BOTH LONGTOWN PRACTICES)		

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. H. C. Barr Dr. I. M. Johnstone Dr. G. F. Lewis Dr. R. W. Corner, Penrith	Mrs. E. J. Relph Mrs. M. Judson Mrs. M. P. Leighton (Relief) Mrs. M. M. Osborne (Relief)	Mrs. M. Judson	Miss K. Rigby Mrs. J. Stevenson
Dr. G. H. Kilgour Dr. C. H. Thomson, Penrith	Mrs. V. M. Lamb Mrs. E. J. Woodall Mrs. M. Hammersley (Relief)	Mrs. V. M. Lamb	Miss D. Roulstone Mrs. M. Hammersley (H.V. Assist.)
Dr. J. B. Scott Dr. I. O. Miller Dr. A. M. Deall, Penrith	Mrs. S. A. Barnes Mrs. E. Plant Mrs. M. M. Barnard (Relief) Mrs. E. Woodhall (Aux.)	Mrs. S. A. Barnes	Miss C. Gardiner (Group Adviser)
Dr. H. Hutton Dr. R. M. Yule, Silloth	Miss G. Jobson Mrs. N. Reay	Miss G. Jobson	Miss R. O'Farrell
Dr. T. M. Dolan Dr. G. A. H. Jones Dr. N. Gray, Wigton	Mrs. A. Addison Mrs. M. Hope Mrs. M. Jones (Relief) Mrs. M. Thom (Relief)	Mrs. A. Addison	Mrs. D. Lancaster (Group Adviser) Mrs. M. Hedworth

General Practitioners	Home Nurses	Midwives	Health Visitors
General Practitioners Practising Outside the Administrative County :—			
Dr. K. Gillow Dr. T. Mooney Dr. T. Gardner Dr. G. Raitt Dr. J. Haworth Dr. A. Frizell Dr. A. Backman, Carlisle	Mrs. E. M. Stafford (Surgery Nurse)		
Dr. G. Jolly Dr. W. C. Menzies Dr. W. P. Honeyman Dr. N. C. Frame Dr. J. Kidd, Carlisle	Mrs. J. Branthwaite Mrs. F. Yeomans		Miss E. A. Lockhart
Dr. E. M. Simpson Dr. I. L. Roy Dr. B. Spencer Dr. W. G. H. Allan, Carlisle	Miss A. A. Cockton Mrs. M. Thom (Relief)	Miss A. A. Cockton	Mrs. D. Lancaster

General Practitioners	Home Nurses	Midwives	Health Visitors
All other Carlisle City Doctors			
	Mrs. J. Branthwaite Mrs. F. Yeomans Mrs. D. Jefferson (Relief)		Miss E. A. Lockhart
Dr. P. Delap, Appleby	Mrs. E. J. Woodhall	Mrs. V. M. Lamb	Miss D. Roulstone
Dr. J. O. Ogilvie, Glenridding	Mrs. M. J. Matthews Mrs. D. Scoon (Relief)	Mrs. M. J. Matthews	Mrs. M. J. Matthews
Dr. D. M. C. Ainscow, Temple Sowerby	Mrs. V. M. Lamb Mrs. E. J. Woodhall	Mrs. V. M. Lamb	Miss D. Roulstone

SOUTHERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER 1971

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. Sharp Dr. G. W. S. Burgess, Distington	Miss J. Hardie Mrs. M. Donnan Mrs. S. Hunter (Relief)	Miss J. Hardie	Miss J. Hardie
Dr. W. G. McKay Dr. C. Donald Dr. H. Johnston Dr. N. McLeod, Frizington and Cleator Moor	Miss H. Spencer Miss M. Proctor Mrs. F. D. Clarke (Relief)	Miss M. Proctor	Mrs. P. Fitzgerald Miss E. Miller (Geriatric Visitor)
Dr. W. T. Hunter Dr. J. Veitch Dr. I. W. McAndrew Dr. J. W. Strain Dr. E. Braithwaite, Egremont and Cleator Moor	Mrs. A. Gell Mrs. V. Wrightson Mrs. M. Toole Mrs. A. Rae Mrs. D. Adair (Relief)	Mrs. V. Wrightson	Miss M. Gibson Miss R. Sheppard Mrs. A. Donald
Dr. A. S. Smith Dr. L. Henry, Egremont and Cleator Moor	Mrs. F. Corkhill Mrs. A. C. O'Hagan (Relief)	Mrs. V. Wrightson	Miss A. Parkinson

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. Loudon Dr. J. W. Jago Dr. J. M. Kirk, Seascale	Miss D. James Mrs. E. Brannan Mrs. M. Marshall Mrs. P. Heggie (Relief) Mrs. E. Gallentry (Surgery Nurse) Mrs. A. Brightman (Relief Surgery Nurse)	Miss D. James Mrs. M. Marshall	Miss D. James (Group Adviser) Mrs. M. Marshall Mrs. M. Cutler
Dr. A. M. Smith, Seascale	Mrs. J. Capp Mrs. E. Moore (Relief)	Mrs. M. Marshall	Mrs. M. Marshall
Dr. A. E. Jackson Dr. M. J. Leverton Dr. A. J. Todd Dr. I. C. C. Mathieson, Millom	Miss I. Wilson Mrs. I. Booth Mrs. M. Wilson Mrs. S. Troll Mrs. M. Fazackerley (Relief) Mrs. M. R. Fowler (Surgery Nurse) Mrs. V. Armstrong (Aux.)	Miss I. Wilson Mrs. I. Booth Mrs. M. E. Moorhouse (Relief)	Mrs. I. E. Bowe (Group Adviser) Miss M. Robinson
Dr. R. N. Galloway Dr. M. C. Nicolson Dr. B. T. Higgins Dr. R. H. Pearson, Whitehaven	Mrs. I. Routledge Mrs. B. Tinnion Mrs. A. Keenan (Surgery Nurse) Mrs. W. Roberts (Relief)	Mrs. A. King	Mrs. W. Batey Miss J. Lancaster

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. R. W. Chalmers Dr. A. P. Timney, Whitehaven	Mrs. M. West Mrs. K. Smith	Mrs. A. King	Miss I. Alcock
Dr. J. Gilmour Dr. B. Moss, Whitehaven	Mrs. M. Swinburne Mrs. I. Smith (Relief)	Mrs. A. King	Miss I. Alcock
Dr. H. A. Fleming Dr. J. G. Dickson Dr. E. Graham, Whitehaven	Miss J. Woodend Mrs. M. Vincent (Relief)	Mrs. A. King	Miss A. Singleton
Dr. R. C. MacFarlane Dr. N. McLeod, Whitehaven	Mrs. E. Brannon Mrs. D. Cameron (Relief)	Mrs. A. King	Mrs. A. Petch Miss E. Miller (Geriatric Visitor)

WESTERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER 1971

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. T. Fletcher Dr. E. B. Herd Dr. D. E. Holloway, Cockermouth	Miss A. I. Kirk Miss M. Musgrave Mrs. V. Sherwood Mrs. E. Swindle (Relief) Mrs. J. Thomas (Relief)	Miss A. I. Kirk Miss M. Musgrave (for all Cockermouth practices)	Mrs. M. Lythgoe Miss A. Dixon
Dr. A. G. Abraham, Cockermouth	Mrs. K. Lytollis Mrs. E. Swindle (Relief)		Miss M. Reynolds
Dr. R. J. M. Irvine, Cockermouth	Mrs. M. E. Dobson Mrs. N. Robinson (Relief)		Miss M. Reynolds
Dr. J. A. Harrow, Keswick	Miss S. M. J. Iliffe Mrs. J. E. Barnes (Relief)	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. Mitchell Dr. M. R. Turnbull, Keswick	Mrs. S. Wilson Mrs. J. E. Barnes (Relief)	Miss M. Casey	Miss M. Casey
Dr. T. Donaldson, Keswick	Mrs. M. J. Cox Mrs. J. E. Barnes (Relief)	Miss S. M. J. Iliffe	Mrs. A. E. Campbell

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. I. F. Smith, Keswick	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. H. Bird	Mrs. J. E. Barnes (Relief)		
Dr. A. W. Rattrie	Miss A. Chadwick	Miss O. Pickering	Mrs. A. Conway
Dr. K. Longstaff	Miss O. Pickering	Miss A. Chadwick	Mrs. L. Messenger
Dr. B. J. Havard	Mrs. J. Bacon	Mrs. J. Bacon	Mrs. A. Irving (Geriatric Visitor)
Dr. F. W. Clark	Mrs. E. Foster		
Dr. C. M. Yule	Mrs. G. Gilbertson (Relief)		
Dr. K. M. A. Slinger, Maryport			
Dr. R. E. Fletcher	Mrs. J. Palin	*Mrs. M. K. Tunstall	Miss A. Jackson
Dr. R. H. Fletcher	Mrs. L. Daniels (Relief)	Miss J. Cunliffe (Ante and Post Natal Care for all Workington Doctors)	Mrs. J. A. Graham
Dr. A. Craig, Workington			
Dr. D. N. Fitzgerald, Workington	Mrs. M. I. Lowis		Mrs. M. Hewitson
	Mrs. H. E. Buchanan (Relief)		
Dr. N. McKerrow	Miss M. Young		Miss E. J. Surtees
Dr. P. I. Rutherford	Mrs. D. Fisher		Mrs. M. Ainsworth
Dr. K. A. Sugathan	Mrs. M. K. Tunstall		
Dr. A. W. B. Lawson, Workington	Mrs. D. Harrison		
	Mrs. M. J. Spedding (Relief)		

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. Pavey-Smith	Mrs. M. Hamilton		Mrs. J. V. Clark
Dr. I. R. McLeod	Mrs. E. Fagan		Miss L. Tracey
Dr. A. Y. Rathnam, Workington	Mrs. K. I. Bell (Relief)		
Dr. C. Robinson	Mrs. J. M. Brown		Miss G. Davies
Dr. M. A. Majahed	Mrs. J. M. Potts		Mrs. A. M. Wandless
Dr. W. D. Baston, Workington	Miss J. Cuncliffe		
	Mrs. M. McAvoy (Relief)		
Dr. G. M. Thomas, Workington	Mrs. M. I. Lowis		Mrs. M. Hewitson
	Mrs. H. E. Buchanan (Relief)		
Dr. R. N. R. Grant, Workington	Mrs. M. I. Lowis		Miss J. Tracey
	Mrs. H. E. Buchanan (Relief)		
	Mrs. M. B. White (Home Nurse — Relief)	Work with all Workington practices	
	Mr. D. Irving (Bath Attendant)		

* Domiciliary confinements covered by an agency arrangement with West Cumberland Hospital Management Group.

ADMINISTRATION

In 1971 the administration of the department underwent its biggest re-organisation for many years, and possibly the biggest since 1948. What had been jointly health and welfare for ten years became health only when the Social Services Department was established on 1st April. There had been considerable preparatory discussion with the Director of Social Services and the County Council's Management Services Unit had undertaken a survey to ascertain the required establishments of the two departments when the functions were divided. Staff were kept informed. Consequently, everyone was fully prepared for the event and all the functions scheduled for transfer were handed over simultaneously on the appointed day. This was undoubtedly facilitated by the fact that the required number of staff had volunteered to transfer to posts in the new department and, where necessary, staff were trained in post in the preceding two or three months to take on any duties which would be new to them.

Simultaneously, the administration of the junior training centres passed to the Education Department, although there was no transfer of staff other than those employed in the centres.

A total of over 500 staff were transferred out of the department to the Social Services and Education Departments, of whom thirteen were from the administrative, clerical and typing side.

These radical changes apart, the administrative organisation has continued on the same basic lines, in so far as the three area offices have continued in being to deal with the day by day management of services under the direction of Area Medical Officers. Each area office serves a population of about 75,000. The area committees to which the Area Medical Officers were formerly responsible have been discontinued and all items which need committee or council approval are now submitted direct to the Health Committee for consideration. This streamlining of committee work was in conjunction with a greater and more clearly defined delegation of responsibility to me. Where the powers and responsibilities delegated to me related to day to day management of services they were further delegated to Area Medical Officers so that they might more efficiently discharge their duties. As a result, the Health Committee is able to concentrate its attention on matters of policy and principle, leaving the administrative detail to the officers. In the circumstances, the deci-

sion to disband the three area committees and the General Purposes and Joint Health and Education Sub-Committees has been fully justified.

Headquarters office continues to deal directly with matters relating to the ambulance and dental services and with policy, training and finance covering all the other aspects of the local authority health services and the school health service.

There is no doubt that the administration of services has been eased considerably and made more effective by the ready co-operation of the other branches of the health service and the voluntary organisations. There is excellent liaison with them and this is facilitated by cross representation on committees and groups.

The Local Maternity Liaison Committees in each of the two hospital management areas continue to be active with my deputy acting as secretary. I, or my deputy, are able to attend meetings of the Special Area Committee of the Regional Hospital Board, the West Cumberland Hospital Management Committee, the Garlands Medical Advisory Committee and the Cumberland Local Medical Committee. My deputy is a member of the Garlands Hospital Management Committee and the Chief Nursing Officer is a member of the East Cumberland Hospital Management Committee.

The Cumberland Executive Council and the Special Area Committee of the Regional Hospital Board are represented on the Health Committee, the Executive Council by two general practitioners.

The department is able to maintain close links with the environmental health services of the county, district councils by virtue of the fact that the Area Medical Officers are also medical officers of health to the district councils in their areas. Nominally, the Area Medical Officers spend half their time on district matters but this assessment was based on the assumption that each would have a deputy and would be able to give one-third of his time to district work. Unfortunately, there has always been difficulty in filling the posts of deputy and it is now virtually impossible to do so. No further efforts are, in fact, being made to fill those posts in view of impending health service re-organisation.

The only exception to the general rule of the Area Medical Officer acting as district medical officer of health is in the somewhat isolated rural district of Alston. There the general practitioner is also part time medical officer in department for the County Council and medical officer of health to the rural district council. As he also provides the medical care at the local hospital it is probably fair to say that Alston already has closely integrated health care.

Surprisingly, the recruitment of staff other than deputy area medical officers has eased considerably. Part time medical officers in department are available to the extent that for the first time for many years medical staff is almost up to full strength. Although it has proved impossible to retain dental auxiliaries for any length of time, it has been possible to get a full complement of dental officers. The response to advertising for chiropodists has been better than expected and the staffing of the speech therapy and orthoptic services has improved through the locally organised scholarship schemes. There has been no undue difficulty in the recruitment of nursing staff and a steady flow of part time staff has been assured by the return to nursing clubs. There is no lack of applicants for posts in the ambulance service.

Although the department has undergone a great deal of change in the last decade there is clearly much more reorganisation to come in the next few years. At the time of writing there is insufficient detail to indicate how the staff of the department will be affected but the aim, obviously, must be to organise and manage the existing service so that the transition to an integrated health service can be as smooth as possible. To this end the already close liaison with other branches of the health service must become even closer.

GENERAL STATISTICS AND SOCIAL CONDITIONS OF THE AREA

The Registrar General's mid-year estimate of population for the administrative county for 1971 is 219,270 — a drop of 3,770. There was a natural increase of 571 thus indicating a total outward migration of 4,341 persons. It should be pointed out, however, that this estimate is the first to be based on the 1971 preliminary census figures and does not bear strict comparison with earlier years which were based on the 1961 Census.

What is particularly significant though, is that the preliminary census figures confirm the fact which has been evident in the estimated figures, which is that there has been an outward migration from the county between the 1961 and 1971 census. The difference between the 1961 figure of 223,202 and the preliminary 1971 figure of 220,512, plus the natural increase during this period of 10,106 indicates a total outward migration of 12,796, representing a loss to the county of 3.5 persons per day or a total of 5.7% of the population as it was in 1961. It will be interesting to see the effects of this movement on the remaining age/sex structure of the county when the full breakdown of the 1971 census becomes available.

The following table shows the migration position by county district :

District Populations 1961 - 71

	Population 1961 Census	Population 1971 Preliminary Report	Population Increase	Population Decrease	Natural Increase	Natural Decrease	Migration Inward	Migration Outward
URBAN DISTRICTS								
Cockermouth U.D.	5,827	6,365	538		246		292	
Keswick U.D.	4,765	5,169	404			218	622	
Maryport U.D.	12,393	11,615		778	497			1,275
Penrith U.D.	10,927	11,299	372		345		27	
Whitehaven M.B.	27,566	26,720		846	1,884			2,730
Workington M.B.	29,552	28,414		1,138	1,566			2,704
RURAL DISTRICTS								
Alston R.D.	2,105	1,909		196		12		184
Border R.D.	29,644	29,252		392	418			810
Cockermouth R.D.	20,966	21,519	553		776			223
Ennerdale R.D.	30,859	31,006	147		2,487			2,340
Millom R.D.	15,094	14,070		1,024	770			1,794
Penrith R.D.	11,638	11,377		261	539			800
Wigton R.D.	21,866	21,797		69	778			847
A.C. Total	223,202	220,512	2,014	4,704	10,306	230	941	13,707

Net outward migration 1961 - 1971 — 12,796

Although the figures for the preliminary report for the 1971 census will be subject to minor modifications, the main trends as shown above will remain and it is particularly significant that the bulk of the outward migration has been from the industrial areas of West Cumberland where in Maryport U.D. — 10.5%, Whitehaven M.B. — 9.9%, Workington M.B. — 9.2%, Ennerdale R.D. — 7.5%, and Millom R.D. — 11.9% of the population of 1961 have left the area. There has been an increase in the less industrialised and more residential urban districts of Cockermouth, Keswick and Penrith, where the main increases have been at Cockermouth 5.0% and Keswick 13.0% of their 1961 population.

Vital Statistics

Births

There has been a slight rise in the number of births to 3,310 with a corresponding rise in the birth rate from 14.6 births per 1,000 total population in 1970 to 15.1 this year. I can attach no particular significance to this change.

Forty-one stillbirths have been recorded this year, giving the lowest ever number and also the lowest ever rate of 12.2 stillbirths per 1,000 live and stillbirths.

These encouraging facts have been offset by the high number of early neonatal deaths (43) which has affected the perinatal mortality rate to give 25.1 stillbirths and first week deaths per 1,000 live and stillbirths. The value of the perinatal mortality rate as a yardstick of maternity and child care is given greater credence in this area, when analysis of the rate over the past three years shows where, even though the stillbirth or early neonatal figures have varied, extreme fluctuations in one group have been offset by compensating factors in the other to give a steady average rate of 25.0.

The infant mortality rate of 19.6 deaths of children under one year old per 1,000 live births is the highest since 1966 and is mainly due to the high number of early neonatal deaths (43).

Maternal Mortality

One maternal death has occurred during 1971, but since this is at present in the process of being reported to the Registrar General it is not included in his statistical returns. This death therefore gives a rate of 0.3 deaths per 1,000 total live and stillbirths.

Mortality

Although the number of deaths occurring in the county has remained fairly constant for the fourth consecutive year, the crude death rate of 12.5 deaths per 1,000 total population has increased slightly and is one of the highest rates since 1963. This is due mainly to the drop in the population figure, and the increasing number of elderly.

There is no appreciable difference in the number of deaths from lung cancer or from bronchitis, although deaths from bronchitis have not continued the favourable downward trend indicated in 1970.

Deaths from heart disease have increased by 8.5% this year rising from 952 in 1970 to 1,033, the highest total since the revision of the International Classification of Diseases in 1968 made strict comparison possible.

The proportional mortality indicator showing the proportion of deaths at age fifty years and over to total deaths in the population remained constant at 90.1%.

% of Deaths over 50 years 1962 - 1971

Year	Cumberland	England and Wales
1962	87.7	89.2
1963	89.4	89.5
1964	89.8	89.0
1965	89.5	89.5
1966	90.4	89.8
1967	90.1	89.8
1968	89.9	90.4
1969	90.7	90.3
1970	90.1	90.5
1971	90.1	Not available

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County — 967,054
Rateable Value (April 1st, 1971) — £8,037,483
Estimated Product of 1p Rate (1971-72) — £77,312
Population (Census 1951) — 217,540
Population (Census 1961) — 223,202
Population (Census 1st Preliminary Report 1971) — 220,512
Population/1971 Mid-Year Estimate — 219,270

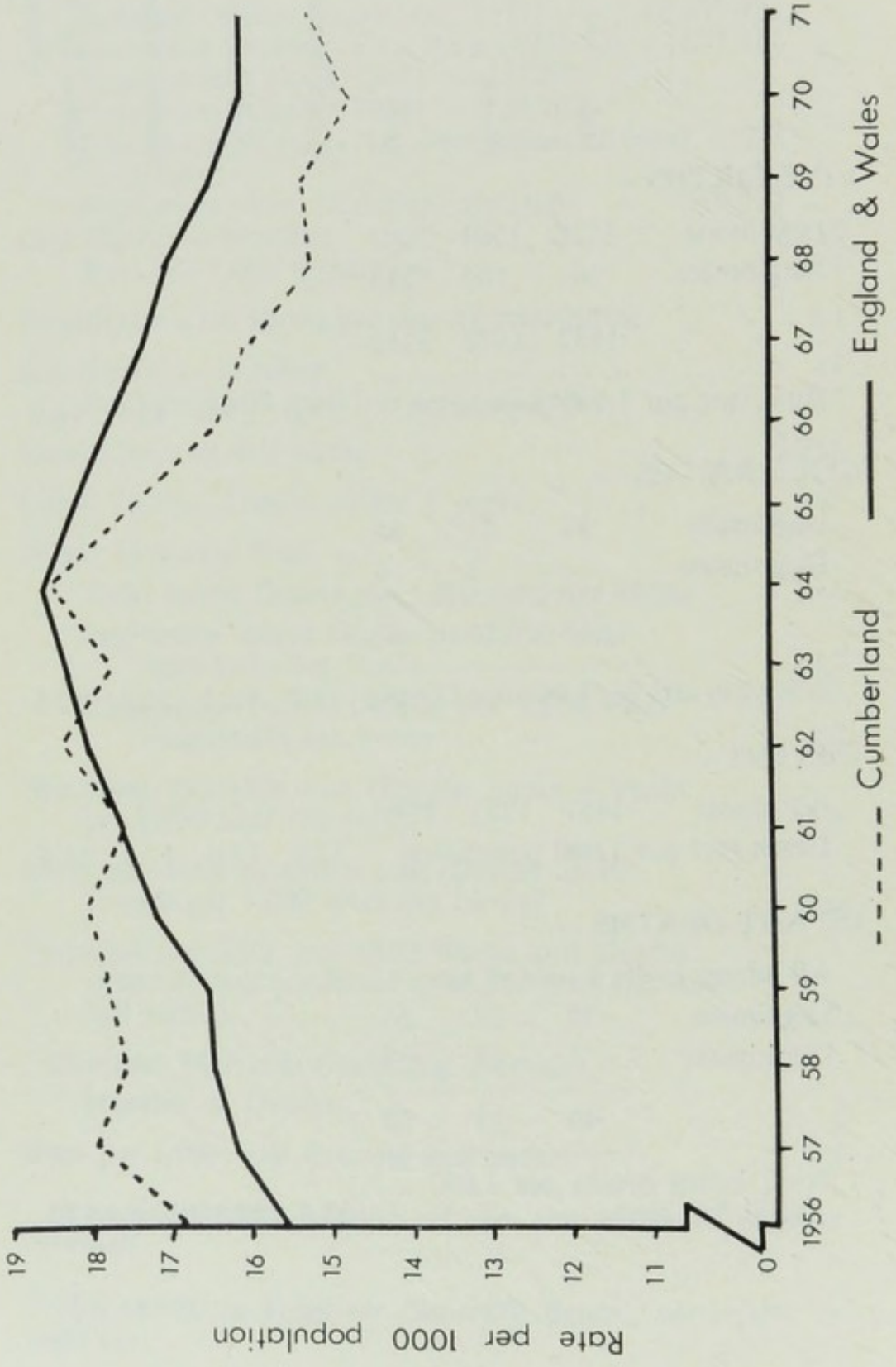
Live Births — Number	3,310
Rate per 1,000 population	15.1
Illegitimate Live Births per cent of total births	6.4
Still Births — Number	41
Rate per 1,000 total live and still births	12.2
Total Live and Still births	3,351
Infant Deaths (Deaths under 1 year)	65
Infant Mortality Rate —	
Total Infant Deaths per 1,000 total live births	19.6
Legitimate Infant Deaths per 1,000 total legitimate live births	19.7
Illegitimate Infant Deaths per 1,000 total illegitimate live births	18.8
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	15.4
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births)	13.0
Perinatal mortality rate (Still Births and Deaths under 1 week combined per 1,000 total live and still births)	25.1
* Maternal Mortality (including abortion) —	
Number of Deaths	1
Rate per 1,000 total live and still births	0.3

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

* Not shown in Registrar General's figures, see report on page 28.

	Male	Female	Total	Urban Districts	Rural Districts	Admin County	England and Wales (Provisional)
LIVE BIRTHS —							
Legitimate	1528	1569	3097				
Illegitimate	104	109	213				
	1632	1678	3310				
Birth rate per 1,000 population				15.8	14.6	15.1	16.0
STILL BIRTHS —							
Legitimate	17	21	38				
Illegitimate	—	3	3				
	17	24	41				
Still birth rate per 1,000 total births				14.7	10.4	12.2	12.5
DEATHS —							
All causes	1457	1282	2739				
Death rate per 1,000 population				12.3	12.6	12.5	11.6
INFANT DEATHS —							
All infants under 1 year of age —							
Legitimate	39	22	61				
Illegitimate	1	3	4				
	40	25	65				
Total infant deaths per 1,000 total live births				13.5	24.2	19.6	17.5

LIVE BIRTH RATE 1956 - 1971
Cumberland and England & Wales



BIRTHS, DEATHS, INFANT MORTALITY AND POPULATION IN THE YEAR 1971

DISTRICT	BIRTHS					DEATHS					INFANT MORTALITY										
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor	Stillbirths	Stillbirth Rate	Total Deaths	Deaths per 1,000 of population	Comparab lity 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
URBAN DISTRICTS :—																					
Cockermouth	98	4	102	16.1	1.00	1	9.7	62	9.8	1.08	1	1	—	1	1	9.8	9.8	9.8	2	19.4	6350
Keswick	46	2	48	10.0	1.15	—	—	58	12.0	.80	—	—	—	—	—	—	—	—	—	—	4820
Maryport	172	14	186	16.0	.96	4	21.1	180	15.4	1.12	5	5	—	4	4	26.9	21.5	21.5	8	42.1	11660
Penrith	143	12	155	13.5	1.00	5	31.2	157	13.7	.96	1	1	—	—	—	6.5	—	—	5	31.3	11470
Whitehaven	432	32	464	17.6	.93	3	6.4	295	11.2	1.18	6	6	—	5	4	12.9	10.8	8.6	7	15.0	26420
Workington	418	33	451	15.8	1.00	8	17.4	343	12.0	1.15	6	5	1	6	4	13.3	13.3	8.9	12	26.1	28540
Aggregate	1309	97	1406	15.8	.98	21	14.7	1095	12.3	1.10	19	18	1	16	13	13.5	11.4	9.2	34	23.8	89260
RURAL DISTRICTS :—																					
Alston	26	—	26	14.2	1.25	—	—	22	12.0	.82	—	—	—	—	—	—	—	—	—	—	1830
Border	382	22	404	13.8	1.12	3	7.4	429	14.7	.87	8	8	—	8	6	19.8	19.8	14.9	9	22.1	29210
Cockermouth	254	15	269	13.1	1.02	2	7.4	252	12.3	1.09	5	5	—	3	3	18.6	11.2	11.2	5	18.5	20540
Ennerdale	440	34	474	15.1	.99	4	8.4	340	10.8	1.24	13	10	3	8	8	27.4	16.9	16.9	12	25.1	31350
Millom	184	15	199	14.4	1.08	3	14.8	161	11.6	1.28	—	—	—	—	—	—	—	—	3	14.9	13860
Penrith	155	8	163	14.5	1.07	2	12.1	114	10.1	1.05	2	2	—	2	2	12.3	12.3	12.3	4	24.2	11240
Wigton	347	22	369	16.8	1.05	6	16.0	326	14.8	.92	18	18	—	14	11	48.8	37.9	29.8	17	45.3	21980
Aggregate	1788	116	1904	14.6	1.05	20	10.4	1644	12.6	1.04	46	43	3	35	30	24.2	18.4	15.8	50	26.0	130010
Admin. County	3097	213	3310	15.1	1.02	41	12.2	2739	12.5	1.06	65	61	4	51	43	19.6	15.4	13.0	84	25.1	219270

BIRTHS AND DEATHS STATISTICS

Year		Estimated mid-year population	Births: Number	Births: Rate	Deaths: Number	Deaths: Rate	Excess of births over deaths
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	...	224,650	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
1966	...	225,260	3,670	16.3	2,761	12.3	909
1967	...	225,100	3,601	16.0	2,552	11.3	1,049
1968	...	225,700	3,400	15.1	2,789	12.4	611
1969	...	224,440	3,401	15.2	2,757	12.3	644
1970	...	223,040	3,247	14.6	2,729	12.2	518
1971	...	219,270	3,310	15.1	2,739	12.5	571

PERINATAL DEATHS 1956 — 1971

Year	Stillbirths	Early Neo-natal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal Deaths per 1,000 total births	
				Cumberland	England & Wales	Cumberland	England & Wales
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	28.3
1965	80	37	117	20.0	15.8	29.3	26.9
1966	60	40	100	16.1	15.4	26.8	26.3
1967	70	38	108	19.1	14.8	29.4	25.4
1968	44	36	80	12.8	14.3	23.2	24.7
1969	47	39	86	13.6	13.2	24.9	23.4
1970	49	34	83	14.9	13.0	25.2	23.4
1971	41	43	84	12.2	12.5	25.1	22.3

MORTALITY TRENDS IN CUMBERLAND

Year	Under 1	1 —	5 —	15 —	25 —	45 —	65 —	75 +	Total
1941	197	252	61	100	256	628	665	804	2963
	6.6%	8.5%	2.1%	3.4%	8.6%	21.2%	22.5%	27.1%	Rate 13.8
1951	124	45	12	43	149	637	731	1086	2827
									Rate 13,2
1961	88	7	19	19	86	570	747	1189	2725
									Rate 12.3
1962	108	15	13	15	114	574	759	1125	2723
									Rate 12.1
1963	87	8	11	33	97	648	721	1208	2813
									Rate 12.5
1964	76	19	14	24	88	626	705	1118	2670
									Rate 11.8
1965	66	11	13	29	89	618	750	1130	2706
									Rate 12.0
1966	77	6	13	25	96	588	732	1224	2761
									Rate 12.3
1967	61	7	11	29	84	593	696	1071	2552
	2.4%	0.3%	0.4%	1.1%	3.3%	23.2%	27.3%	42.0%	Rate 11.3
1968	66	9	16	28	100	632	789	1149	2789
	2.4%	0.3%	0.6%	1.0%	3.6%	22.6%	28.3%	41.2%	Rate 12.4
1969	64	9	13	19	71	631	792	1158	2757
	2.3%	0.3%	0.5%	0.7%	2.6%	22.9%	28.7%	42.0%	Rate 12.3
1970	59	9	8	19	93	591	766	1182	2729
	2.2%	0.3%	0.3%	0.7%	3.4%	21.7%	28.1%	43.2%	Rate 12.2
1971	65	10	13	21	77	621	755	1177	2739
	2.4%	0.4%	0.5%	0.8%	2.7%	22.7%	27.5%	43.0%	Rate 12.5

CAUSES OF DEATH

	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.	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.
ALL CAUSES	2739	62	58	180	157	295	343	1095	22	429	252	340	161	114	326	1644
B4 Enteritis and other Diarrhoeal Diseases ...	3	—	—	—	1	—	—	1	—	—	—	1	—	—	1	2
B5 Tuberculosis of Respiratory System	3	—	—	—	—	2	—	2	—	1	—	—	—	—	—	1
B6(1) Late effects of Respiratory T.B.	6	—	—	1	—	1	1	3	—	2	—	—	—	—	1	3
B6(2) Other Tuberculosis	1	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1
B11 Meningococcal Infection	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1
B14 Measles	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1
B18 Other Infective and Parasitic Diseases ...	3	—	—	—	—	—	—	—	—	2	—	—	—	—	1	3
B19(1) Malignant Neoplasm, Buccal Cavity, etc.	2	1	—	1	—	—	—	2	—	—	—	—	—	—	—	—
B19(2) Malignant Neoplasm, Oesophagus ...	14	—	1	2	1	2	3	9	—	2	—	2	—	—	1	5
B19(3) Malignant Neoplasm, Stomach	62	3	1	8	4	6	11	33	2	4	7	4	4	—	8	29
B19(4) Malignant Neoplasm, Intestine	66	—	3	3	2	8	9	25	2	10	8	9	3	5	4	41
B19(5) Malignant Neoplasm, Larynx	2	—	—	—	—	—	—	—	—	—	1	1	—	—	—	2
B19(6) Malignant Neoplasm, Lung, Bronchus ...	107	4	—	9	5	9	22	49	—	19	12	13	7	3	4	58
B19(7) Malignant Neoplasm, Breast	34	—	—	2	2	4	6	14	—	4	4	3	6	—	3	20
B19(8) Malignant Neoplasm, Uterus	15	—	—	—	3	—	2	5	1	3	—	3	1	—	2	10
B19(9) Malignant Neoplasm, Prostate	13	—	—	1	2	1	—	4	—	3	—	—	2	1	3	9
B19(10) Leukaemia	23	1	—	1	5	1	—	8	—	4	1	3	3	—	4	15
B19(11) Other Malignant Neoplasms	134	3	3	9	12	13	19	59	1	17	13	21	8	5	10	75
B20 Benign and Unspecified Neoplasms	7	1	—	—	—	—	1	2	—	2	5	2	—	—	1	5
B21 Diabetes Mellitus	25	1	—	1	1	5	3	11	—	4	—	1	1	1	2	14
B22 Avitaminoses, etc.	4	—	—	—	—	—	2	2	—	—	—	2	—	—	—	2
B46(1) Other Endocrine etc. Diseases	3	—	—	—	—	—	1	1	—	1	—	—	1	—	—	2
B23 Anaemias	5	—	—	—	—	—	2	2	—	—	1	1	—	—	1	3
B46(2) Other Diseases of Blood, etc.	1	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1
B46(3) Mental Disorders	8	—	—	—	1	3	1	5	—	1	1	—	—	—	1	3
B24 Meningitis	2	—	—	—	—	—	1	1	—	—	—	1	—	—	—	1
B46(4) Multiple Sclerosis	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
B46(5) Other Diseases of Nervous System ...	18	—	—	4	1	1	1	7	—	3	—	3	2	1	2	11
B26 Chronic Rheumatic Heart Disease	28	—	1	1	—	2	5	9	—	8	2	—	1	1	7	19
B27 Hypertensive Disease	42	—	1	1	1	1	4	8	—	9	8	8	1	2	6	34
B28 Ischaemic Heart Disease	875	17	19	60	48	86	113	343	7	136	83	106	58	38	104	532
B29 Other forms of Heart Disease	116	4	9	5	8	12	6	44	3	14	10	15	6	11	13	72
B30 Cerebrovascular Disease	435	13	10	30	33	55	43	184	3	72	34	46	28	26	42	251
B46(6) Other Diseases of Circulatory System ...	132	4	1	8	6	15	15	49	—	26	9	13	5	6	24	83
B31 Influenza	7	—	—	1	—	2	1	4	—	—	—	3	—	—	—	3
B32 Pneumonia.	112	3	1	8	6	11	16	45	—	21	9	19	3	6	9	67
B33(1) Bronchitis and Emphysema	100	2	2	6	7	13	16	46	—	12	8	19	4	2	9	54
B33(2) Asthma	4	—	—	—	—	1	1	2	—	—	—	2	—	—	—	2
B46(7) Other Diseases of Respiratory System ...	34	—	2	4	1	4	2	13	1	3	5	3	3	—	6	21
B34 Peptic Ulcer	15	1	—	—	1	1	3	6	—	4	2	1	—	—	2	9
B36 Intestinal Obstruction and Hernia	4	—	—	1	—	—	1	2	—	—	—	—	—	—	2	2
B37 Cirrhosis of Liver	8	—	—	—	1	3	1	5	—	—	1	1	—	—	1	3
B46(8) Other Diseases of Digestive System ...	26	—	1	1	—	3	3	8	1	3	1	4	1	1	7	18
B38 Nephritis and Nephrosis	14	—	1	—	1	1	1	4	—	2	2	3	2	1	—	10
B39 Hyperplasia of Prostate	5	—	—	—	—	—	—	—	—	—	2	2	1	—	—	5
B46(9) Other Diseases, Genito-Urinary System ...	19	—	1	2	1	1	2	7	—	3	2	2	2	—	3	12
B46(10) Diseases of Skin, Subcutaneous Tissue ...	2	—	—	—	—	—	—	—	—	2	—	—	—	—	—	2
B46(11) Diseases of Musculo-Skeletal System ...	12	—	—	—	—	3	3	6	—	—	2	2	—	—	2	6
B42 Congenital Anomalies	24	1	—	—	—	3	2	6	—	4	5	4	—	1	4	18
B43 Birth Injury, Difficult Labour, etc.	14	—	—	1	—	—	3	4	—	3	1	3	—	—	3	10
B44 Other Causes of Perinatal Mortality ...	22	—	—	3	—	3	2	8	—	1	2	4	—	—	7	14
B45 Symptoms and Ill Defined Conditions ...	28	1	—	1	—	11	3	16	—	—	1	1	1	1	8	12
BE47 Motor Vehicle Accidents	27	1	1	1	—	1	1	5	—	9	3	2	2	2	4	22
BE48 All Other Accidents	52	1	—	4	2	7	9	23	—	9	3	7	2	—	8	29
BE49 Suicide and Self-Inflicted Injuries	15	—	—	—	1	—	1	2	—	5	—	—	3	—	5	13
BE50 All Other External Causes	3	—	—	—	—	—	1	1	—	—	2	—	—	—	—	2

CUMBERLAND COUNTY PERINATAL DEATHS

(locally compiled figures)

Analysis of Causes of Perinatal Deaths during 1971

Cause of Death	Stillbirths Premature	Stillbirths Full-time	Deaths during 1st Week	Total
Toxaemia	5	—	5	10
Ante Partum Haemorrhage	4	—	3	7
Placental Insufficiency	3	1	1	5
Complications of Rhesus Factor				
— Antibodies present	—	—	1	1
— Hydrops foetalis	—	2	2	4
Premature	2	—	15	17
Congenital Malformations	7	2	6	15
Tentorial Tear	—	1	1	2
Asphyxia —				
Prolapse of cord	—	—	—	—
Cord round neck (including true knot)	—	2	—	2
Intra Uterine	1	1	1	3
Atelactasis	1	—	5	6
Cerebral Haemorrhage	—	—	2	2
Malpresentation	2	—	—	2
Post Maturity	1	—	—	1
Maceration	1	2	—	3
Pneumonia with Septicaemia	—	—	1	1
No known cause	2	—	—	2
Total	29	11	43	83

Increase in premature deaths due to multiple births — 1 set of premature triplets and 2 sets of premature twins.

INFANT MORTALITY

Cause of Death	Age in Weeks Under 1	1 to 4	4 to 52	Total
Toxaemia	5	—	—	5
Ante Partum Haemorrhage	3	—	—	3
Placental Insufficiency	1	—	—	1
Complications of Rhesus Factor				
— Antibodies present	1	—	—	1
— Hydrops foetalis	2	—	—	2
Premature	15	1	—	16
Congenital Malformations	6	4	4	14
Tentorial Tear	1	—	—	1
Asphyxia	1	—	1	2
Atelectasis	5	—	—	5
Meningitis	—	2	2	4
Cerebral Haemorrhage	2	—	—	2
Pneumonia and Bronchitis	1	—	4	5
Accident	—	1	1	2
Other Causes	—	—	2	2
	43	8	14	65

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales for 1962 to 1971 are as follows :—

Year	Rates per 1,000 total live births Cumberland	England and Wales
1962	26.4	21.7
1963	22.0	21.1
1964	18.3	19.9
1965	16.9	19.0
1966	21.6	19.0
1967	16.9	18.3
1968	19.4	18.3
1969	18.8	18.1
1970	18.2	18.2
1971	19.6	17.5

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 employment 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 COMMUNITY NURSING SERVICES

The report 'Home from Hospital' by Muriel Skeet, S.R.N., for the Dan Mason Reseach Committee, has been very much in our thoughts this year in planning our objectives for better patient and family care.

Miss Skeet felt there was a need for urgent attention in the provision of two-way communications between hospital and local authorities. She felt there should be planned discharge schemes for patients, deployment of health visitors to provide routine counselling, and deployment of senior community staff to provide comprehensive supervision for patient care at home.

The Mayston report on a nursing management structure in the local authority nursing services has taken much time and energy in preparing an appropriate structure for the county.

There is clearly a need for a new sound management structure if the nursing service is to cope with the needs of a vastly changing scene.

During the past ten years, nurses who were working in isolation have been brought into teams with general practitioners for the continuing care of patients and their families, not only in the home but in the surgery.

The number of nursing staff has increased with the use of married part-time and relief staff. The communication problems this brings is not lessened with the separation of the health and welfare departments. Community nurses have become very much involved with training of young nurse students from the general and psychiatric hospitals.

We have also during the past two years co-operated with the two maternity units in providing the community programme for the year's integrated midwifery training. Apart from these commitments we have had our own in-service training courses and lectures in an effort to keep up to date with the advances in medical and nursing practice.

An ever increasing array of new equipment for use in patient care and health education also needs to be tried and assessed.

This needs communicating, co-ordinating and teaching skills. It also needs the effective control of a more complex system.

The management structure produced took all this into account as well as the age range and distribution of the population. It is very much hoped the structure will be implemented in 1972 and that a more effective system will ensue.

These two reports in fact complement each other — the management structure providing the trained staff to enable better communications and supervision so that effective care can become a reality.

During the year joint study days were held with the hospital and community staff to discuss nurse training, and Miss Skeet's report. In West Cumberland this resulted in the nursing officers setting out a pilot scheme enabling each patient, who was discharged from the hospital, to be visited at home by one of the community nurses. Unfortunately, our communications were faulty but after meeting representatives of the general practitioners it is hoped to get this scheme restarted early in 1972.

Discussions have taken place between the paediatric and geriatric departments in the hospital service and liaison schemes are under way.

Invitations were also extended to the community nursing officers to join meetings of the surgical division in East Cumberland, to discuss the early discharge of surgical patients and continuing nursing care of these patients at home, rather than their return to the ward or out patients. Nursing officers have also attended the medical division and the newly formed general practitioner division in the West Cumberland group.

Apart from these more formal meetings, hospital and community nursing staff have many informal discussions and have not only growing understanding of each other's problems but also an awareness of the importance of good communications if a continuity of patient care and family support is to be achieved.

I am sure the future is set fair for unified nursing service.

At a more local level, nursing teams working alongside their general practitioner colleagues are consolidating their team approach to community care.

I have joined with a small Sub-Committee of representatives from the Local Medical Committee, the Chief Nursing Officer to discuss matters of common interest including nurse training, the legal position of the nurse, procedures carried out in general practitioners' surgeries, and the question of first visits to patients who may actually have requested a visit from a doctor. These meetings have been of value, and it is hoped to put this Committee on a more formal and permanent basis.

There obviously is a need for a meeting place to discuss policy and matters of mutual concern for staff working in the group practice setting.

The provision of suitable premises remains a problem, and until health centres are established, housing under one roof medical and nursing staff along with other colleagues, and with proper clerical and technical help, the effective use of skills cannot be used to the full, for all round community health care.

Study days and staff lectures have continued throughout the year, covering a variety of clinical and social subjects, and occupational health visits to the British Steel Corporation, at Workington, and the Metal Box Company in Carlisle.

During the year all of our nurse education programmes have been circulated to the general and psychiatric hospitals. This has been very much a two-way affair, for not only have we been able to welcome hospital and occupational health colleagues to the community nurse lectures but we, in turn, have been able to take part in lecture programmes arranged by hospital nursing staff.

Training for nurse management has continued at first, middle and top management level. Senior nursing officers have continued to lecture to the first and middle management courses.

Community nursing staff have also given lectures and talks to other professional and voluntary groups.

We have again welcomed visitors from overseas who have studied our medical and nursing services. These included a senior matron from India, and doctors from Yugoslavia, the U.S.A. and Canada. Two Canadian medical students have also spent part of their elective period in Cumberland.

Mrs. Lancaster, Geriatric Liaison Officer, comments :—

"My work as the geriatric liaison officer is limited because of other commitments. However, I feel this is a very necessary and interesting post. The medico-social worker has a great deal of information regarding the patient, his family and environment, but even so it is sometimes necessary to make known to Dr. Chin, consultant geriatrician, and his staff, the health visitors' or district nurses' knowledge of the situation. After all, prior to admission of the patient, one of the community health teams has more than likely been in daily contact with the situation and all the difficulties involved, and most important, the mental and physical strain put on relatives caring for the patient.

Another important aspect of this post is to keep the geriatrician informed of the progress of the patients rehabilitated back into the community.

It has been rather difficult in arranging for my nursing colleagues to accompany me on the rounds as they too have many commitments. But I do hope that at least one member from each group practice will make a visit, so that we can all appreciate what Dr. Chin and his team are trying to do, that is wherever possible to rehabilitate the patient back into the community where he belongs. From this contact not only will we appreciate the work of our hospital colleagues, but they too will appreciate the nursing care, rehabilitation and occupational therapy that we in the community do under sometimes very difficult and adverse conditions."

'RETURN TO NURSING' CLUBS

The annual advertisement for the 'Return to Nursing' Clubs unfortunately coincided with the postal strike. However, 36 ex-nurses throughout the county made contact with the area nursing officers and were enrolled for the first time.

Members who joined in earlier years, continue to show great interest in the programme of lectures which is organised in Carlisle, Workington and Whitehaven. They have included

talks by general practitioners, community nursing and social work staff as well as more specialist clinical lectures given by consultant medical staff.

We have been grateful to our hospital colleagues for arranging visits to the intensive care and central sterile supplies units and for the accompanying talks by the sisters in charge. For nurses who have been away from professional work for some years these visits are especially valuable in demonstrating the highly technical development of nursing care, as well as sophisticated disposable equipment and new methods of sterilisation.

Members of the full and part-time nursing staff do attend for some sessions if they have a particular interest in the subject matter.

Table I

Total number enrolled	140
Average attendance at 'Return to Nursing' meetings	62
Number of nurses from the clubs employed during 1971	10
Number of nurses from the clubs employed since 1966	47

In addition to the above, three members have been employed by the Social Services Department, two as school matrons, and five for Marie Curie Day and Night Nursing Service.

It will be seen that there is a large number of trained nurses in the community who still wish to retain links with the profession. They remain a useful recruitment pool for the community and hospital services, either in full or part-time employment. We have also been pleased to call upon them in time of emergency.

The area nursing officers, who are responsible for the running of these clubs, are to be congratulated in helping to maintain the interest of members over the years.

Mrs. M. Dalton, clinic nurse, reports :—

"The 'Return to Nursing' Club formed by the Cumberland County Council Health Department, at the instigation of Dr. Leiper, several years ago as a means of interesting married nurses in the possibility of their return to their profession, has been an unqualified success.

From the first meeting, when approximately sixty nurses attended, the Club has prospered, numbers have fluctuated but interest has been maintained throughout.

The lectures, given by consultants in all branches of the medical profession, together with those given by local authority doctors, health visitors, nurses and social workers, have been of the utmost benefit and edification to those of us, who through many years absence from the nursing scene while raising our families, are out of touch with present day medication and procedures.

We all thoroughly enjoy the visits paid to old people's homes, ambulance stations, intensive care units and central sterile supplies departments, to mention but a few. These have given us a new insight into modern developments in community care.

To sound a personal note, I for one have availed myself of the opportunity presented by the purpose of the club, i.e. to enable married nurses to obtain posts suitable to their needs, and owe my present post as a clinic nurse to the club. This position gives me an absorbing interest outside my home and family which, together with the activities of the club, keep me abreast of nursing and medical developments, of which I would otherwise be unaware.

In my case, therefore, and I am sure in that of many others of my colleagues, the club has justified its existence and will be of equal benefit to many others similarly placed."

HOME AND SURGERY NURSING

There have been some interesting new trends in this service during the year. The service has been fully established by registered and enrolled nurses, the latter slowly taking their place in the general practitioner teams. In the future these nurses will, I am sure, be in a much more even proportion in the staffing establishment.

Five nursing auxiliaries are also members of the team and a help in releasing their registered and enrolled colleagues for patient care, needing their special skills. Here again it is hoped to increase the number of this grade of staff, in an effort to use trained staff more effectively.

Unsuitable premises remain an obstacle to the full deployment of nursing staff. Ideally one would wish for adequate treatment rooms to be available for nursing staff in health centre or general practitioner premises, for where they are available we see the true integration of the nursing and general practitioner services, joint consultations taking place, patient referred directly and swiftly to the nurses, and a lack of unnecessary visiting for all concerned.

Arrangements with Northumberland County Council were completed, and at the beginning of 1971 nurses from the general practitioner teams in the Brampton and Gilsland areas continued care of the patients and families over the borders, providing a continuity of care which had not been possible before with the group attachment nurses stopping care at the border.

The Scottish nurse from the Newcastleton practice continues to care for those patients living in Cumberland.

Cumberland nursing staff continues to care for families in the Patterdale area by arrangement with Westmorland County Council.

Table I

No. of visits of Cumberland nursing staff to Northumberland	282
No. of visits of Northumberland nursing staff to Cumberland	33
No. of visits by Roxburghshire nursing staff to Cumberland	624

Following discussions with the West Cumberland Hospital Management Group, district nurses in the Southern and Western areas have been supplied with equipment from the Central Sterile Supplies Unit. It is hoped to enlarge this to all areas when arrangement for an enlarged C.S.S.U. is available to the East Cumberland Hospital Group.

The increased provision of disposable items and pre-packed items has continued, and should be completed in 1972.

This does mean the community nursing service has available to it the same high standard of equipment and sterilisation as her counterpart in the hospital service. It also helps to provide a safer and more effective system of care.

Table II

Number of Patients nursed

	1967	1968	1969	1970	1971
Total No. of persons nursed	6,331	7,891	10,155	10,311	10,284
Aged under 5 years	361 (5%)	414 (5%)	579 (5%)	451 (5%)	469 (5%)
Aged over 65 years	3,516 (56%)	4,153 (53%)	4,637 (46%)	4,825 (46%)	4,457 (43%)
Other age groups	2,454 (38%)	3,324 (42%)	4,939 (49%)	5,035 (49%)	5,358 (52%)

It will be seen that the total number of patients nursed in 1971 was 27 less than in 1970, but considerably more than in previous years.

Table III

Number of Nursing visits

	1967	1968	1969	1970	1971
Over 65's visits	113,747	130,979	146,107	156,503	149,746
Other groups	58,668	46,381	51,483	51,204	47,785
Total No. of nursing visits	172,415	177,360	197,590	207,707	197,531

The most interesting fact is the trend to even greater involvement in the under 65 age group. This in part must be due to early discharge from hospital, but also the continuing integration of the nurse into general practice and all age groups in the general practice population.

Although the total number of patients over 65 has dropped, these patients have required more nursing visits, many have long term illnesses and many require terminal care. In 1971 the visits per patient over 65 years old was 33.6, and during 1970 the visits per patient was 32.4.

However, the decrease and not increase in the number of over 65 year olds, despite our increasing aged population, does need some comment. There is no doubt the older population do seem to be healthier than their predecessors. Better nutrition, more suitable housing with adequate heating systems must go some way to achieving better health.

Medical science has also played its part in the use of new drugs — antibiotics, drugs for hypertensive conditions, vaccines against influenza, and many more which either prevent disease or enable patients to be independent for a much longer span of time than was possible in the past. It also means patients are able to be more mobile and able to attend for treatments in surgery premises.

Table IV

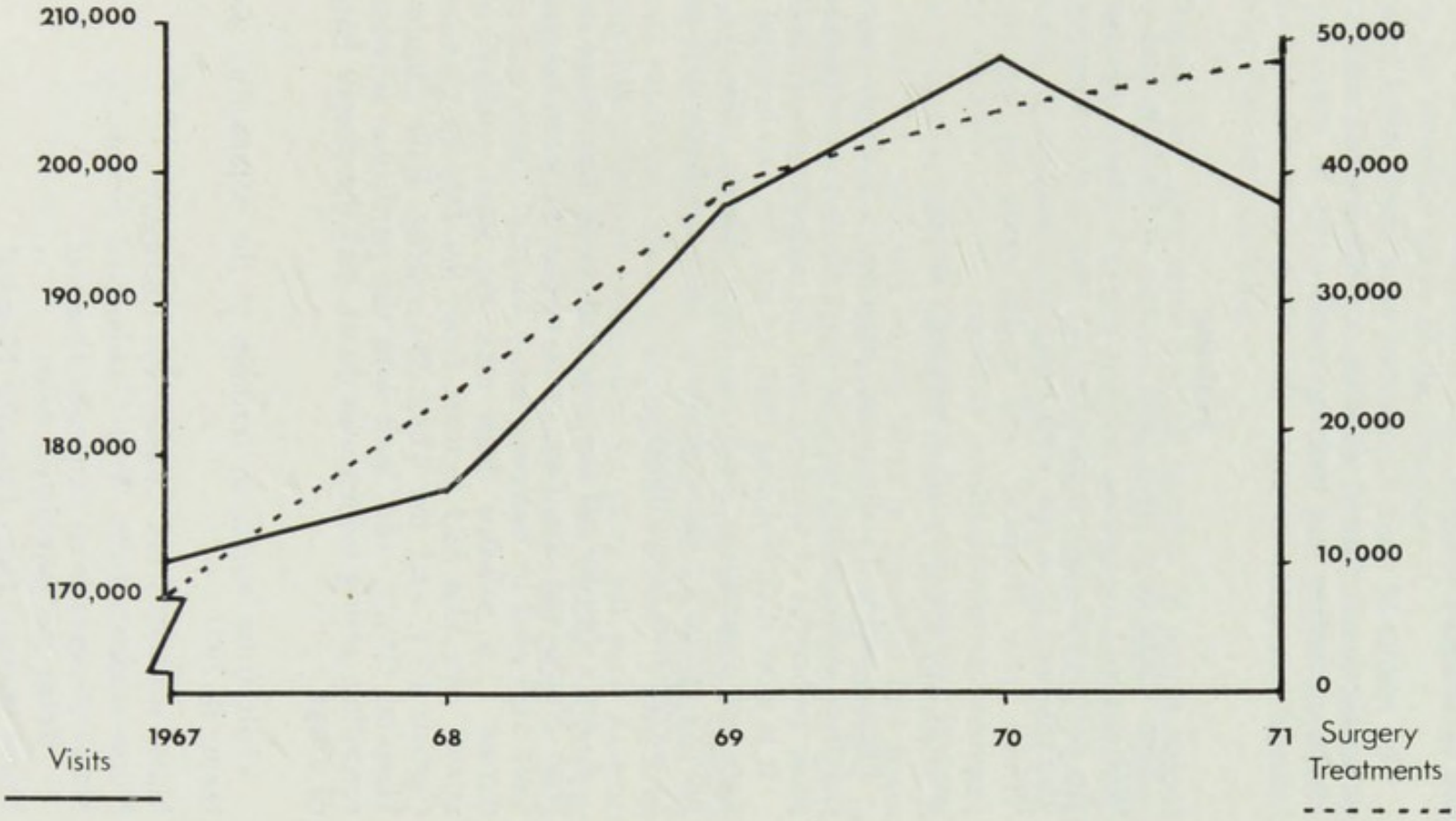
Surgery Treatments

1967	1968	1969	1970	1971
8,007	23,935	37,639	44,721	47,799

Surgery treatments continue to rise but not nearly as steeply as in previous years, a saturation point may have been reached. Wherever adequate premises are available, nurses are using them to carry out treatments in the surgery and, as I have stated before, unless other premises do become available it is impossible to start new surgery sessions.

During the year discussions were held with each member of the district nursing staff to try and ascertain the quality of the team approach to care, the way nursing skills were being used, or misused, the need for an on call system, the records kept, and the nurses' opinion about extra staffing needs and services for patients nursed at home, or in the surgery. We were also interested to know if the nurse training needs were being met.

CUMBERLAND — SURGERY TREATMENTS AND VISITS 1967 - 1971



Another important question was to see if the nurses were operating within a legal framework. In some instances, this was not so and they were advised particularly with regard to the carrying of drugs.

The results of these discussions were most useful in helping us to carry out future planning for the service, and to look afresh at staffing and training needs.

Training

Two study days were held — one in Carlisle and one in Whitehaven, to discuss modern nurse training schemes and the part community nurses had to play in this training. This was followed by a talk with hospital colleagues on the report 'Home from Hospital', and a discussion on the ways to improve communications between nurses working in the general, psychiatric and community fields.

Fifteen senior district nurses attended a five-day course for practical work instructors, to help them to understand the basic principles of teaching and the assessment of students.

It is most disappointing that, as yet, the two hospital management committees have not been able to offer the community option to nurse students, when we have staff trained to accept this commitment.

A study day for all the practical work instructors entitled 'The Nurse and the Law' was very well attended and we were also glad to welcome many hospital sisters and charge nurses. A solicitor dealt with the legal position of the nurse. We also had lectures from the Deputy Coroner for Carlisle City, and the Chief Pharmacist, East Cumberland Hospital Group, who dealt with the particular problems of recording, giving evidence in court, and the proper handling of drugs.

Visits from nurses in training to the community nursing teams in 1971 :—

Nurse students from Cumberland Infirmary	31
Nurse students from West Cumberland Hospital	44
Nurse students from Garlands Hospital (from the psychiatric field)	13
Nurse students from Dovenby Hospital (from the mental subnormality field)	5

Marie Curie Memorial Foundation

The Marie Curie Foundation funds are only used for patients suffering from cancer and, in particular, those who are in the terminal stage of the illnesses.

In 1971 twelve patients and their families were helped by the provision of extra nursing care and night attendants. Eleven patients were given help towards extra nourishment, bedding, fuel and clothing.

Although this may seem a small number of people helped, the cost in fact came to several hundreds of pounds. During the year the Marie Curie Foundation, which previously had reimbursed the full cost, asked if the County Council could give them some financial aid and it was agreed to contribute 25 per cent of the cost.

The actual number of patients dying at home of cancer in 1971 was 215 and has varied little in the past few years. This does indicate that the community nursing services, in partnership with relatives and friends, are managing to carry the vast amount of care.

The problem of terminal care does raise the wider issue of whether there should be a similar service available for patients other than those suffering from cancer. There is no comparable voluntary association to cater for such patients whose needs may be equally great. The Health Committee has agreed to £250 being set aside for extra help in such cases.

MIDWIFERY

The domiciliary midwifery service has continued against the now familiar background of a high hospital confinement rate in which the provision of a safe and economic domiciliary midwifery service becomes increasingly difficult.

This year has seen a further drop in the total number of babies born at home and only 3.5 per cent of mothers in the county were confined outside the hospital setting. This in turn means that domiciliary midwives are using their skills even less.

Table I

Number of deliveries conducted by domiciliary midwives during 1971 :—

8 district nurse/midwives	Nil
4 district nurse/midwives	1
6 district nurse/midwives	2
4 district nurse/midwives	3
3 district nurse/midwives	4
1 district nurse/midwife	5
2 district nurse/midwives	6
1 district nurse/midwife	7
3 district nurse/midwives	8
1 district nurse/midwife	11
1 district nurse/midwife	12

Many of the mothers who were delivered at home were at risk by reason of age, parity, or abnormal obstetric history. Out of a total of 117 births at home, 46 mothers came into this 'at risk' category. The position is one of continuing concern to the midwifery staff and the nursing officers.

CUMBERLAND — TOTAL BIRTHS (Live & Still)
CONFINEMENT PERCENTAGES 1966 - 1971

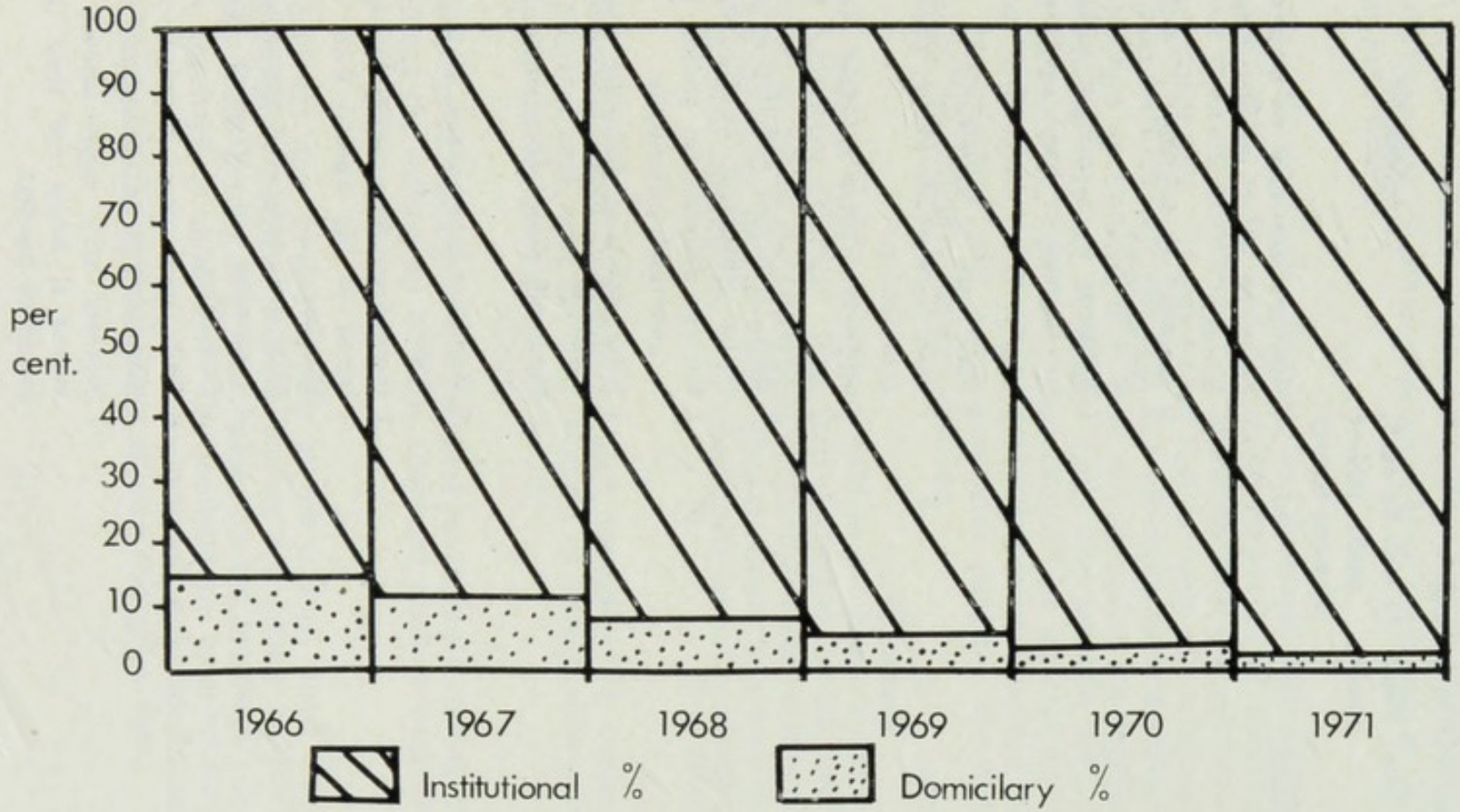


Table II

Mothers whose babies were confined at home, or before arrival at hospital.

Area	Total number	At risk by age*, parity and/or obstetric history	Complications
South	38	10	1 Mother transferred to hospital because of delay in first stage of labour.
			2 Admitted to hospital — delay in second stage.
			1 Stillbirth to a mother unbooked for hospital or home confinement.
			3 BBA †
			1 Baby born in ambulance.
West	20 (including 4 agency)	8	1 Baby born which was an abnormal presentation.
			1 Stillbirth (BBA hospital booked case).
			2 BBA (1 Mother admitted to hospital for delivery of the third stage).
North	59	28	1 Forceps delivery (at home). Baby in abnormal presentation.
			1 Baby delivered following malpresentation.
			1 Perinatal death (Premature Baby 29/52).
			1 Mother haemorrhaged after third stage.
			1 Premature Baby (30/52) transferred to the Special Care Unit Hospital.
			1 Baby with congenital abnormalities transferred to Hospital Special Care Unit.
			4 BBA
			1 Baby born in an ambulance.
			2 Mothers very rapid labours delivered at home and then transferred to hospital.
	117	46	

*Age — over 35 years or under 18 years.

Parity — primipara or fourth and subsequent pregnancy.

† BBA — 'Born before attendance' of midwife or medical practitioner.

In 1970 there were 159 deliveries at home, 87 of which were at risk by the same criteria.

Early in the year a questionnaire was discussed with all the midwifery staff to try and determine standards of practice and the working involvement of midwives with general practitioner colleagues. It was found that in some areas regular antenatal sessions were not held and the much needed service of following up mothers who were not attending for regular examinations, was not in being. Only one midwife held a clinic on her own, eight held joint clinics with general practitioner colleagues, and fifteen midwives were involved in joint consultations with some antenatal patients, the rest attending the ordinary surgery sessions.

This survey did demonstrate a need to produce a code of good midwifery practice. The final document, having been approved by all of the consultant obstetricians and discussed and agreed at the two maternity liaison committees, and the local medical committee, was distributed to all midwifery staff.

Discussions were held with all staff, including the subject of antenatal care, and the film 'Margin of Safety' shown to groups of nurses throughout the county.

Talks are still going on with general practitioner colleagues regarding the setting up of joint antenatal sessions with the midwives in the nursing team.

There are now twelve centres in the county, apart from three hospital centres, holding classes for young mothers, usually those having their first babies on the psychoprophylaxis approach to child birth. The mothers are most enthusiastic about the help they get in understanding the mechanics of labour, and the subsequent assistance this gives them.

In some areas the accommodation is inadequate and the nursing staff are operating under some difficulties with lack of space, the clinic rooms being too small for a class of mothers to carry out these special exercises on mattresses, which are a necessary part of the equipment.

Table III

Total number of new mothers seen by the midwife at antenatal sessions held in G.P. surgeries	1105
Number of these mothers booking after the fourth month of pregnancy	456
Number of new mothers attending classes (216 booked for hospital confinement 5 booked for home confinement)	221
Total attendances	1680

With the fall in domiciliary confinements the number of antenatal visits to mothers at home has fallen, as has the number of postnatal visits to mothers delivered at home. However, to counterbalance this work, there is an increase in the number of mothers discharged from hospital before the tenth day who have been cared for by the domiciliary midwives.

Table IV

Midwifery Visits

Year	Antenatal visits paid to mothers at home (domiciliary and hospital bookings)	Postnatal visits to mothers delivered at home
1969	5,346	4,492
1970	5,853	3,253
1971	5,406	2,404

Table V

Early Discharges of Mothers from Hospitals

Year	No. of Mothers discharged within 48 hours	No. of Mothers discharged 2nd — 8th day	Total number of visits to Mothers discharged before 10th day
1969	146	1,117	4,630
1970	162	1,028	4,361
1971	190	1,186	5,553

The Agency arrangements with Workington Hospital whereby hospital midwives deliver mothers at home has continued but only four babies have been delivered by them in 1971. Seven mothers were actually booked for home confinement by this Agency, three of whom were later referred to and delivered in hospital for obstetric reasons. In 1969 there were 12 home bookings, five of which were delivered in hospital, and in 1970 there were 13 home bookings four of which were delivered in hospital. It is interesting that this agency commitment is also a declining one.

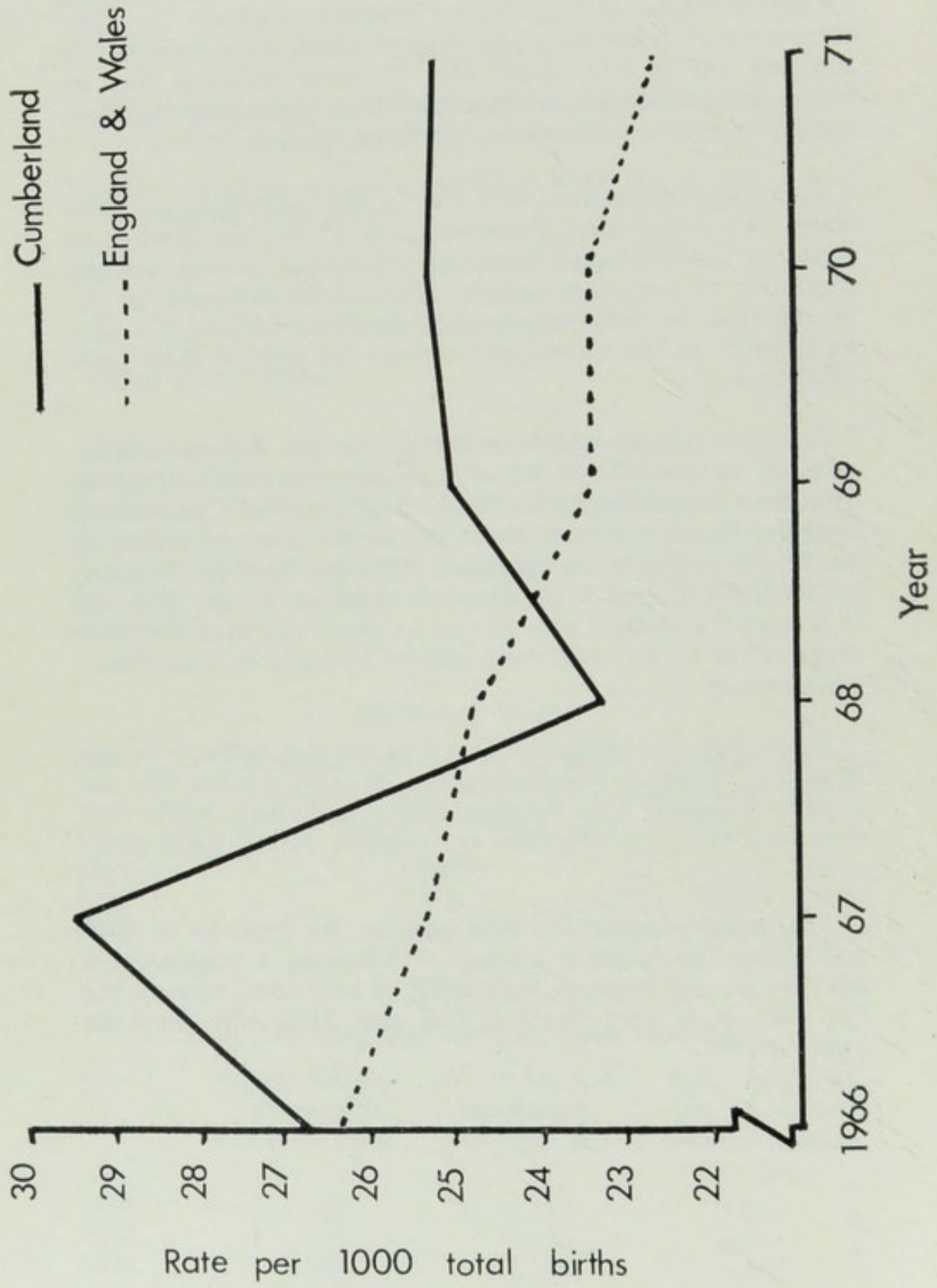
Following discussions with one of the consultant obstetricians, two community midwives now attend the consultant clinic in the Maryport Hospital. This has provided some continuity of care for mothers who will be delivered in the Workington, or West Cumberland Maternity Units, but may well return to the community service for part of their postnatal care.

During the year nurse midwives in the Southern area, involved in home deliveries were issued with maternity packs from the Central Sterile Supply Unit of the West Cumberland Hospital Group. (These packs are identical to those used in the labour rooms in the hospital). After use they are returned to the C.S.S.U. and a sterile pack re-issued to the midwife. It is hoped to extend this system to nurse midwives in other areas of the county who may still be involved in domiciliary confinements.

There was one maternal death as yet not counted in the Registrar General's statistics, see p 28. This mother was not acutally involved with the domiciliary midwifery service but died following an operation in hospital during early pregnancy.

The perinatal mortality rate remains the same as in 1970 and above the national average. Following a concentrated effort to try and improve the quality of ante natal care during the year, it is very much hoped that 1972 will show an improvement.

PERINATAL MORTALITY RATE — CUMBERLAND AND ENGLAND & WALES 1966 - 1971



Midwifery Training

The training programmes continue for the integrated midwifery schemes, taking place at the City Maternity Hospital, Carlisle, and the West Cumberland Hospital, Whitehaven.

The students spend twelve weeks in the community, working with the community nursing staff in the general practitioner teams. They have all expressed their appreciation of this experience, saying it gives them much greater understanding of the mothers they are caring for in the hospital and a sympathy for the many problems which beset some families.

Weekly study days are held, alternately at the two hospitals, the course ending with a written paper and general assessment of the course. Each student also writes a family case history, which is presented for part of the final assessment mark.

There were 26 midwives trained in the county during 1971.

Two further study days were held to teach the psychoprophylaxis methods of child birth.

Miss B. Cox, the Central Midwives Board Nursing Inspector, visited the East Cumberland Hospital Group, in November, and also visited and discussed problems with the teaching midwives. She visited one group practice. Miss Cox expressed satisfaction at the community nursing programme.

Six midwives attended the statutory refresher courses in 1971.

Number of midwives on the Roll in 1971 :—

In the community service	36
In the hospital service	64
	100

Miss J. Byatt, who was non-medical supervisor of midwives, and did so much producing the code of good practice, and in the teaching of student midwives, left to become Chief Nursing Officer to the London Borough of Hillingdon.

Miss J. Reid, Southern Area Nursing Officer, took over the task of non-medical supervisor of midwives in August, 1971.

Local Maternity Liaison Committees

Both East and West Cumberland Local Maternity Liaison Committees met twice during the year and considered a wide range of topics affecting the maternity services. The most fundamental of these from the local authority point of view was the subject of the future management of the remaining very small number of domiciliary confinements. This was the concern of both East and West Cumberland Committees and there was evidence of an increasingly wide acceptance of the need to encourage all mothers to have their actual confinement in hospital and for the remaining few home confinements to be dealt with from a hospital based midwifery service as far as the midwife's services are concerned. Subsequent to the meetings of the West Cumberland Committee joint talks have been held by the Senior Consultant Obstetrician and the County Medical Officer with groups of general practitioners.

Other subjects under regular discussion are family planning services; statistics, particularly relating to perinatal deaths; and detailed matter of more local concern in any one particular area such as the exact pattern of antenatal care of hospital booked cases; planned 48 hour discharge; agency schemes; and in one instance, a communication problem related to Rh. iso-immunisation investigations. Reference has already been made above to the consideration by these committees of the code of practice for domiciliary midwives.

The Local Maternity Liaison Commitees undoubtedly serve a very useful purpose in bringing together regularly all branches of the health service concerned in midwifery matters. They will, in my view, prove to have been the historical forerunners of the patient-group approach to integrated health service management in the future Area Health Authorities.

Congenital Malformations

The number of babies with congenital malformations observed at birth in 1971 was 45 involving a total of 51 malformations. Of these babies, 38 were live births and 7 were still births. The number of cases in 1970 was 47, and in 1969, 49.

Since 1964 the total number of cases notified is 441.

The table below shows the analysis of the malformations during 1971.

	Males		Females		Total	Total
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Central Nervous System	5	—	5	4	10	4
Eye, ear, etc.	—	—	—	—	—	—
Alimentary System	2	—	3	—	5	—
Heart & great vessels	—	—	—	—	—	—
Respiratory system	—	—	—	—	—	—
Uro-genital system	8	—	—	—	8	—
Limbs	7	—	6	1	13	1
Other skeletal	—	—	—	—	—	—
Other systems	—	—	1	—	1	—
Mongolism	—	1	1	1	1	2
Other malformations	—	—	—	—	—	—
Totals	22	1	16	6	38	7

As in previous years the commonest malformations were those of the limbs, mainly cases of talipes, though the figures include one case where the left hand was missing and another where hand and forearm were missing. Abnormalities of the central nervous system include 8 cases of spina bifida and 5 of anencephaly.

A separate analysis of the 6 babies born with multiple malformations is set out below.

Stillbirths	Deaths
1. Abnormality of both arms and micrognathia.	4. Spina bifida and talipes.
2. Anencephaly, exomphalos, hare lip and cleft palate.	5. Spina bifida and hydrocephalus.
3. Anencephaly, myelomeningocole.	6. Cleft palate and right testicle not palpable.

It will be recalled that this arrangement for notification of congenital malformations was an 'early warning system' following the thalidomide tragedy. As such it is clearly valuable even if limited to those deformities noticeable at birth, and it is gratifying to see the numbers of notifications remaining steady.

Thanks for this are due especially to those midwives in hospital obstetric departments who notify births and are careful to add information on congenital malformations.

PREMATURE BIRTHS

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					
	Total Births	Died			Total Births	Died			Total Births	Died				
		Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days		Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days		Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	In Hospital	At Hospital 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	13	6	4	—	1	1	—	—	—	—	—	—	3	—
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	22	10	1	—	—	—	—	—	1	—	—	—	10	1
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	37	1	4	—	—	—	—	—	1	—	—	—	9	1
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	50	3	—	—	1	—	—	—	—	—	—	—	4	—
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	84	—	—	—	4	—	—	—	—	—	—	—	1	—
6. Total	206	20	9	—	6	1	—	—	2	—	—	—	27	2

HEALTH VISITING

With the return of five new health visitors from training, and an easing of recruitment, a full establishment has been maintained throughout the year. There are 40 full-time health visitors on the staff.

At the inception of the new Social Services Department, in April 1971, there was some discussion about the rôle of the health visitor. These discussions did, I think, help to clarify the separate rôles of the social worker and the health visitor, and also to indicate areas where there is bound to be some overlapping. The health visitor with her nursing background and her specialist training is committed to a wide surveillance of child development and to counselling and supporting young parents. She is committed to the prevention of disease, advising on the right nutrition for the family members, and the persuasion of parents to see that the necessary immunising programmes are carried out on their young children. Because of their close working with their general practitioner colleagues, their involvement with the practice population, and their knowledge of the 'at risk' groups, the health visitors are also the primary case finders, referring when necessary patients or clients to the appropriate medical or social agency. They support and advise families with handicaps or those who are socially inadequate, usually in close association with social work colleagues, while health education of all age groups remains another of the health visitor's main functions.

Again, in the field of health care of the elderly at home, the health visitor fulfils a vital rôle as a key member of the family health team. Insofar as screening has been possible on a group practice basis in certain areas at age 75 the health visitor has worked closely with the doctors and home nurses in this scheme. She also works in collaboration with social work colleagues in the day by day health and welfare care of the elderly in the practice.

Table of Cases and Visits for 1971

	Cases	Visits
Babies born in 1971	3,419	15,006
Babies born in 1970	3,435	11,211
Babies born in the years 1966-1969	5,646	13,867
Persons aged 65 and over	4,278	19,835
Mentally disordered persons	137	682
Persons discharged from hospital	100	—
Other cases	3,412	7,516
On account of tuberculosis	118	202
On account of other infectious diseases	175	279
Totals	20,720	68,598

These figures indicate a generally upward movement in volume of work and with the increase in staff the caseloads have been more manageable. More visits were made to very young babies (15,006 compared with 13,693 in 1970) where a set pattern of physical and mental assessment is now in being, backed up by special clinic sessions.

Visits to the over 65 year olds have increased, many for special screening tests or assessment and observation.

Visits to persons in the other age groups have increased also and this is again an indication of the health visitor involvement — along with her district nurse colleagues — with a wider spectrum of the total population.

Total Number of Visits

	1968	1969	1970	1971
Visits to babies and children under 5 years	49,801	44,836	40,599	40,084
Visits to other age groups	4,148	5,829	7,181	7,516
Visits to patients over 65 years	17,001	17,925	18,146	19,835
Visits to patients with mental disease	784	885	810	682

The pattern of the work in general practitioners' surgeries shows changes as an increasing proportion of the immunising of children is now carried out in the surgery, with appointments arranged from the computer programme. Health visitors do attend many of these sessions and are increasingly involved in the organisation and running of child health sessions in the general practitioners' premises, when the accommodation permits.

Number of cervical smears taken by health visitors at G.P. surgeries	1,075
Number of vaccinations and immunisations at G.P. surgeries	8,024
Number of patients seen for other reasons at G.P. surgeries health and social advice, etc..	5,276
Number of child health sessions held with G.P. in surgeries	1,119

876 cervical smears were also taken by the health visitors in local authority clinics.

Liaison schemes with the hospital departments have continued, the western and southern area nursing officers each visiting the consultant geriatricians each week and taking part in case conferences.

In the northern area a liaison scheme was started this year whereby one of the group advisers visits the geriatric wards each week, and reports to the geriatrician on the home conditions of patients newly admitted. She has been able to keep her colleagues informed in the field regarding the progress of patients and any need for special arrangements to be made on discharge. The scheme is still in its infancy but already there are much improved communications between the hospital and community staff to the advantage of everyone.

At the end of the year a small liaison scheme was also started with the paediatric department of the East Cumberland group, but this is still in embryo and the results will be clearer in 1972.

General communications between hospital and community staff are improving all the time, and the need for continuity of care is well appreciated by all. Last year 2,478 visits were made to hospital to visit patients.

Training

Three health visitor scholarships were awarded in 1971, the candidates being admitted to training schools in the Autumn. One of the male district nurses was accepted into the school at Aberdeen — one of the few to accept male nurses for health visitor training.

A special study day was held for health visitors at the Technical College in Carlisle. The first half dealt with marriage guidance, and we were glad to welcome three marriage guidance counsellors to help with the discussions and guide us in an understanding of the many matrimonial problems which are a part of any health visitor's work load. In the afternoon the consultant paediatrician gave lectures on the causes of congenital abnormalities, and modern methods of neonatal surgery.

At the end of the year we had a visit of the team from the Audiology Department of Manchester University, to revise with all health visiting staff the techniques of screening for deafness in young children. This was a marathon exercise, but a much needed one. We await their official report to aid us in a possible replanning of this vital aspect of screening.

The five health visitor students all returned for their supervised practice before finally qualifying.

In addition, eleven students from Bolton, Manchester and Liverpool were provided with experience in working with group practitioner teams and health visiting practice in a rural setting.

Health visitors have been involved in the continuing education of nurses from other specialities, i.e. nurses from the general and psychiatric fields, and students from the integrated midwifery courses.

Nursing officers have taken part in teaching activities in the various hospitals, on community nursing topics, and lectures have been given to the nurse management courses held at the two technical colleges.

HEALTH EDUCATION

Teaching for healthy living is an integral part of the health visitor's task. Much of this work is carried out in visits to the homes, in an informal manner, and with no special aids other than the skill to put the subject over in a meaningful way to a particular patient or family. Sometimes it is useful to back this up with simple written facts and the health visitors do draw on the stock of special leaflets available covering every subject from taking children on holiday to menus for old people, and the health hazards of smoking. More formal sessions have been held in clinics, surgeries and, of course, in schools.

The clinic sessions have tended to specialise on antenatal care, on mothercraft and on the needs of young babies. Films and discussions have also been focussed on the needs of toddlers. Simple hygiene talks have been given to all age groups, and a very important aspect of healthy living, suitable nutrition, has been featured. In this day and age, the main problems are caused by too much food. Health visitors are still holding special sessions for obese people and supporting them through the painful slimming process.

Smoking and health remains a crucial subject, and is included whenever possible in health education sessions. 'Converts' have helped by spreading literature and stickers for cars. To be effective in this day of very sophisticated advertising, health education material must be of the highest standard. During the year we have experienced some difficulty in obtaining posters and other material which will effectively relate to a particular audience. Obviously much research still needs to be done on the most effective methods of tackling some of the more difficult problems in our community today, notably, the smoking habit and the excessive use of drugs and alcohol. Health visitors have also held discussions on these very problems.

Marriage and family planning have become part of a planned programme of education; perhaps most important of all, helping people to see the need for responsible relationships, not only in marriage but in every day life. The spread of the sexually transmitted diseases shows an irresponsible attitude to sexual relationships. These problems among many others have been tackled by the health visitors during the year.

Total sessions during 1971 were as follows :—

Schools	211
Clinics	51
Antenatal classes	305
Mothers' Clubs	6
Other Organisations	56
Surgeries	60
Total sessions :	689
Total attendances :	9,237

One of the most important fields of activity in health education is, of course, in the schools. Here, in addition to a substantial if concealed content of 'health' in education generally, much direct effort is expended.

With a full establishment of health visitors and a stable staff of ten school nurses, health education sessions have increased in the schools and some new and interesting programmes started for boys and girls in all the age groups. This is most encouraging and is obviously the way ahead in an area where there is a captive audience which, with good teaching technique and up-to-date health education material,

can be stimulated to question their responsibility, not only for their own health care but the responsibility they have to their friends at school or in the community. This is particularly important when we are thinking of the dangers, not only to physical health, but also mental health and the havoc which occurs through excess use of tobacco, drugs and alcohol. Havoc may also be caused through irresponsible sexual relationships and the resulting rise of venereal diseases in our society.

Health visitors have accepted the challenge and in planning with school staff have included lectures and discussions on the problems of excess. In some instances the medical officers have joined in these teaching sessions with the boys and girls.

With the raising of the school leaving age it is hoped that many more programmes will be jointly planned between health department and school staff on personal relationships, the responsibility of parenthood and the actual care of babies and young children.

Miss Simpson reports on her work at Caldew School, Dalston :—

"For four years I have been giving health education talks in Caldew School, Dalston. These talks are given to fifteen-year old girls, who are in their final year at the school. The first three years we worked systematically through a programme, including talks on human reproduction, normal pregnancy and childbirth, care of the baby, smoking, drugs and alcohol, venereal disease, and in conjunction with these we used films, filmstrips, leaflets and posters. In 1970 the form teacher wrote to the Headquarters of the National Association of Maternal and Child Welfare regarding information of their basic course on the care of children, and certificate. This course includes theoretical and practical work, and there is a written and oral examination. The girls showed a greater interest in the talks and practical work, making notes for folders. After the examination the Association did ask for some of the folders to be sent to Headquarters, and out of a number of eleven pupils there was only one who failed to get the Certificate. We are now doing the course again this year, but we also continue with the other general subjects, especially smoking and drugs."

Mrs. Messenger also reports on an interesting programme for older girls :—

"I am at the present time undertaking with a group of 14/15 year old girl pupils at Netherhall Comprehensive School a programme of health education. This programme was planned with the Senior Mistress and the teacher in charge of the Home and Economics Department. The group is not particularly academic and many leave school at Easter. The programme devised has been planned to last the school term and involves one afternoon weekly.

Later in the year, it is planned to give a similar course to the more academic girls, and I have been asked to talk to the older boys. There may be a need to change and add to the programme but this is a matter I must discuss further with the teachers before making any alterations to the planned programme.

Recently I completed a three-session course with eleven girls who are doing the Duke of Edinburgh Bronze Award in Community Service in relation to the elderly.

In October I was asked to participate in a Design for Living weekend course at Derwent School. This involved two sessions — Child Care and the Health Service. Those taking part were doing the Duke of Edinburgh Gold Award."

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."

CARE OF MOTHERS AND YOUNG CHILDREN

I drew attention last year to the transfer to the Social Services Department of certain aspects of care of mothers and young children which were previously with the Health Department. I am glad to say this transfer of responsibility was effected smoothly during 1971 and the staff of both departments have worked well together to provide continuity of care. There remains with the Health Department those aspects of this work which are more directly associated with health rather than social support.

Advances during the year will be noted in the dental service in connection with the extension of the fluoridation of water supplies to South Cumberland and the commencement of the dental screening of three year old children. In the work of the Child Health Centres the movement continues to be towards more planned developmental testing of young children.

CHILD HEALTH CENTRES

The trends over the past two years have continued, with a lessened use of local authority centres and a greater use of the general practitioner premises. In fact, the number of sessions and attendances is nearing an equal distribution.

Attendances at Local Authority Child Health Centres

1968-1971

Year	No. of centres provided at end of year	No. of child health sessions held per month at centre	No. of children attending during the year and who were aged			Total No. of children who attended during year	Total attendances during year
			Under 1 year	1—2 years	2—5 years		
1968	32	131	3086	1450	1728	6264	31326
1969	29	134	1927	1812	1697	5436	31018
1970	27	90	2287	2794	2438	7529	20720
1971	26	104	2365	2761	2652	7778	18651

The number of attendances at well baby sessions in group practice centres was 14,656 involving 21 separate practices.

The total immunising programme is now with the general practitioner and many health visitors attend and help to run these sessions. However, it is the true child health session which has continued to expand, and could with adequate premises expand still further, mothers attending with their babies and small children for advice on feeding and care, and most importantly, the observation of the milestones of development — physical, mental and emotional. Screening tests can also be carried out, including the most important hearing tests. Here again much depends on the adequacy of the premises.

Apart from these sessions, which are mainly conducted by health visitors, there are those taken by the general practitioners and, in the local authority clinics, by medical officers, all with the same aim of early detection of abnormalities in child development, and the advice to mothers on correct nutrition and care. Increasingly these basic screening and advisory clinics are becoming the province of the family health teams and the medical officers of the local authority are taking up the challenge of more detailed developmental screening. Thus the main development during the year has been the increase in clinic sessions staffed by medical officers specially trained in the skills of developmental paediatrics. This service of developmental examination of pre-school children continues to develop in each area as the constraints of staff and finance allow. A vital element of this work lies in the early detection of minimal physical and psychological defects which, undiscovered and uncorrected, may prove a substantial, if sometime subtly concealed, handicap.

I include now an account of the work from the Western Area where the main growing point has been. Dr. Hargreaves, Western Area Medical Officer, and his medical colleagues write as follows :—

"1971 has seen the continuation of periodic developmental screening examinations in the pre-school child — the service now being offered to the whole Workington area, including Seaton, using an appointments system based on a comprehensive and continuously updated birth register covering the age range 0—5 years.

The service, as it stood at the beginning of 1971 when all screening tests were carried out by a medical officer at 6 weeks, 6 months, 10 months, 18 months, and 2, 3 and 4 years — the key ages when certain levels of development are known to be recognisable — was of necessity revised as it was found to be far too demanding on medical officer time.

In order to use our medical manpower to the best advantage it was decided that the medical officer would examine all the children in the 6 months and 3 years age groups (excepting that in the case of a domiciliary birth the medical officer would see the child routinely at 6 weeks), and any 'at risk' or handicapped children at 10 months, 18 months, and 3 and 4 years — the children being called up by a post card appointment to a clinic at a specific time and date, and the health visitors would undertake a modified system of examinations on the non-risk and non-handicapped children at 6 weeks (6 months in the case of a domiciliary birth), 9 months and 18 months.

The health visitors would in fact test these children in their own homes and complete a questionnaire assessment form compiled to reveal the child's expected level of development in each age group — a form simply and very clearly presented requiring only a tick or a cross in a box opposite each of five questions under four main headings, viz., locomotion and posture, vision and fine manipulation, hearing and language and speech development, and behaviour (which includes everyday skills and social development). The whole, when completed, gives a fair picture of the child's development. There is space on the form for the health visitor to give any additional information which she considers necessary.

These 'milestone assessments' are reviewed by a medical officer and every child falling below the expected level of development in one or more areas is called up for full developmental examination by a medical officer. Any query raised by the health visitor is also investigated.

The appointments system is backed up by visits to the homes of defaulters by the health visitors — a satisfactory arrangement which ensures that as far as possible all the children are seen at key ages insofar as their development is concerned by at least one member of the clinic team, and chronic defaulters revealed, and attempts made by explanation of aims, adjustment of appointment times and persuasion to encourage these mothers to attend as they are more than often the ones most in need of help and advice. At the

moment approximately 60 per cent of mothers and children are keeping appointments, and the percentage is gradually rising, which is most encouraging.

Meanwhile, the health visitors are now holding their own child health clinics at the general practitioner surgeries to give general health advice to mothers and babies.

As the value of early developmental testing becomes more apparent, I would forecast an ever closer liaison with the general practitioners in the area — we already have very close links with the consultant paediatrician. Also, as more experience is gained in the techniques of developmental testing and the interpretation of results, it is hoped that children with delayed development will be picked out at the earliest possible age and the underlying handicap or handicaps, whether physical, mental or social, identified and assessed. In this way these children (and their parents) will be helped as early as possible to come to terms with, to compensate for, and in some cases even to overcome their handicaps, and generally be given support and understanding by all concerned in their welfare.

We are especially grateful for the helpful co-operation of Dr. J. W. Platt, the consultant paediatrician in this area, in sending us reports on each baby as he leaves the maternity division, and for the many relevant reports concerning children in the pre-school age group generally. On occasion, as already implied, we have been able to reciprocate in giving developmental reports to Dr. Platt when requested."

WELFARE FOODS

The Welfare Foods Order of April, 1971, introduced a fundamental change into the welfare foods service. Up to then it had been a service which carried a general subsidy but the subsidies have now been removed and those who are assessed as financially able to pay are charged the full price of the foods. To balance this, however, the financial limit for getting free foods has been increased, with the result that twice as much national dried milk was issued free in 1971 as in the previous year. The increase was from 1,313 tins to 2,656 tins, but as the following table indicates, this is only a small proportion of the total amount of food distributed.

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin Tablets (Packets)	Orange Juice (Bottles)
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,943
1964	74,886	4,909	2,236	36,389
1965	78,047	4,636	1,881	39,053
1966	74,902	4,326	1,771	41,636
1967	69,460	4,131	1,405	43,459
1968	67,116	3,844	1,138	42,705
1969	50,851	3,531	1,176	46,198
1970	47,359	3,330	1,198	48,635
1971	42,276	2,348	847	44,765

The number of all items distributed is substantially reduced in 1971. The increased price of national dried milk for most recipients is undoubtedly the main reason for its decline in popularity as its financial advantage over proprietary brands has been eliminated. It is in the towns where there is the alternative of proprietary brands that the biggest decline in sales is apparent. In the country areas mothers have continued to rely on welfare foods distribution points.

Cod liver oil has been withdrawn from sale and from January, 1972, orange juice was no longer recognised as a welfare food.

Basically, the distribution has continued along the lines of previous years. In the larger towns it is through shops, whereas in the rural areas it is mostly from the homes of individual volunteers. Many of them are members of the W.R.V.S. and twenty-five distribution points are manned by them, mostly in the northern area.

Proprietary brand foods are only sold alongside welfare foods where distribution is from shops and it is the authority's policy that proprietary brand foods should not be sold in clinics.

As most of the distribution centres are quite small, the foods are distributed to them from central depots maintained by local authority staff. In the northern area the W.R.V.S. provides transport. Money is collected from the distribution points by the authority's staff when fresh supplies are delivered and the staff are also responsible for operating a stock imprest and ensuring that food is sold within the shelf life.

The arrangements for the distribution of foods continues to operate at a high standard, which is due in no small part to the W.R.V.S. and other volunteers, to whom the community owes a great debt of gratitude.

DENTAL SERVICE

The local authority dental service continues to provide fully comprehensive treatment for all who wish to attend the clinics which are held in the following places :—

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

In addition, there are dental units in a number of the larger schools.

Over the last ten years all the major dental units have been completely re-equipped and are now up to a high standard. The lesser used units have had the best of the equipment which has been replaced in the larger units.

Two or three years ago it seemed that the authority was likely to have difficulty filling vacancies for dental officers and steps were therefore taken to recruit two dental auxiliaries. Both have now left and it looks as though it is going to be extremely difficult to retain the services of auxiliaries unless they have local family connections or particularly wish to work in the Lake District. Fortunately, however, and somewhat unexpectedly, it has proved possible once again to recruit dental officers, with the result that the authority is now up to the full establishment of 11. One can only hope that this happy state of affairs will continue. Quite apart from the difficulty in giving continuity of service when there are staff vacancies, there is a human problem involved in the employment of dental surgery assistants. They join the staff expecting that the spectre of redundancy will not arise but whenever a dental officer resigns the authority has to think carefully about the position of the surgery assistant. Clearly, she cannot be employed indefinitely without any surgery

assistant's duties to perform yet the authority does not wish to lose the services of experienced staff or create a climate where it would be difficult to recruit assistants because of the likely temporary nature of their work. So far the problem has been met reasonably satisfactorily by transferring the surgery assistants to other duties until a new dental officer could be appointed and take up duty, but problems will arise if there is once again difficulty in filling posts.

There is virtually no change in the proportion of patients coming within the various categories treated — pre-school children, school children and expectant and nursing mothers. It is hardly surprising that the number coming within the last category changes little as they are eligible for treatment through the local authority service for such a short period that they could almost be expected to seek any treatment necessary through their own general dental practitioners.

Nevertheless, I believe that more expectant and nursing mothers should be having dental treatment through one or other of the services available, especially as they are a priority group under the National Health Service Act, 1946, and I believe that this omission could be remedied quite simply by obstetricians and general medical practitioners examining ante-natal patients for the first time checking to see whether any dental treatment is necessary. They could then refer them to their own dentist, to the local authority or, if in hospital, to the hospital dental clinic. Very few medical practitioners appear to be doing anything about this important aspect of health.

It is expected that there will be a change in the number of pre-school children treated in the future. During 1971 arrangements were worked out for children to be given appointments for dental examination as soon as possible after their third birthday. It was felt that the administrative side of this could be accomplished quite easily by having the necessary appointment cards and appointment lists produced on the County Council's computer using the information already on tape for the immunisation programme. It was not necessary to add any information, although the allocation of children to the various clinics posed a slight problem because all immunisation is carried out by general practitioners in their own surgeries. This was overcome by inviting the children to attend the clinic nearest to their general practitioner's surgery, it being easy to relate the practice code numbers already on tape to selected clinic numbers. A check indicted that such a system would give the correct clinic for around 90% of cases and that in many others it would be an acceptable

alternative to the nearest. In only one practice, which covered a very rural area, was this system unsatisfactory. To meet the needs of the child patients of that practice a list of those children who will become three years of age during the next twelve months is produced annually on the computer and they are then allocated individually to the most convenient clinic. Requests for a change of clinic from any parent are, of course, accepted.

In considering the arrangements it was decided at the outset that the appointments would be for examination only and this is stressed on the appointment card. Where treatment is found to be necessary further appointments are offered, although the parents are also told of their right to have the treatment carried out by a general dental practitioner if they so wish. The opportunity is, of course, taken to give a little dental health education, to advise on diet or on harmful habits such as thumb and finger sucking. Each child attending is given, free of charge, a beaker, toothbrush and a tube of toothpaste.

By carrying out examinations only it is possible to make six appointments for the first fifteen minutes of each session and one every five minutes thereafter. This allows for a few absentees and first indications are that the attendance rate is around 50%. I feel that this is as good a start as could be expected for a scheme covering attendances for non-acute dentistry, especially in the middle of winter.

The only paper work for the dentist or his surgery assistant is indicating, on the appointment form produced on the computer, whether the child listed did attend and, if so, how many extractions and fillings were considered necessary. This information is stored on the computer and should, in due course, give some interesting statistics about the condition of teeth in different parts of the county, especially in areas with and without fluoridation to a dental optimum of one part per million of public water supplies. Preliminary indications on the relatively small number so far examined would suggest that the teeth of those in areas with fluoridation are much better than might have been the case three years ago.

Before implementation the scheme was, of course, discussed in the Local Dental Committee and the health visitors have done much to publicise it. Doctors were asked to recommend their patients, wherever they had the opportunity, to take their children along to the clinics in response to these invitations. The response so far suggests that the scheme is worth while.

One matter of importance that one expects to see more provision made for in the integrated health service is dental treatment for the old and infirm. Many of the patients coming within this category are housebound and, at the present time, there are no facilities for domiciliary treatment in the dental service. I believe that there should be some provision for general dental practitioners and local authority dentists to make domiciliary visits in such cases without any financial loss and for transport to be provided where necessary to bring such patients to the surgery.

Although the use of rose hip syrup, blackcurrant juice and orange juice sweetened with sugar has been shown to be a causative factor in the production of dental decay, many mothers still feel that children benefit from their use, whereas all the vitamin 'C' necessary to health can easily be obtained by giving the child a well balanced diet. By no means sufficient importance is placed on diet as a means to creating good general and dental health, but one sincerely hopes that our rising generations of parents will have sufficient knowledge and patience to prepare attractive and nourishing meals, which will lead to fitter and more healthy children. A good sound diet need not be expensive, but it does take time and trouble to prepare and with so many mothers at work this is not always easy, but surely one should devote more time and care to children during their formative years.

In certain areas oral hygiene is particularly poor and few parents do more than tell their children to clean their teeth. The only way to ensure that proper cleaning, or indeed any, is carried out, is to go with the child and both do it together. Example is the only way, and there is no doubt that a firm habit of toothbrushing established in a young child is seldom broken.

FLUORIDATION OF PUBLIC WATER SUPPLIES

1971 marked a further step forward in the County Council's plans ultimately to have the fluoride content of all the public water supplies in the county adjusted to the optimum level of one part per million. This was the introduction of fluoridation to the Ennerdale Lake source of the South Cumberland Water Board, which serves a population of about 45,000. The plant was commissioned on 23rd August, 1971, and uses liquid as opposed to the powder used in the other main scheme in the county. The equipment is of the latest type with sophisticated safety devices, but also with the consequent inevitable "teething trouble".

In total about 107,000 people in three parts of the county now have the benefit of fluoridation; those in the Whitehaven/Ennerdale areas getting their water supplies from Ennerdale Lake; those in the Cockermouth/Maryport/Workington areas served from Crummock Water and those in two parishes around Gilsland which are served from South West Northumberland. Altogether this represents about 50% of the population of the administrative county.

Work was to have begun on the fluoridation of the water supply to Carlisle and the surrounding areas in 1971 but this was deferred by Carlisle Borough Council on financial grounds. However, the principle of fluoridation having been accepted, after considerable debate, one hopes that work on the project might go ahead in 1972. The population of the county area involved is about 30,000 and they mostly get their water from the two sources agreed for fluoridation — Castle Carrock and Cumwhinton.

There is no further progress to report on the area served by the Eden Water Board, which decided some time ago to take no action on fluoridation, influenced no doubt by the attitude of Westmorland County Council, which opposed it.

Millom Rural District Council is anxious to have the fluoride content of its main source of supply, that from Baystone Bank, adjusted. It is hoped that the South Cumberland Water Board will consider this when the teething troubles of the Ennerdale supply are overcome and they are able to make use of the valuable experience gained there.

There is agreement in principle with the West Cumberland Water Board, which has two years' experience of the trouble free scheme at Crummock Water, to the fluoridation of its Quarry Hill and Hause Gill sources of supply. No starting dates have been settled as the intention was to synchronise the installation of fluoridation plant with other improvements at the works.

Throughout the county there are very many small sources of water supply where it will not be economic to undertake fluoridation. The benefits of fluoridation for those served by these schemes depends on the long-term re-organisation of supplies.

Regular sampling of the fluoridated supplies by the authority goes on to ensure that the fluoride level is maintained between the permissible limits. The samples are analysed in

the Workington laboratories of British Steel Corporation and there are arrangements for any significant fluctuations to be notified immediately so that appropriate action can be taken.

A survey of children's teeth in selected areas of the county was undertaken by Professor P. Jackson, Professor of Children's and Preventive Dentistry at Leeds University, in 1968 so that at a later date the dental benefits of fluoridation can be clearly demonstrated. He is not due to make his follow-up examinations until 1973 but it is hoped to get an earlier, if not quite reliable, guide from information which will become available from the dental examination of three year old children which begins in 1972.

Progress towards the goal of county wide fluoridation has proved slower than was originally hoped, although in retrospect this is probably not surprising in view of the difficulties inherent in dealing with five water undertakings and three other local health authorities. Local Government re-organisation and the re-organisation of water authorities should, in due course, speed the process although by then 60% of the present administrative county should be adequately covered and it is difficult to visualise this rising to more than 80% without re-organisation of the small sources of supply.

FAMILY PLANNING

It is now some forty years since the Family Planning Association was inaugurated, and in 1947 under Section 51 of the National Health Service Act, local authorities were enabled with the approval of the Minister of Health to make arrangements for the giving of advice on contraception.

In Cumberland during 1971 the Family Planning Service has again progressed. At a meeting of the Health Committee, in January, the County Council agreed to make a grant to the Family Planning Association of £1,000 per annum. However, at a further meeting of the Committee, in April, they were told that the Family Planning Association had rejected the grant as it did not fit in with any of the six schemes they were operating, and that local authorities should choose a specific scheme and meet costs as they arose. The Chairman met officials of the Association who were firm in their ruling that the Authority must choose a particular scheme. After studying all the schemes it was agreed that the Family Planning Association, as Cumberland's agent, would operate Scheme 6. Under this scheme the Family Planning Associa-

tion provides free consultations and supplies to medical cases, no service being provided on behalf of the local health authority to non-medical cases. The definition of medical cases being "any woman whose health in the opinion of the **examining doctor** would be expected to suffer by the increased mental, physical or social burden placed on her by pregnancy." It is estimated that Scheme 6 will cost the local health authority £1,000 a year, but was an open-ended commitment.

In addition to the seven regular clinics a new one is due to open early next year in Cockermouth. The premises will be provided rent free and equipped by this Authority. In Carlisle there is also an extra fortnightly evening session which is available to county clients, and there is now an increasing awareness by the public for the need of family planning.

Meetings have been held between myself and the Family Planning Association regarding an agency arrangement for a domiciliary family planning service and the suggestions made in the Department of Health and Social Security Circular 36/71. Discussions are still being held to find a way to implement some form of domiciliary scheme, which would be complementary to the existing family planning service, and linked to the special consultant family planning clinic now operating in the hospital service.

I thank the Family Planning Association for their help during 1971.

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

The County Council's scheme for vaccination and immunisation against the major preventable infections has, over the years, undergone repeated adjustment and modification as new immunising agents became available and expert advice varied on techniques and schedules. Throughout, however, two things remained fairly constant, viz. reliance upon community health education, mainly through nurses and doctors, to ensure maximum uptake by parents; and the advantage regularly taken in schools of the 'captive' school child to reinforce certain protections, always, of course, with parental consent and co-operation. The former feature, the splendid painstaking work of field staff in stimulating parents, has now been greatly reinforced by the computer-activated individual call-up by appointment; while the latter feature will soon disappear as children have protection reinforced immediately **before** school entry, and carried out by the family doctor and his team.

The calculation of the child population's immunity state at any point in time involved a rather complex procedure assessing the proportions completely up to date in their protection schedule. While this is still possible and of significance, it is now possible to produce a more accurate index of the protection state of specific year groups of children because the computer-stored records can provide this very quickly and precisely.

Cumberland's scheme based on computer-stored records and call-up by appointment to family doctors began with children born on 1st January, 1969, and it is now possible to confirm that the proportion of children born in that year who are at present fully protected according to current vaccination schedules stands at 91%. This is the real vindication of all the administrative and technical work which has gone into this scheme. Previously the 'immunity index', calculated as mentioned above purely on numbers of protections given in year groups rather than on personal particulars of each individual child, remained obstinately around the 75% mark. This represented also the national average for the main infections such as diphtheria and poliomyelitis. It was always possible, of course, that the older 'immunity index' was something of an underestimate of the true protection state which may well in reality have been nearer the 80% figure. This is because the arrangements for collecting records of protection given was always of limited efficiency to the extent to which some doctors did not regularly submit records. Such a deficiency

can occur only very rarely in the computer operated scheme due to the checks and monitoring which are in-built. Nonetheless, the overall improvement demonstrated in the case of children born in 1969 is most gratifying, and although the final result for primary protection of all 1970 births is not yet available the indications are towards a similar result to that achieved for children born in 1969.

The schedule of vaccinations and immunisations currently advised is set out below and is adjusted in detail to allow of completion of primary protection against diphtheria, tetanus, pertussis, poliomyelitis and measles, plus the 'school entrant' reinforcement of diphtheria and tetanus and poliomyelitis **before** a child starts school. The only subsequent reinforcement is of diphtheria and tetanus before school leaving and this too in due course will be by appointment with the family doctor. Thus after 1974 when children born in 1969 reach school entry age there will be few immunisations carried out in schools other than B.C.G. protection against tuberculosis. The final pattern of protection against rubella (German measles) is not clear but at some stage it will no doubt be woven into a consolidated schedule of protections. Meantime, it is advised and provided for girls in the thirteen year age group.

Schedule of Vaccination and Immunisation Procedures

6 months	Diph./Tet./Pert. and Oral Polio.
8 months	Diph./Tet./Pert. and Oral Polio.
14 months	Diph./Tet./Pert. and Oral Polio.
15 months	Measles.
4 years 6 months	Diph./Tet. and Oral Polio.

Diphtheria, Tetanus, Pertussis and Poliomyelitis

I show below the tables which have annually been shown of the actual numbers of protective procedures undertaken during 1971, the figures in brackets relating to 1970 :—

Diphtheria Immunisation

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

Primary Courses — pre-school children ...	2,597	(2,035)
Primary Courses — school children ...	192	(353)
Reinforcing injections — pre-school children	57	(890)
Reinforcing injections — school children ...	2,678	(2,763)

Tetanus Immunisation

During 1971 the following numbers of children were immunised :—

Primary Courses — pre-school children ...	2,598	(2,033)
Primary Courses — school children ...	204	(372)
Reinforcing injections — pre-school children	67	(902)
Reinforcing injections — school children ...	3,304	(3,863)

Whooping Cough Immunisation

The numbers of children immunised in 1971 were as follows :—

Primary Courses — pre-school children ...	2,590	(2,028)
Primary Courses — school children ...	33	(24)
Reinforcing injections — pre-school children	46	(845)
Reinforcing injections — school children ...	333	(259)

Poliomyelitis Vaccination

Primary Courses — pre-school children ...	2,644	(2,268)
Primary Courses — school children	274	(401)
Reinforcing injections — pre-school children	26	(161)
Reinforcing injections — school children ...	3,121	(3,561)

The reduction in the figures from 1970 for school reinforcing of diphtheria, whooping cough and tetanus protection is accounted for by the fact that the current schedule of vaccinations and immunisations no longer provides for a reinforcement dose at 10 years of age. The increase in the number of completed primary courses in pre-school children emphasises the efficiency of the computer call-up programme.

The figures are difficult to interpret in detail because of the complex changeover situation to the computer-activated appointment system, and comments on them are subject to the main facts mentioned above about the improved performance for whole year groups. This is reflected in these tables mainly in the improved figures for primary courses in pre-school children in respect of diphtheria, tetanus, pertussis and poliomyelitis. This is bound in turn to result in a corresponding reduction in school entrant children requiring **primary** course of protection.

Measles

All children reaching fifteen months of age are now offered measles protection as part of the overall scheme, and this is now forming the main element in community protection against this infection. In 1971, 2,814 children were protected of whom 2,137 were in the group given appointments through the computer. This, like the other primary courses, will come to represent almost a whole 'year-group' of children. In addition measles vaccination will continue to be offered to children entering school who have neither previously had measles nor vaccination against it. Thus many missed in the early campaign can be brought in but it is still disturbing to record small outbreaks of measles in certain parts of the county among children who should have been protected since 1968. A recent inquiry into a group of these produced a variety of reasons for non-protection, some still harking back to a temporary suspension of vaccine in 1969, but mainly traceable to lack of parental diligence in spite of repeated reminders by health visitors and others. Nevertheless, the substantial reduction in notified measles as shown on page 123 is very encouraging.

Rubella

As indicated above rubella vaccination is now available to thirteen year old girls, and in 1971 2,234 vaccinations were carried out in the schools by school medical officers. It seems sensible to offer this important protection to girls when they enter secondary school and so in the current year area medical officers are offering protection to a double year group with a view to continuing the procedure in the first year in secondary school.

Tuberculosis

Once again B.C.G. vaccination against tuberculosis was offered during the year to 12-13 year old children, 3,186 children received a preliminary skin test and of these 162, i.e. 5.1%, were found positive. The remainder who represent the majority susceptible to tuberculosis infection were offered B.C.G. vaccination, a total of 2,858 being in fact so protected. 310 children had already had B.C.G. vaccination for some reason and 12 were already under the care of the chest clinic.

MEASLES NOTIFICATIONS — CUMBERLAND
4 WEEKLY PERIODS

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

In this section of the report an account is given of a group of services which in their particular spheres are of the greatest importance to the community. The value to a particular family of a simple item of nursing equipment under the loan scheme or the personal comfort afforded to an elderly person by chiropody, can be out of all proportion to the cost of the service.

I am again very grateful to Dr. Hambridge and Dr. Southern, Consultant Chest Physicians in West and East Cumberland, for their reports which are published in full as appendices to this report.

CERVICAL CYTOLOGY

The local authority services for the screening of women for the early detection of cancer of the cervix continue to function quite satisfactorily; and the progress towards a group practitioner based service is continuing. This progress is reflected in the decreasing number of women examined in local authority clinics and the increasing number examined by local authority staff and general practitioners in group practice premises, as is shown in the following table :—

	1969	1970	1971
Women examined in L.A. clinics	1,622	1,411	921
Women examined in G.P. premises	3,834	4,040	4,166

In all 12,625 smears were examined by the East and West Cumberland Hospital laboratories during the year, 3,334 of these were taken by county staff, 8 of which were on domiciliary visits. Of the 12,625 smears examined 59 proved positive giving a rate of 4.7 per 1,000 women examined.

It is not possible to determine how many of these smears are as a result of an initial request or which are due to the recall system. The analysis of the situation is complicated by several factors, for example — movement between hospital management areas, premature repeat smears and change in type of clinic attended.

The following table shows the number of deaths from cancer of the cervix over the past decade. It is interesting to note the decrease, both locally and nationally, since the service was started on any reasonable scale in the mid-sixties :

Deaths from cancer of the cervix uteri

	Administrative County	England and Wales
1962	11	2,511
1963	13	2,465
1964	23	2,577
1965	16	2,453
1966	16	2,483
1967	15	2,449
1968	6	2,434
1969	10	2,417
1970	10	2,343
1971	9	Not available

5 Year Recall

During the year the names of some 400 women were passed to the administrative areas of the county to arrange appointments for re-examination under the local recall arrangements.

The main feature of the year was the issue by the Department of Health and Social Security of the arrangements for routine recall of women for periodical re-examination under the national scheme of screening for the prevention of cancer of the cervix. This called for the introduction and use of the revised national request/record form as from 1st January, 1972.

A joint meeting of local authorities, hospital authorities and executive councils concerned in the area was arranged by Dr. Inglis, Consultant Pathologist, to discuss the acceptance and implementation of the scheme.

It was decided that the scheme would be adopted in the area, but because the national scheme can only be initiated for women whose details had previously been received by the National Health Service Central Register, Southport, it would be necessary to carry on with the local arrangements for recall using the national form as from 1st January, 1972. This would ensure that women re-examined in 1972 would come under the national system in 1977, and that the local system would operate up to 1976.

The local recall system will take the following pattern. Consultant pathologists in the area will prepare each month a list showing all women due for recall. The list will then be examined by the appropriate executive council and all

women who have died from whatever cause or left the area will be eliminated. Further lists will then be drawn up on a group practice basis and passed to the appropriate group practice team who will check and eliminate all women who are currently referred to gynaecologists or who should otherwise not have an examination. The list will then be returned to the executive council and passed on to the local health authority who will arrange appointments through nursing staff attached to group practices, either at the practice surgery or at local authority clinics. In due course the nursing staff will report non-attenders and follow-up action will be taken.

NURSING EQUIPMENT ON SHORT-TERM LOAN

This service continues to expand, both in the quantity of equipment issued each year, and also in the type of equipment available for loan. During 1971 over 1,200 items were issued to domiciliary patients, including 36 ripple beds, compared with 19 during 1970. There were 667 larger items issued on loan (for details please see the table below) and in addition 600 or so smaller items which include raised toilet seats and rails, bath seats and rails, tripod walking sticks, urinals, bed pans, lazy tongs and helping hands.

The British Red Cross Society became agents for the scheme in 1963 and have provided an economical and efficient service. Very little cost is incurred in distribution. Annual replacements cost about £900, and extra equipment is added, when required, to the stores.

There are three depots, situated in the three geographical and administrative areas of the county, the British Red Cross Society providing the premises at Carlisle and Workington. At Whitehaven the depot is operated from within the county premises.

The growth of this service is, I feel, due to the work of the family health care teams, early discharge of patients from hospital after illness and accidents, and the rehabilitation of patients in their homes, many of whom rely almost completely on the equipment for their independence in daily living. In view of the extra work, and the now considerable storage space needed to meet the extra demands, the economics of the service were discussed and the Health Committee decided that the next financial year would see an increase in the grant to the Society.

All equipment is supplied free and on temporary loan, being recalled when it is no longer needed.

I would like to express my thanks to the British Red Cross Society for their valuable help in operating this service.

Commodes	161
Crutches	17
Hoists — hydraulic	6
Hospital beds	18
Lifters (Penryn)	3
Invalid Chairs — adult	71
junior	4
car type	62
Mattresses — rubber	28
Walking aids	261
Ripple beds	36

DOMICILIARY PHYSIOTHERAPY

Early in 1971 this service continued in very limited form through the service of two part time Physiotherapists, but at the time of writing this report I look forward to the return from training of the first holder of the joint scholarship provided by the County Council and the West Cumberland Hospital Management Committee. I am glad to say that a further scholarship has been taken up by another promising young lady whose return will in due course improve the service still further. I hope to extend during 1972 the domiciliary physiotherapy service to some further group practices in the county.

CONVALESCENCE

The number of Administrative County patients sent for convalescent treatment continues to decrease and the following table shows this decline over the past seven years :—

	No. of admissions
1965	144
1966	99
1967	49
1968	55
1969	39
1970	35
1971	28

For the third consecutive year all patients have been admitted to the Silloth Convalescent Home, thirteen coming from the Western administrative area of the county, eleven from the North and four from the South.

In past years it had been the practice to assess the financial circumstances of any person sent for convalescent treatment in order to see if they could make a contribution towards the cost, and, where appropriate, the amount due was collected. The assessment had been carried out by welfare officers experienced in this type of work, but with the transfer of these officers to the Social Services Department, it became necessary to re-appraise this particular function of the service.

Investigation showed that over the previous two years administrative costs involved in the assessment and collection service were far in excess of the amount recovered and the council therefore decided that the practice of assessment of income for patients admitted to convalescent homes be discontinued.

Over the past seven years the average age of patients attending the Home has increased and more elderly patients are being referred for treatment. Consequently the problems associated with the elderly have increased and the nursing service has of necessity been adapted to cope.

In addition to this authority, other local health authorities make use of the Home and in the financial year 1971/72 a total of eight authorities sent 164 patients who averaged a stay of exactly two weeks each. The management also has a contractual arrangement with the Newcastle Regional Hospital Board whereby twenty beds are reserved for the convalescence of hospital patients. This quota has been exceeded on quite a number of occasions.

In July of this year the Board considered the question of relinquishing their responsibility and terminating the contractual arrangements as it was considered that the facilities offered could only be described as a "recuperative holiday" rather than the "active planned and integrated treatment" which had been recommended by the working party on "Convalescent Treatment" in 1959.

There has been a great deal of discussion on the merits and demerits of this course of action, not the least of which is the possibility of the closure of the Home due to lack of support and thereby leaving the Special Area of Cumberland and North Westmorland void of convalescent facilities. Discussions are still taking place and no definite resolution has as yet been made.

MENTAL HEALTH

During the year, many of the Mental Health activities have been re-organised with the formation of the Social Services Department and the physical removal of the Child Guidance Clinic from the Portland Square Clinic. A very satisfactory liaison exists between the workers in these two fields of Mental Health and this Department.

During the year, voluntary activity for Mental Health has become highly organised in the new "Cumbria Association for Mental Health." This association meets generally, at Garlands Hospital and already has a membership representative of Cumbria. It seeks to supplement and co-ordinate its activities with those of other voluntary organisations already involved with Mental Health.

One of the Mental Health problems which gives particular concern in the Northern Area, is that of the elderly mentally ill person, living in the community. This is particularly a problem in the typical case where an elderly lady living alone in remote surroundings is becoming increasingly demented or, more often, acutely confused. Such persons need a great deal of support from both the Health and the Social Services teams.

Throughout the county Health Visitors made 682 visits to 137 cases of mentally disordered persons, this compares with 810 visits to 177 cases in 1970.

CHIROPODY SERVICE

In the years immediately after the establishment of the authority's chiropody service for the elderly, the physically handicapped and expectant mothers, the number of patients referred for treatment increased rapidly, but the rate of expansion seems to have fallen off considerably in recent years. The increase was down to 3% in 1970 and in 1971 it dropped to rather less than 1%. In actual numbers it was an increase from 6,503 patients on 1st January, 1971, to 6,564 on 31st December. The total number of treatments given also increased by 1% — from 28,203 to 28,502. There is almost certain to be a continuing increase in numbers, if only in line with the growing number of elderly in the county, but the rate of increase is likely to vary from year to year because of staffing and other factors.

The principal "other factor" might well be the number of handicapped persons referred for treatment. In 1969 there were 114 such cases; by 1970 it had increased to 162, and by the end of 1971 there were 222.

There are only six expectant mothers getting treatment, a number which has remained surprisingly static throughout the years since the service began.

For all practical purposes the chiropody service can be regarded as for the elderly as they account for almost 97% of the patients. Consequently it is not surprising to find that a survey in one part of the county showed an absentee rate of 8½%; indeed it is gratifying to see that it is slightly lower than before although this may have been due solely to the unusually mild winter. Neither is it surprising that a substantial proportion of those referred for treatment are also certified by their general practitioners to be in need of domiciliary treatment. In 1971 it was 29% of all patients, an increase of 1% over the previous year, which was in turn 1% up on 1969. Domiciliary visits do, of course, involve a large amount of travelling time for the chiropodists, especially those in the more rural areas, in addition to which the chiropodists frequently have to carry out the treatment under very poor conditions. We are, therefore, all grateful to those volunteers who put their cars and services at our disposal so that those who can be taken to clinics for their treatment get it under the better conditions which prevail there.

At the end of the year there were 35 patients still awaiting their initial appointment. Some waiting to be seen for the first time is almost inevitable when the chiropodists already have full case-loads and make re-appointments well ahead. The normal frequency of treatment is regarded as about two monthly although the chiropodists have discretion to increase or reduce the frequency as they believe necessary in individual cases. In this the chiropodists are assisted by the nurses and health visitors, as Mrs. G. Garrett, M.Ch.S., S.R.Ch., reports:

"The health visitors and home nurses are most obliging over helping me in any way they can, particularly in keeping an eye an cases in isolated villages which does save me making return journeys simply to check anything myself. Also, they are most helpful in dealing with cases which are not severe chiropodial ones — one or two nail trims can be left four months when I know the nurses are checking the condition of the patients during their own routine calls."

The staffing situation continues to be reasonably satisfactory. Although two full time chiropodists left during the course of the year they were both replaced, although not without some break in the continuity of treatment of their patients. This is a recurring problem and, while the authority makes alternative arrangements for urgent cases to get treatment, the identification of those cases by a stranger to the case-load has not been easy. The newly appointed chiropodist has the same problem and to help to overcome it a system is being evolved to mark the case cards with colour signals. It is expected that this will be of considerable benefit when vacancies occur in the future.

The staffing establishment was increased by one towards the end of the year so that a chiropodist who had previously been employed in a part time capacity could take up full time work with the county. He already had about 360 patients but, nevertheless, he will be able to give some welcome relief to the two full time staff who had the highest case-loads. The establishment is now nine full time staff, although it has never been possible to get the chiropodist to enable the case-loads of the part time staff to be reduced to a maximum of 300 each in accordance with the authority's policy. The other eight posts are filled and, in addition, there are ten chiropodists in private practice who treat patients on a per capita or sessional basis. They have a total of 1,795 patients referred to them under the county scheme and can, therefore, be regarded as the equivalent of three full time members of staff. Together, the staff provide a service at the following places in the county :

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

The staff is not evenly shared between the three administrative areas of the county because, even although the population of the areas is not significantly different, the number of patients referred for chiropody does vary considerably. In the southern area there are 1,789 patients; in the northern area 2,186 and in the western area 2,589. The difference does not end there as the proportion of patients said to need

domiciliary treatment is 22% in southern area, 29% in northern area and 33% in western area. This is despite the fact that the western area is the most urban and, in general, probably has better public transport than the other areas. Patients referred under the category of handicapped number 58 : 61 : 103 in the respective areas, while all six of the expectant mothers being treated live in the western area. It is difficult to find any reason for this and one can only assume that there is a greater awareness of the service by patients and doctors in the west and a greater anxiety to use it.

To help in the long term recruitment of staff the authority has introduced a scholarship scheme on the lines of those which have already proved invaluable in maintaining a steady flow of staff for the speech therapy and orthoptic services. Briefly, the authority gives a grant in excess of that which would be paid by the education authority and in return the scholarship holder undertakes to join the county staff for not less than two years immediately after qualifying. The first scholarship holder is already under training.

Meetings between general practitioners and chiropodists to effect a closer liaison have continued and in this context the following comment by Mrs. G. Garrett is of interest :

"The meeting we had recently when 'we' i.e. the county, met 'them' i.e. the general practitioners, and for a few hours became truly 'us' was very helpful and interesting. It is a useful thing to meet people who might otherwise just be a disembodied voice on a 'phone or a signature on a piece of paper."

It is clear that through regular appointments the chiropodists come to know many of their patients well and become a go-between for other services. They become involved in other things which trouble their patients and the changeover to decimal currency was one of these, as Mr. G. H. Thomas, M.Ch.S., S.R.Ch., the Chief Chiropodist, reports :—

"The chiropodists found themselves in many instances acting as instructors or advisers to the elderly patients. I lost count of the number of grocery lists I checked during the first few weeks of the changeover. The attitude of the elderly patients was very markedly divided between those who claimed that they would never understand it to those who were amazed at how easy it all was. One elderly patient refused to have anything to do with 'that patent money' and

had to be restrained from throwing his change into the rubbish bin until I explained that it was really worth 1/6d."

The fee remains at 12½p. per treatment, whether at the clinic or surgery or in the patient's own home. The private practitioners who see patients under the county scheme on a per capita basis retain these charges, which are deducted from the fees payable to them by the authority.

The re-equipment of chiropody clinics has begun. Most were established in 1960 or shortly afterwards with whatever equipment could be obtained quickly. Much of it was of a poorer standard than can be obtained now and it is hoped to re-equip two or three clinics a year until all are brought up to a good standard. What has been accomplished so far seems to have met with the approval of the chiropodists. Mr. W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N., considers that :

"The re-equipping of Park Lane Clinic, Workington, and the establishment of an appliance fabrication unit at the clinic has taken the chiropody service another step forward in its development. The unit is a great improvement on the individual pieces of apparatus that took up much of the working space surrounding the patient's chair with their attendant hazards to the elderly patient."

On the same topic, Mrs. D. E. Smart, M.Ch.S., S.R.Ch., considers that :—

"The new type of chair (hydraulic) will help to overcome the danger to patients in negotiating the step on the existing chairs."

The chiropody service is now firmly established in Cumberland. Thoughts are turning to a pilot scheme for a service to school children with the long term objective of preventive work rather than an absolute concentration on palliative treatment as at present. The authority has officially accepted it as one of its objectives and it does, of course, appeal to the chiropodists. One can only hope that the necessary finance can be made available in the reasonably near future and that the staff to implement it can be found without any diminution of effort to meet the needs of the priority groups.

It is always of interest to get the opinion of a service from someone who has not been closely connected with it for a long time. Miss P. A. Fisher, M.Ch.S., S.R.Ch., the most recently appointed full time chiropodist, writes :

"In general I feel the chiropody service in Cumberland is of a high standard and is greatly appreciated by the elderly and physically handicapped who receive treatment."

SEXUALLY TRANSMITTED DISEASES

From statistics supplied by Dr. Bell, Consultant Venereologist, it is evident that the position in the administrative county for syphilis — 6 cases, and gonorrhoea — 50 cases, remains fairly stable, as can be seen in the following table. There is an increase in the "other conditions" from 140 in 1970 to 167 this year.

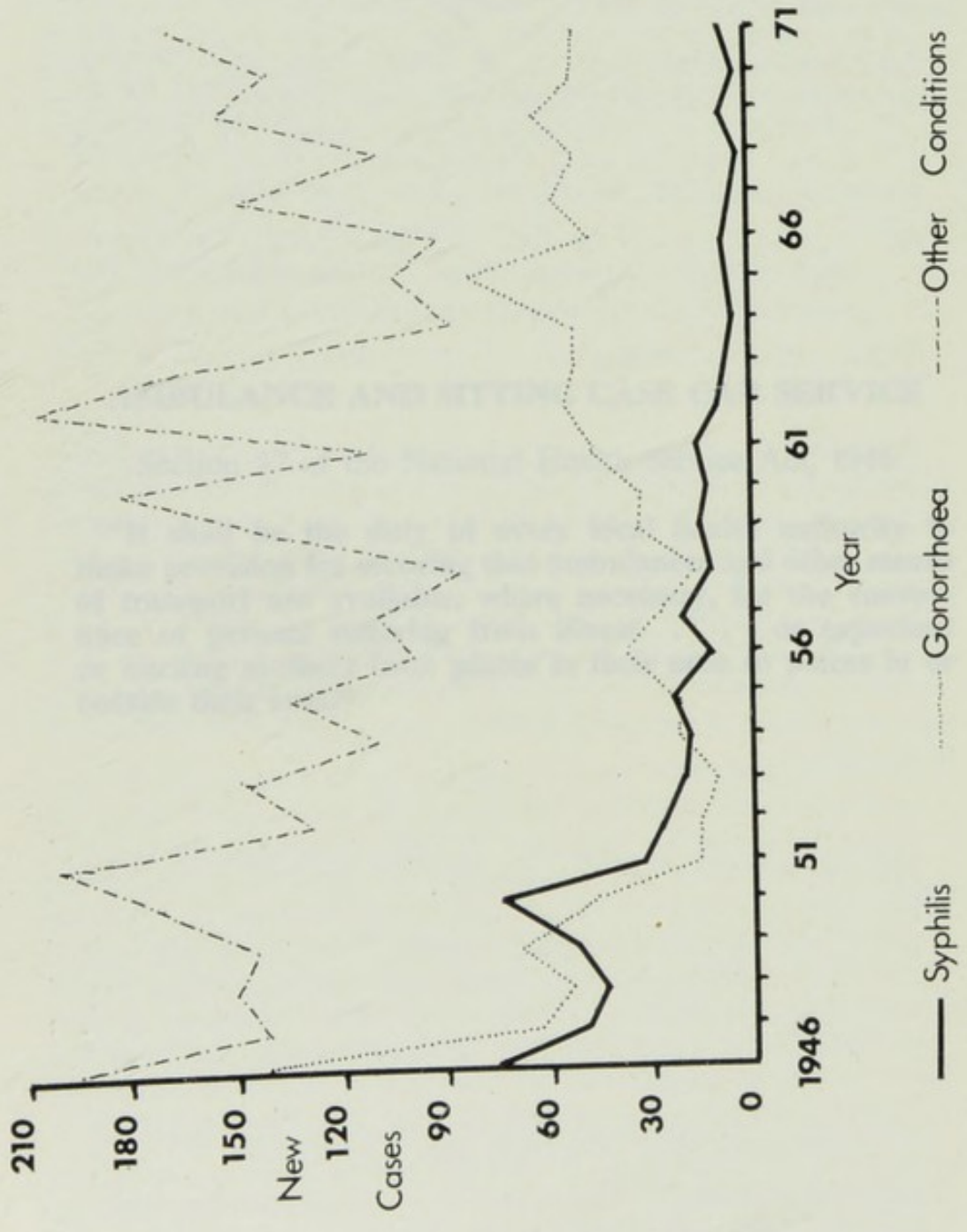
Year	Syphilis	Gonorrhoea	Other Conditions	Total
1962	7	53	206	266
1963	6	50	157	213
1964	3	50	87	140
1965	5	83	104	192
1966	6	46	92	144
1967	5	59	146	210
1968	2	51	107	160
1969	6	62	154	222
1970	2	52	140	194
1971	6	50	167	223

The Health Education programme has been continued in schools and health visitors have attended refresher lectures given by the consultant venereologist and by Dr. Grant.

The suitability of some of the Health Education Council publicity material has been brought into question this year and the matter is at present being gone into with the Council. A new supply of self-adhesive labels showing the local facilities for the treatment of V.D. has been ordered as a result of liaison between this department, the consultant venereologist, and district medical officers of health. The labels are to be displayed in public and transport cafe toilets throughout the county.

The local authority contact tracing machinery still exists although it has only been used once this year. The case in question was investigated by a health visitor who successfully traced the contact, a young lady in the southern administrative area.

SEXUALLY TRANSMITTED DISEASES — NEW CASES PER YEAR — 1946 - 1971 ADMINISTRATIVE COUNTY OF CUMBERLAND



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."

COUNTY AMBULANCE SERVICE

This year has seen a major step forward in the development of the Ambulance Service following consideration of the final report of the Management Services Unit which had been asked to undertake a comprehensive review of the service. When the recommendations were being drawn up particular regard was given to the increase in efficiency which it was anticipated would follow the establishment of :—

(a) stations manned on a 24 hour basis and reducing wherever possible the number of day stations at which standby duty is carried out, which can never be regarded as being the most efficient method of answering an emergency call during the evening and night;

(b) a central control to deal with all requests for ambulance transport combined with the introduction of the most modern methods of communication;

(c) a central workshop.

Following consultations with the National Union of Public Employees it has been agreed there is a need to ensure adequate communications down to every level of responsibility in the service, and thus improve staff relations generally. It has therefore been decided to establish a County Ambulance Consultative Committee on which each station will have a representative. All of this represents the biggest advance in the development of the service since a directly provided service was introduced in the years 1962-65 and is dealt with in more detail below.

The main proposals of the Management Services Unit were :—

(1) that a 24 hour ambulance station be set up in the vicinity of Maryport to replace both the established day station at Wigton and the temporary arrangements at Maryport where, pending the issue of the final report of the Management Services Unit, it had been decided to establish a day station to take over the contractual arrangements at Maryport and Cockermouth.

(2) that a unified central operations control be established;

(3) that a central workshop for vehicle maintenance and repair be established and that the Wigton Station be used for this purpose;

(4) the appointment of a Staff Officer to be mainly responsible for training.

The consultations with all those concerned, which followed the issue of these recommendations, were both long and thorough. The recommendations were submitted to the District Councils concerned for their views and this was followed by meetings between members of the Health Committee and the District Councils. As a result of the wide publicity which the proposals received in the press, representations were also received from other numerous organisations. All of these were considered at length by the Health Committee who finally decided that :—

(a) a 24 hour station be set up at Maryport to cover Maryport and Cockermouth;

(b) the Wigton Station be retained on its present basis;

(c) the Central Workshops be established at Maryport;

(d) a Maryport ambulance be stationed during the day at Cockermouth Cottage Hospital.

It is anticipated that Central Control will be brought into operation on 1st June, 1972. It will be housed in the health department offices and be linked to all the out-stations by means of telex, radio and telephone. On its introduction all requests for transport will be dealt with centrally and the work allocated to each station will be transmitted to them daily by means of the telex equipment. Because of this centralisation a greater output of work of both vehicles and men is anticipated.

It is also hoped to set up the Central Workshop at about the same time. This will be housed in the premises now also housing the Maryport Station. Because certain adaptations are necessary to bring the accommodation up to the required standard in the ambulance station, it is planned to have the comparatively minor adaptations necessary for Central Workshop purposes to be carried out at the same time. However, neither of these will be done until the County Council have purchased the premises, negotiations for which are now in hand.

The West Cumberland Hospital Management Committee kindly put a room at the disposal of the ambulance crew at Cockermouth Hospital, included them in the hospital messing arrangements and provided adequate standing space for the ambulance. I am indeed grateful to the Management Committee for their help which was so readily forthcoming.

Consequent upon the decision to out-station a Maryport ambulance at Cockermouth and to keep open the Wigton Station the standard of service being provided in the Border and Ennerdale areas was considered. As the service which had been provided in those places since the last reorganisation of the ambulance service had been satisfactory and had not provoked a complaint from the public it was decided that the present arrangements should continue.

Arising from the completion of the motorway through Cumberland and Westmorland it was considered essential that the day station at Penrith should be upgraded to a 24 hour a day station in order that accidents, particularly those occurring on the more isolated stretches over Hardendale Fell in the neighbouring County of Westmorland, could be dealt with as quickly as possible. This allayed the anxiety of the police who were most concerned about possible delays in the clearing of the motorway following accidents. Suitable financial arrangements have been agreed with Westmorland.

During the year the Department of Health and Social Security issued guidance relating to the rationalisation of radio frequencies used by ambulance services throughout the country. This will mean that in future all ambulance services will operate in the "High Band" range of frequencies; at present county authorities operate in the "Low Band" and municipal authorities in the "High Band." A different method of sound modulation will also be used. The purpose of this rationalised frequency allocation is to facilitate co-operational communications between ambulances and controls, e.g.

(a) An ambulance moving into the territory of a neighbouring authority will be able to communicate with the ambulance control of that authority.

(b) Ambulances provided by several neighbouring health authorities at the scene of a major accident could all be controlled on one channel.

Because of this need for what is known as "inter switchability" it will be necessary for authorities to replace their present single channel equipment with multi-channel equipment.

The equipment now in use is rapidly approaching the end of its useful life as all the sets are between seven and ten years old, and the advice which has been received is that seven years should be regarded as the maximum life of the

equipment but, in any case, for various technical reasons it would have been impossible to modify it. It has therefore been decided that all the equipment be replaced during the year 1972/73. When it is in operation the service and central control in particular will be equipped with very efficient methods of communication.

General practitioners and hospitals who have radio equipment operating on the ambulance service frequency have been informed of these developments and it is anticipated that their changeover of equipment will be in step with the changeover in the ambulance service.

In September, 1969, Dr. McCarthy, Fellow of Nuffield College and the Oxford Centre for Management Studies, was asked to inquire into the causes of industrial action taken in the areas of certain ambulance authorities. One of his recommendations was that authority and/or station committees be established in every employing authority along lines laid down in a "guide line" agreement at national level.

Considerable work on the drafting of these guide lines has been carried out at national level and guidance is still awaited. Nevertheless, the value of such a committee is recognised and the trade union concerned has been told that, although it cannot be set up on a formal basis until national guide lines have been issued, the authority is prepared, until they have been received, to set up consultative machinery on the understanding that it is a purely interim measure.

Operations

The demand on the service has increased throughout the year; the number of patients carried has increased by 3,540 (2.6%) and the number of miles by 108,727 (8%). These increases have been due to the conveyance of patients to the Kidney Unit, Royal Victoria Infirmary, Newcastle, and the intensive physiotherapy centre at Chester-le-Street, Co. Durham, all necessitating long journeys. The reduction in the provision of public transport must also be a contributory factor but its impact should not be exaggerated as this has always posed a problem and must be expected to do so in such a rural area as Cumberland. However, whatever the difficulties are, the needs of the patients have always and will continue to be placed first. Thirty-nine accidents have been dealt with on the M6 motorway but none of a very serious nature. As was to be expected there has been a considerable

reduction in the number of accidents attended on the A6 but the number of accident and emergency calls in the Keswick area has increased from 171 to 228, a rise of 33%.

Transport continues to be provided to take patients to group practice surgeries and approximately 3,000 patients are currently receiving transport for this purpose.

This is provided only if the patient is unable by reason of ill-health to use public transport and that it is in the patients' interest that they should be seen in the surgery rather than in their own homes. Before such a service is started it is made clear to the general practitioner concerned that the provision of this service is not to be used as a means of releasing him from his obligation to visit patients in their homes.

However, besides the benefit which the patients obtain from such a service there are certain advantages as far as the ambulance service is concerned. For example, a little more latitude can be allowed in deciding transport arrangements to hospital after a general practitioner has examined the patient. In addition plaster checking and removal of stitches can be done locally thus obviating in some cases long journeys to hospital.

During the year ten births occurring in ambulances were satisfactorily dealt with compared with 17 last year.

I cannot forsee any change in the continued increase in the use of the ambulance service as an intensive rehabilitation centre is being established in West Cumberland and a geriatric day hospital and psychiatric day hospital are planned for East Cumberland in the near future. All of these will have a considerable impact on the service, and may well require a review of the establishment of vehicles and men to meet the need, although every effort will, of course, be made to make the fullest possible use of existing resources.

Training

During the year 11 ambulancemen attended six-week training courses at the Regional Training Centres in Newcastle, Lancashire and West Riding of Yorkshire. The subsequent report on their achievements show that they continue to attain an excellent standard which reflects great credit upon themselves and the Cumberland Ambulance Service and also

demonstrates the value of the local training they receive on entry into the service and before attending the Regional Centres. With the appointment of a staff officer whose main responsibility will be training, even further improvement should be seen. It is essential to remember that the training given at these Regional Training Centres is basic training and that follow-up in-service training is essential, a point which the Department of Health and Social Security emphasise. This type of training has never been neglected in this service as there is an organised programme of in-hospital training. I continue to be indebted to those hospital consultants who give this training and in particular to Mr. P. A. M. Weston who ever since he took up his post as Consultant Surgeon, Accident and Emergency Department, Cumberland Infirmary, has played a leading role in the training of ambulancemen in East Cumberland. I am sure that all whom he has taught are as sorry as I am that he has taken another appointment. I cannot let this opportunity pass without saying how very grateful I am to him for all his efforts in furthering the training of our ambulance staff. I am very pleased to include the following report in which he reviews his association with the ambulance service.

"It is sad to be leaving the Cumberland area after eight years with the Accident Service. Much has happened during this time and I welcome this opportunity of paying tribute to the work of the Ambulance Services in the Cumberland area. In the stress of an emergency the first contact of patients with the world of hospitals is through the ambulance service. The attendants and drivers with whom I have worked, have never allowed outside problems to interfere with their cheery, sympathetic, and skilful attention. The Cumberland area is remarkable for the long distances that have to be covered and this brings added responsibilities when looking after the seriously injured or ill. During recent years ambulance personnel and doctors (both hospital and family) have come to work much more closely together — as part of a team which involves in addition the other rescue services (police, fire and mountain rescue teams). It may perhaps be worth while reviewing what has been achieved at this particular time, when so much emphasis is being laid on improving the Accident Services throughout the country.

Equipments and techniques in handling patients: The installation of suction in the ambulances was a major step forward, and this has been supplemented by the carrying of airways and ambu bags. The new type of stretcher trolley

can be located centrally in the ambulance so that ambulance attendants and doctors can have all round access for resuscitation and treatment whilst in transit to the hospital. The addition of inflatable splints for distally sited upper and lower limb fractures has required the mastering of new techniques and has increased very considerably the comfort of such patients. More recently too the use of Entonox (half oxygen, half nitrous oxide) has allowed relief of pain in the conscious patient, without the necessity of giving depressant or nauseating drugs such as morphine or pethidine. On arrival at the hospital transfer of patients to a new type of variable height trolley by sliding rather than by lifting has been another step to reduce pain in the seriously injured patient. In all these changes the officers as well as the men have co-operated whole-heartedly with the hospital staff.

Training and Administration : Training of ambulance personnel had been extended by "in-service" training, even before the recommendations of the Millar report were made public. All members of the ambulance service have spent at least a week in the hospital during which they have learned what goes on in the different hospital departments and have learned at first hand some of the new techniques — particularly the management of airways. This practical instruction has proved to be of greater value than frequent courses of lectures and has, in addition, allowed the hospital staff to get to know the men and their problems at first hand.

The siting of the County Ambulance Station adjacent to the hospital is another big step towards integrating hospital and ambulance services.

Alongside these developments have come improved communications including the provision of a direct land line and of a two-way radio on the ambulance frequency. Sets have been sited not only in the Transport Office and in the Accident Department at the Cumberland Infirmary but also in my own car and more recently in the cars of some of the general practitioners in the Penrith area. This has enabled myself and more recently the Penrith doctors to link up with the ambulances and help with the more difficult resuscitation problems. I would like to record here my appreciation of the numerous occasions when I was taken by the ambulance service (and on some occasions by the police) to meet seriously injured patients en route to the hospital. Whilst I do not think that this extension of the service has resulted in

any dramatic reduction in mortality, it allowed me to learn the problems facing the ambulance service at first hand, so that I was better able to help the ambulance service to solve some of the many problems which have faced them. I think the recent extension of this service to include properly equipped and trained general practitioners in the area is a natural development. Over the long distances which some of the most seriously injured patients have to travel in this area, the problems of resusciation and patient care are such as to demand not only a skilled ambulance attendant and a general practitioner but also a specialist's help from the hospital. Thus I hope that the combined approach which we have developed will continue in the future. I would like, however, to make very strongly the point that the incursion of doctors into the ambulance in no way diminishes the status of responsibilities of the ambulance attendants. On the contrary it has extended their sphere of action considerably, introducing as it has done new equipments, new techniques and a new type of partnership with the medical profession.

All that I have said so far has emphasised the importance of continuing co-operation and ever-closer integration between the rescue services and the medical profession at all stages in the care of the seriously ill and injured. Already the professional rescue services have formed a joint Rescue Services Committee which meets at regular intervals to discuss individual problems and developments as they arise. I would hope that in the future this committee will include — at least at some of its meetings — members of the interested branches of the medical profession.

It is to be hoped that the Department of Health and Social Security will support more actively medical participation in the rescue services as an essential part of the integrated accident service to which we all aspire.

Finally I would like to say what a privilege it has been to work with all the keenly interested and skilled members of the accident team — particularly the nursing staff of the Accident Department in the Cumberland Infirmary, and the Cumberland County Ambulance Service."

For the second time since the introduction of a directly provided service a team from Cumberland represented the region in the finals of the National Competition. Although they did not win their's was a most praiseworthy performance.

Stations

After much delay the building of the new Carlisle Station near the Cumberland Infirmary was finally completed in November. It has taken ten years to achieve this purpose-built building as the station was first housed in most unsatisfactory buildings in the Gaol Yard in June, 1962, on a temporary basis. It is an excellent station and very much appreciated by the staff.

Mr. J. Butler, Officer in Charge, comments as follows :—

"This is an ideal ambulance station which has been well planned to give excellent working conditions, and is an easily worked station. The Control Room is well situated with a full view of all vehicles leaving and returning to the station. The men have a pleasant mess room with full cooking facilities.

There are adequate storage rooms for blankets and first aid equipment, and as we have our own petrol supply this saves considerable time and mileage, especially at night.

There is good access to and from the station. It was thought prior to moving that the parking of vehicles in Infirmary Street would cause problems but this has not arisen."

The station at Maryport referred to earlier came into operation on 1st April and is housed in premises rented from the Maryport Urban District Council.

Mr. Chapman, the Officer in Charge, reports on the progress throughout the year as follows :—

"First I feel I must thank the following people; all the members of Maryport ambulance staff for their hard work and endeavour in cleaning and preparing the premises we took over in April, 1971. They did a first class job; the general practitioners, whose area we cover for their co-operation at all times and in all emergencies; and, of course, the police whose help we needed from the beginning to ensure that we had a clear exit from the station and into the main thoroughfare.

Although not a purpose-built station, I am sure that when all the necessary adaptations have been carried out it will compare very favourably with the purpose-built stations and give us all the facilities and amenities that they enjoy.

One aspect of the service that pleases me greatly is the fact that we appear to be attracting younger men into the work. I feel sure that this is because we are now able to project a much better image and they realise that this is specialist work in a very demanding but rewarding field.

Meeting people from all walks of life, treating and caring for them in various ways under all kinds of conditions, gives great satisfaction. Each day we seem to be called on more and more. The more professional we become, the more other branches of the medical services, other emergency services and the general public realise we are the experts in our field. This seems to lead to a much better liaison with hospitals' staff, the welfare services as well as the general practitioners. Our knowledge and skills are being sought after in all kinds of emergencies.

Ambulancemen continue to keep a watching brief over the elderly and disabled with whom they come into contact in the course of their work, communicating whenever necessary with the Social Services."

Approval has been received from the Department of Health and Social Security for the erection of purpose-built stations at Millom and Keswick. Building will commence on the former during 1971/72 and on the latter in 1972/73. These moves are very much welcomed as it will be possible to replace the existing contractual arrangements in Keswick with a directly provided service as well as the far from satisfactory temporary premises at Millom in which the staff have had to work since 1963.

Accident and Emergency Scheme — Penrith

The general practitioner group in Penrith whose cars are fitted with radio operating on the ambulance service have been called out to accidents and emergencies throughout the year. There may well have been some initial concern on the part of the ambulance crews as to exactly what their role would be, both short and long term, but experience showed they had no grounds for concern. Throughout the year both ambulancemen and doctors have worked well together and this can only have resulted in better treatment for the patient who is always the first priority, and also helped in furthering the training of the ambulancemen in the observation of the patient, a very important factor in ambulance

aid, all of which enhances the status of the ambulanceman. Joint training sessions involving both doctors and ambulancemen are contemplated.

Other doctors are keenly interested in these arrangements which have attracted local financial support and I am sure that the scheme will continue to develop. I foresee the day when the whole of the motorway and M6 from the Border to Shap and the A66 in North Westmorland to Keswick will be covered.

Emergency Services Liaison Committee

As the operational work of the ambulance service requires close liaison with the Police and Fire Service particularly in relation to road traffic accidents, it was felt there was a need to establish an Emergecy Services Liaison Committee, the primary object of which was the promotion of the closest possible co-operation and working relationship between the three services. Small points of difficulty could be settled as they occurred instead of being allowed to accumulate without being resolved.

The experience throughout the year has shown the value of setting up the committee. For example, it is now accepted by the other services that the removal of a trapped casualty should only be carried out under the direction of the ambulancemen. I am sure the work of this committee which has been extended to include the emergency services in Westmorland, will continue to develop; already questions relating to major accidents procedures in relation to the motorway and the call out of doctors have been referred to it for advice.

Equipment

During the year the Department of Health and Social Security issued guidance on the resuscitation equipment which they recommend should be carried on all ambulances. There was very little which we did not already carry and this will be remedied during the coming financial year.

The experiment in the use of Entonox which was carried out last year in East Cumberland proved very effective, in the alleviation of pain generally but particularly in the case of a patient who was trapped.

It is a self-administered gas and is offered by the ambulance crew to patients, only when they are conscious and have no facial or jaw injuries. Pain following injury (fractures, etc.) is the most frequent indication for its use, but there is no reason why it should not be used for medical and surgical emergencies (e.g. coronary thrombosis or perforated ulcer). The use of Entonox in midwifery is already well established.

The use of the equipment which has now been recommended by the Department of Health and Social Security will be extended throughout the service next year when further finance will be available.

Vehicles

During the year orders were placed for one traditional ambulance and five dual-purpose vehicles but delivery is not expected until early in 1972. During the year delivery was taken of three traditional ambulances and one dual-purpose vehicle but these were vehicles ordered last year.

In order to improve the safety factors in ambulances generally the Department of Health and Social Security issued recommendations. All new vehicles will have these new safety specifications incorporated. It is not possible to carry out all the recommendations on the existing fleet because some involve structural alterations but all that were possible have been carried out.

Hospital Car Service

During the year the voluntary members of the Hospital Car Service carried 36,015 patients and covered 614,375 miles. A debt of gratitude is owed to these drivers, who carry out their duties most cheerfully and in all kinds of weather.

This service is very much appreciated by all patients but especially by the elderly, as is evidenced in the following comments of two Hospital Car Service drivers :—

Mrs. I. Benson of Millom writes :—

"It is pleasant to meet the patients and if one is prepared to spend the time one can become quite involved. I find loneliness is a great enemy of the old people, who are really the kindest and most thankful of all the patients.

One old lady who was a regular for a while for physiotherapy gave me the money to pay her rates and electric bills. I bought her Christmas cards, posted her parcels, even bought the postal order for her football pools. It is good to be trusted, but alas for her the treatment finished with much regret on her part, as she lives in the country and is another of the very lonely."

While Mr. H. Graham, Dovenby, Cockermouth, comments:

"I have participated in this service for the last ten months and have found it a most interesting and satisfactory occupation, more so, because previously I spent twenty years as a male nurse.

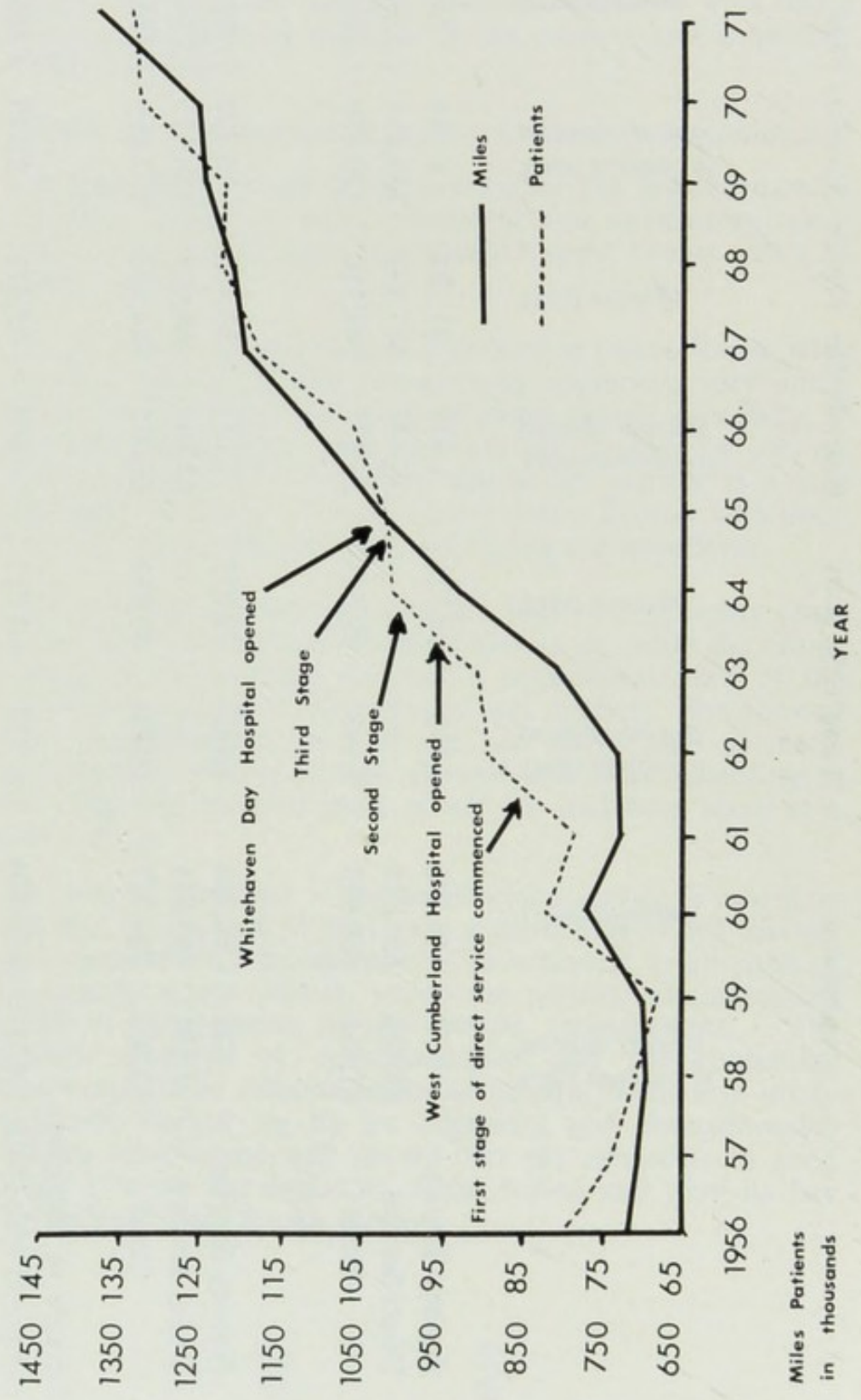
Since I entered the Hospital Car Service I have found, with very few exceptions, that the patients appreciate very much the service provided for them. Elderly people especially, if they are well enough, seem to enjoy the journey by car, no doubt, because they live alone and a car journey is a rare experience for them. I find at times that a journey with them is all too short owing to their interesting conversations.

To give you one instance, I took a lady of over eighty years to the West Cumberland Hospital and as we made the return journey in the evening she had a magnificent view of the lights of the town of Whitehaven and district. She showed great excitement as she said she had never seen so many lights before and the joy she showed was most rewarding to me. She told me that most of her life had been spent in a quiet village."

It will be seen that a new streamlined service is emerging and that by the end of next year a directly provided service, with purpose-built buildings, will be extended to all parts of the county except Alston, where the peculiar circumstances justify a continuation of the present arrangements. The modern methods of communication and the continuing improvements in vehicles in terms of equipment and safety standards backed up by an organised and comprehensive training programme will ensure that the service is in good shape to meet the demands of the future and play its key role in the future health service.

	Ambulance		Sitting Case Cars		Hospital Car Service		Summary of all Services	
	Total number of patients carried	Total mileage	Total number of patients carried	Total mileage	Total number of patients carried	Total mileage	Total number of patients carried	Total mileage
1970								
Agency Service	498	13,898	5,198	29,321	1,048	31,384	6,744	74,603
Direct Service	86,988	656,015	—	—	35,427	517,580	122,415	1,173,595
Total	87,486	669,913	5,198	29,321	36,475	548,964	129,159	1,248,198
1971								
Agency Service	622	16,206	4,481	32,833	1,121	33,455	6,224	82,494
Direct Service	91,581	693,511	—	—	34,894	580,920	126,475	1,274,431
Total	92,203	709,717	4,481	32,833	36,015	614,375	132,699	1,356,925
Increase or decrease compared with 1970	+4,717	+39,804	−717	+3,512	−460	+65,411	+3,540	+108,727

CUMBERLAND GROWTH IN THE USE OF THE AMBULANCE SERVICE



GENERAL PUBLIC HEALTH

Infectious Diseases
Inspection and Supervision of Food
Housing, Water and Sewerage

INFECTIOUS DISEASES

The following table shows the relative improvement of the infectious disease situation in the county. As was to be expected, following the re-introduction of an accredited measles vaccine and an intensified vaccination programme in the latter half of 1970, the notifications of the incidence of measles were considerably reduced to 296.

We have now reached the stage where it is estimated that in the community at this point in time there are about 1,000 non-immune pre-school children two years of age and over, and about 600 non-immune school children.

These groups represent those children under school leaving age who are outside of the comprehensive computer call-up programme, and it is hoped that it is possible to give an almost 100% immunity index to children in this group within the next three years, particularly to those children leaving school.

Infective jaundice, first notified in 1968, is the next most common notifiable disease, the number having fallen to 107 cases this year. Wigton Rural District is once again the area where most cases have been notified.

The continuing decrease in the number of respiratory tuberculosis and other tuberculosis notifications is worthy of note. I would like to stress, however, that public and professional opinion should not be allowed to take on any degree of complacency over the comparative eradication of the disease over the past two decades, and an ever vigilant watch must be kept by all concerned against the slightest signs of increase in incidence.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES 1971

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentry	Acute Encephalitis -Infective	-Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Food Poisoning	Tuberculosis -respiratory	-Meninges and C.N.S.	-Other T.B.	Puerperal Pyrexia	Infective Jaundice	Erysipelas	Puerperal Sepsis	Acute Meningitis
Urban Districts :																		
Workington	15	—	—	8	—	—	—	—	—	1	6	—	1	—	—	—	—	1
Whitehaven	2	—	—	1	—	—	—	—	—	—	7	—	1	—	1	—	—	1
Cockermouth	—	—	—	3	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Keswick	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Maryport	3	—	—	42	—	—	—	—	—	—	2	—	—	—	9	—	—	—
Penrith	1	1	—	1	5	—	—	—	—	—	2	—	—	—	—	—	—	—
Rural Districts :																		
Alston	—	—	—	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	4	1	—	43	—	—	—	—	—	2	1	1	1	—	3	—	—	—
Cockermouth	5	2	—	54	—	—	—	—	—	2	2	—	—	—	6	—	—	1
Ennerdale	1	1	—	—	—	—	—	—	—	—	4	—	—	—	—	—	—	—
Millom	11	1	—	9	4	—	—	—	—	1	1	—	—	—	3	—	—	—
Penrith	5	4	—	2	—	—	—	—	—	—	1	—	1	—	12	—	—	—
Wigton	6	5	—	132	4	—	—	—	—	1	2	—	—	—	73	—	—	—
Total for Year	53	15	—	296	14	—	—	—	—	6	30	1	4	—	107	—	—	3
1970	58	14	—	1987	9	—	1	—	—	4	42	—	8	—	140	1	1	—
1969	84	1	—	401	39	—	2	1	—	17	41	—	12	—	82	—	—	—
1968	55	51	—	742	303	—	—	2	2	2	39	1	10	2	46	—	—	5
1967	60	76	—	2204	37	—	—	—	—	2	46	—	11	11	—	—	—	1
1966	184	83	—	1183	14	—	—	1	—	4	54	—	13	33	—	—	—	1
1965	76	17	—	3480	261	—	—	—	31	10	56	2	10	7	—	—	—	—

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

	Total Samples	Genuine	Unsatisfactory
Milk	621	458	163
Other Food ...	61	57	4
	682	515	167

Of the total samples obtained, 163 (26.2%) of the milk and 4 (6.5%) of other foods were unsatisfactory; 59 milk and 58 other foods being analysed by the Public Analyst. In addition to the compositional analysis of milk, tests were also made for the presence of antibiotics but none were detected.

The average quality of the milk samples was 3.62% fat and 8.63% non-fatty solids, the presumptive minimum standards being 3.0% and 8.5% respectively.

In addition to milk samples the Sampling Officers also made informal tests on meat pies to ascertain whether the meat content was to the required standard.

The pattern of milk production in the County is rapidly changing and more and more farmers are installing automatic milking systems where all the milk produced in one day is stored in refrigerated tanks and is collected by large tanker vehicles perhaps daily or every other day. Where such systems are in use it is essential that a sample be taken before the milk is collected because once it is in the collecting vehicle with milk from other farms nothing can be done about it. Quite a number of samples were taken from bulk supplies as well as a number from churns of milk.

The samples which were unsatisfactory included 15 slightly deficient in fat and 85 deficient in non-fatty solids. These deficiencies appeared to be due to natural causes, the milk being genuine but of poor quality. Further samples were taken later and in most cases the quality had improved.

Freezing point tests on a further 25 samples indicated that the deficiencies in non-fatty solids were due to the presence of added water. In those instances where the deficiencies were serious, formal samples were obtained from the same sources of supply and submitted to the Public Analyst. In some cases where the amounts of added water were small, enquiries indicated that this could have been due to faulty cleansing of milking installations. The producers concerned were advised to take more care in this operation and further tests indicated that the advice had been heeded.

Thirty-eight milk samples submitted to the Analyst were from six different farms as follows :—

8 samples from churns with added water ranging from	0.8% to 9.1%
6 samples from churns with added water ranging from	12.9% to 30.1%
13 samples from churns with added water ranging from	3.2% to 26.7%
3 samples from churns with added water ranging from	9.8% to 16.8%
7 samples from churns with added water ranging from	4.1% to 8.3%

1 from a bulk tank with 17.2% added water.

In each case corresponding "appeal to cow" samples, taken at the conclusion of evening and morning milkings, were of genuine quality. The six farmer/producers concerned were prosecuted and fines totalling £135 were imposed in five instances plus costs of £182.26 while one was granted an absolute discharge on payment of £22.60 costs.

Food other than milk

The four articles of food upon which the Analyst reported adversely were pork sausage and three loaves of bread. The pork sausage was found to contain preservative which was contrary to a statement made by the manager of the shop where the sausage was sold. Apparently the filler used in the manufacture of the sausage contained sulphur dioxide which fact had not been realised by the manager. A notice was afterwards displayed declaring that sausage sold on those premises contained preservative.

The three loaves of bread were each the subject of complaint by the purchasers. A sliced loaf had dark streaks of foreign matter in the slices and the purchaser, unable to obtain any satisfaction from the retailer, reported the matter. The Analyst confirmed extensive contamination by foreign matter composed of vegetable and iron compounds, the high concentration of the latter indicating that the foreign matter was machinery lubricant. The bakery firm concerned was prosecuted and fined £25. The second case concerned bread which was grossly contaminated with mould; legal proceedings would have been taken but the purchaser was reluctant to give evidence in Court therefore the bakers were cautioned. The third loaf contained a beetle and in this instance the bakers were prosecuted and fined £75 plus costs of £6.

Three articles of other food were submitted to the Analyst as a result of complaints by the purchasers. Firstly chocolate coated toffee rolls were alleged to have a musty taste but chemical and microscopical examination did not support this contention. Secondly some toffee was alleged to have caused a child to vomit but the Analyst was unable to find anything wrong with the remaining portion of the toffee. Thirdly some foreign matter in white bread was suspected of being dirt or grease but the Analyst found it to be fragments of a vine fruit and no further action was taken.

Several complaints were received concerning items of food which did not necessiate analysis. A loaf of bread contained a chronium plated nut which appeared to be from machinery at the bakery and for which the bakers were cautioned. A chocolate egg which bore discolourations had most probably been over exposed to light and a firm of sweet manufacturers was cautioned in respect of a "humbug" in which was embedded a piece of metal. Legal proceedings would normally have been taken for the "humbug" but the complainant, a schoolgirl who had been on holiday in the area, was unable to state with certainty at which shop the purchase had been made.

Two further complaints concerned mouldy bread rolls and mouldy sandwiches. It was not possible to establish the condition of the food when purchased therefore no further action was taken except to pass the complaints on to the suppliers of the products.

Following the discovery of the body of a mouse in a bag of flour the complainant refused to give evidence in the event of proceedings being taken and the manufacturers were cautioned.

No action was taken for a loaf of bread alleged to contain a needle. It was apparent the needle had been pushed into the bread after wrapping and it was impossible to determine at what stage this had been done. The possibility that the needle had been inserted after the bread was purchased could not be disregarded.

Milk (Special Designation) Regulations

The only infringements of these Regulations, which govern the retail sale of milk, were instances where suppliers of cartons of milk had failed to label the cartons with their names and addresses.

HOUSING, WATER AND SEWERAGE

Housing

There were 74,298 occupied dwelling houses in the county at the end of 1971 showing a growth rate of 0.5%, which is similar to that for 1970. This indicates an average of 3.3 persons per dwelling.

Of this number 248 are subject to Demolition Orders, Closing Orders or Undertakings and it is estimated that in addition there are 2,310 which are unfit for habitation and cannot be made fit at a reasonable cost. In total this represents 2,558 or 3.4% of all occupied dwelling houses and compares with 3.7% for 1970 and 4.2% for 1969.

In spite of the outward migration from the county, waiting lists for council dwellings are getting longer and 4,739 applications are outstanding compared to 4,412 (1970), 4,183 (1969), and 4,050 (1968).

The number of new dwellings completed during the year has remained fairly constant at 861, but classifications have changed and the drop in the number of general purpose council dwellings has been offset by the increase in private buildings.

House improvement grant applications have increased to 1,121, double that for 1968, and there is an associated increase in the numbers approved (991) and those where improvements have been made and the grant paid (763).

Lastly the housing programme for 1972 is more ambitious, where 1,582 dwellings are expected to be built compared to the 1,492 previously envisaged for 1971.

Water

Two small schemes, for the provision of a water supply to Hill Head in the Border Rural District for Carlisle Corporation, and for laying water mains at Tynehead and Garrigill for the Eden Water Board, have been approved by the County Council.

The Eden Water Board received a lump sum grant from the Department of the Environment for a small improvement scheme at Linden - Ellercow, Langwathby. They also received a grant of half-yearly payments for 30 years for their Pennine Water Scheme.

The County Council made equivalent grants in both cases.

In 1971 the Central Advisory Water Committee published their report on "The Future Management of Water in England and Wales". After consideration of this report by the Government, the Department of the Environment issued a ciruclar in December, 1971, setting out the Government's proposals for the reorganisation of water and sewage services and consultation arrangements. The proposals are far-reaching and envisage the establishment by 1st April, 1974, of ten all-purpose Regional Water Authorities to take over certain of the functions currently performed by River Authorities, Local Authorities, the British Waterways Board, joint water boards and joint sewerage boards.

The Local Authority functions concerned are those relating to water supply and sewage disposal, including trunk sewerage which the proposed Regional Water Authorities would need for the efficient discharge of their duties.

The areas proposed for the Regional Water Authorities in the circular indicate that Cumberland, except for its most easterly part, would be within an Authority area extending from the Scottish Border to Cheshire.

The Government's proposals are being considered by the County Council in accordance with the consultation arrangements provided in the circular.

Sewerage

Five schemes were submitted for the observations of the County Council during the year.

The Border Rural District Council submited schemes for improving sewerage and sewage disposal facilities at Carleton, Carlisle, and for extending the sewerage system at the southern part of Longtown. The Millom Rural District Council submitted a scheme for providing, with the benefit of a contribution from a private developer, sewerage and sewage disposal facilities for Ravenglass including proposed housing and caravan site development there.

Schemes submitted by the Cockermouth Rural District Council and the Wigton Rural District Council related respectively to the extension of the Lillyhall Sea Outfall and to the provision of sewerage and sewage disposal facilities for the village of Blencogo, Bromfield and Langrigg.

The Border Rural District Council received grants from the Department of the Environment of half-yearly payments for 30 years in respect of their schemes at Cumwhitton, Aglionby, Carleton, Smithfield and Harker; and the Wigton Rural District Council received a similar grant for their scheme at Caldbeck and Hesket Newmarket. The Penrith Rural District Council received lump sum grants in respect of their Threlkeld and Greystoke schemes.

The County Council made equivalent grants in all cases.

Information obtained by the Department of the Environment from the sewerage authorities on their programmes for the next ten years indicated that 75% of properties in rural areas are connected to public sewers and that works included in the ten years' programme at an estimated cost of £242,000,000 would increase this to 85%. In Cumberland the present percentage figure is 74% which would be raised to 79% by works proposed by the sewerage authorities over the next ten years which are estimated to cost £880,000.

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. County Council Clinics.

APPENDIX I

Annual Report On Tuberculosis and Other Chest Diseases in West Cumberland by Dr. R. Hambridge

During 1971 there was again a slight fall in the number of known cases of tuberculosis on the Register in West Cumberland: and there was only one death from known disease. However, three further deaths occurred without the diagnosis being made in life, notification thus occurring after post-mortem.

Tuberculosis Register :

	Men	Women	Children	Total	
Respiratory T.B.	305	194	19	518	(576)
Non-Respiratory T.B.	33	34	7	74	(80)
Total	338	228	26	592	(656)

(Figures in brackets relate to comparable data for 1970)

Some 41 cases were removed from the Register for various reasons: of these, 26 cases were removed deemed recovered (65 in 1970). Twelve cases were removed because of death from diverse causes deemed not tuberculous; and three cases were transferred out or removed after reconsideration of the diagnosis.

New Cases

A total of 28 new cases were added to the Register during the year suffering from notifiable active disease. The respiratory group was made up of 17 men, four women and six children. An additional group of respiratory cases requiring observation but not deemed notifiable, contained five men and four women; and there was one non-respiratory male case.

In summary there were 37 new cases of all types notified and not notified compared with 68 such cases in 1970. A total of 16 cases, drawn from the existing Register and new cases diagnosed during the year were infectious at the time of diagnosis (22 in 1970).

Examination of Contacts

The tracing of familial and household contacts of new cases has continued : in the main only children and infants have been seen at Outpatients, adults being referred to the Static 100 m.m. X-ray Units at Workington Infirmary and the West Cumberland Hospital. All children between the ages of three months and 15 years, not already vaccinated with B.C.G. at school, have been tuberculin-tested (1/1000 O.T.) and non-reactors vaccinated. Below the age of three months tuberculin-testing has been dispensed with as was initiated last year : there have been no observable contra indications to this and no infants have developed a Koch Phenomenon after B.C.G. vaccination.

A total of 199 contacts — children over 15 and adults — are known to have passed through the Static M.M.R. Units, no cases of notifiable disease being found.

Of 51 familial contacts tested with 1/1000 O.T., eight were found reactors and of these, five little boys were notified and treated for active primary tuberculous disease.

B.C.G. Vaccination

A total of 177 infants and children, including new-borns was vaccinated during the year (244 in 1970; 331 in 1969).

As in previous years the results of skin-testing, carried out by School Medical Officers under the County Health Department programme of skin-testing and vaccinating 13 year olds, have been forwarded to this Department.

From these it is now possible to show a very favourable trend reflecting the efficacy of contact tracing and subsequent B.C.G. vaccination in those scholars now 13 years old but deemed in infancy to be liable to infection. Of 13 year old children attaining that age in 1964, 1965 and 1966, some 35% in each year gave a positive skin reaction as a result of previous vaccination with B.C.G. These cohorts of course represent children born in 1951, 1952 and 1953 respectively. It was not until the end of 1953 that the programme of contact tracing and extending B.C.G. vaccination to infants of tuberculous households became regularly established as a function of the Chest Service. Once established, however, and providing that B.C.G. was being offered to those infants who in fact would subsequently meet infection, it could be expected that the cohorts of 1954 onwards should show, when aged 13, an increasing proportion of reactors so produced by their earlier vaccination.

This has in fact materialised and the figures for the relevant years are as follows :— the 1954 cohort (aged 13 in 1967) contained 346 total reactors, of which 40% were so by virtue of vaccination. In 1968 the total of reactors was 340 of which 45% were so by virtue of vaccination. In 1969 the 1956 cohort contained 283 reactors and of these 60% have been given B.C.G. and, similarly in 1970, 234 total reactors contained 76% B.C.G. reactors; in 1971 the 1958 cohort produced 221 reactors of which 82% had been given B.C.G. in earlier life.

It can be seen that of almost 600 school-children reacting to tuberculin and born in 1951 some 65% did so by virtue of "natural" infection, and must run the risk of developing subsequent disease. By 1958, of 221 children born that year and reacting to tuberculin, 18% did so because of similar exposure to infection. Not only has the total number of reactors in the school population fallen, but the proportion of these already protected by B.C.G. has risen to something in excess of eight out of ten.

Static Mass X-ray Units

The two 100 mm. units have operated, each on a part time basis, during the year; both of them have been erratic and unreliable because of poor servicing of technical defects, and both units have experienced temporary closures because of unavailability of staff.

The work of the units is set out in tabulated form below, the comparative total figures for 1970 being shown in brackets.

	West Cumberland Hospital		**Workington Infirmary**	
	No. of Miniature Films taken	No. of Patients recalled	No. of Miniature films taken	No. of Patients recalled
General Public	1008	9	832	9
Doctors' Cases	689	30	850	40
Contact Cases	145	2	54	—
Outpatients	191	—	3	—
Firms	891	5	633	3
Scholars	38	—	11	—
TOTAL	2962 (3385)	46	2383 (2320)	52
	Combined Total : 5345 (5705)			

Of the 46 recalled cases at West Cumberland Hospital the following common conditions were diagnosed: Active T.B. 4; Inactive T.B. 7; Neoplasm 3; Sarcoid 3; Acquired Cardiac Conditions 1; Pneumoconiosis without P.M.F. 1.

At Workington similarly, of 52 recalled cases the disorders listed were: Active T.B. 4; Inactive T.B. 2; Neoplasm 9; Sarcoid 2; Acquired Cardiac Conditions 1; Pneumoconiosis without P.M.F. 3.

Once again the proportion of General Practice referrals to both units has been in the order of 27% — 28% as was the case in the previous year: to some extent the erratic function of the units is expressed in these figures.

Outpatient Clinics

Sessions have continued at both Workington Infirmary and the West Cumberland Hospital at which 202 and 215 new patients were seen respectively, totalling 417 (488 in 1970). Old patients seen at these two centres were 443 and 489 respectively, totalling 932 (1133 in 1970). Thus the total Outpatient attendances at both centres was 1349 (1621 in 1970).

Inpatients

Admissions to Homewood continued throughout the year, the proportion of tuberculous to non-tuberculous being expressed in the discharge figures of 39/111, i.e. a total of 150 patients discharged compared with approximately 160 in 1970.

Pulmonary Neoplasm

The number of these cases diagnosed by the Mass X-ray Units during the year was 12. In all, 31 cases were dealt with by the Chest Service comprising 28 men and three women (33 men and five women in 1970). Of these, 16 were investigated with a view to surgical treatment, and of these 16, seven were treated either by pneumonectomy or lobectomy; whilst two were given Deep X-ray Therapy alone.

APPENDIX II

Annual Report on Tuberculosis and other Chest Diseases in East Cumberland by Dr. R. J. C. Southern

Introduction

The records for 1971 show a fall in the number of both new and old patients attending the chest centre. New cases numbered 1195 as against 1593 in 1970. This reflects a fall in the number of new cases of tuberculosis and their contacts and a fall in the numbers attending the Mass Radiography Unit.

Total attendances numbered 7090 as against 8316 in 1970; this fall is partly due to a reduction in patients attending for physiotherapy, B.C.G. vaccination and follow-up X-rays, and partly due to a conscious effort to eliminate all non-essential re-attendances.

Tuberculosis

Table 1 shows the number of cases on the Tuberculosis Registers at 31.12.71.

Table 1

	East Cumberland	Carlisle City	North Westmorland	Total
Respiratory	114 (126)	138 (138)	12 (14)	264 (278)
Non-Respiratory	11 (11)	22 (27)	1 (2)	34 (40)

During the year 40 cases were removed from the Registers, 12 through death. Six of these patients had active disease at the time of death but in only two was tuberculous disease the primary cause of death, and the patients were aged 74 and 85 respectively.

Table 2 shows the number of new cases diagnosed during the year, figures for 1970 being in brackets.

Table 2

	Respiratory				Non-Respiratory			
	M	F	Ch	Total	M	F	Ch	Total
East Cumberland	5	2	—	7 (14)	—	1	—	1 (2)
Carlisle City	10	5	—	15 (26)	—	—	—	— (3)
North Westmorland	—	1	—	1 (1)	—	—	—	— (-)

Table 3 shows the number of beds available specifically for the treatment of respiratory disease. During the year ten of the beds in Ward 18 at the Cumberland Infirmary have been upgraded to match the three dealt with previously.

Table 3

Hospital	Beds available	No. Discharged in 1971	No. Discharged in 1970
Ward 18			
Cumberland Infirmary	13	230	216
Longtown Hospital	26	86	108

The decrease of 18 in the number of new cases of pulmonary tuberculosis brings the figure back into line with those of recent years, up to 1970. The unexpected doubling of new cases in 1970 was fortunately not repeated in 1971. Despite the number of new infectious cases discovered in 1970, in only two of the new cases found in 1971 could any contact with any of those previous cases be established.

Examination of Contacts

A total of 1271 new contacts were seen in 1971 compared to 1462 in 1970. Only one case of active tuberculosis was discovered as a result.

In addition six infants and children were found to be tuberculin positive and were given prophylactic chemotherapy.

All Mantoux negative contacts were offered B.C.G. vaccination.

Mantoux testing and B.C.G. vaccination of hospital staff is now undertaken by the Hospital Staff Medical Officer.

Table 4 shows the number of B.C.G. vaccinations performed during 1971.

Table 4

East Cumberland	Carlisle City	N. Westmorland
59	89	10

The X-ray examinations of tuberculin positive school children revealed no cases of active tuberculosis.

Carcinoma of Bronchus

The number of cases diagnosed at the chest centre shows an increase of two over 1970; in fact there are slightly fewer cases in males and more in females. This reflects the national trend and is attributable to the increase in cigarette smoking amongst females over the past 20 years.

As in the past a relatively small proportion of cases have been suitable for potentially curative surgery; a larger number have had palliative radiotherapy, and a few, treatment with Cytotoxic drugs. The results of treatment remain depressing, and of the 53 new cases diagnosed only 29 had survived to the end of the year.

Of the total of 53 new cases, 21 were diagnosed through the mass radiography unit.

Table 5 shows the details of these cases.

Table 5

New cases of bronchial neoplasm seen at the chest centre in 1971

	Males	Females	Total	Suitable for surgery
East Cumberland	20 (20)	4 (2)	24 (22)	0 (2)
Carlisle City	22 (23)	5 (2)	27 (25)	5 (4)
North Westmorland	2 (3)	0 (1)	2 (4)	0 (0)
	44 (46)	9 (5)	53 (51)	5 (6)

Mass Radiography

In February, 1971, the Unit moved from Brunswick Street to the City General Hospital. In spite of the change of location and its present rather less convenient site the numbers attending have shown a smaller reduction than expected.

In addition to the Static Unit in Carlisle the Mobile Unit from Newcastle carried out one survey in the area, 293 films being taken.

Table 6 refers to the Unit now at the City General Hospital.

Table 6

	1971	1970	1969
Miniature films	5349	6674	6419
Referred for clinical examination	343	434	324
Active Tuberculosis	8	17	4
Inactive Tuberculosis	12	8	14
Bronchiectasis	7	3	5
Neoplasm	21	26	17
Pneumoconiosis	0	2	1
Sarcoidosis	1	1	2
Cardiac conditions	39	30	29
Doctors cases	2402	3014	3152
Contacts from Chest Centre	152	234	37
General Public	1722	2307	2416
Works personnel	1073	1117	814

(The group 'works personnel' includes local authorities employees, school teachers, etc.).

Acknowledgments

My thanks are due to Dr. H. L. R. Sargant and to the nursing and clerical staffs for their continued hard work and co-operation during the past year.

APPENDIX III

County Council Clinics

Centre	Address	Clinic Services
Alston	Cottage Hospital, Alston	Child Health, Chiropody, Dental, Family Planning, Vaccination and Immunisation.
Aspatria	St. Mungo's Park, Aspatria	Child Health, Dental, Chiropody, Social Classes for Blind and other handicapped, Speech Therapy, Mothercraft, and Probation.
Brampton	Union Lane, Brampton	Chiropody, Dental, Mothers' Club and Probation.
Broughton	Nurse's House, Little Broughton	Child Health.
Carlisle	14 Portland Square, Carlisle	Cervical Cytology, Chiropody, Dental, Hearing, Ophthalmic, Orthoptic, Orthopaedic and Speech Therapy.
Cleator Moor	Ennerdale Rd., Cleator Moor	Ante-Natal, Cervical Cytology, Chiropody, Dental, Vaccination and Immunisation.
Cockermouth	Harford House, Main Street, Cockermouth	Cervical Cytology, Chiropody, Dental, Ophthalmic, Orthoptic, Speech Therapy, Developmental Testing, Vaccination and Immunisation.
Dalston	Victory Hall, Dalston	Child Health.
Egremont	St. Bridget's Lane, Egremont	Ante-Natal, Child Health, Chiropody, Dental, Speech Therapy, Vaccination and Immunisation
Frizington	Council Chambers, Frizington	Ante-Natal.
Houghton	The Village Hall, Houghton	Child Health.
Hunsonby	The Village Institute, Hunsonby	Child Health.
Keswick	13 - 15 Bank Street, Keswick	Cervical Cytology, Ophthalmic, Orthoptic Relaxation, Speech Therapy, Developmental Testing Vaccination and Immunisation.

Centre	Address	Clinic Services
	Cottage Hospital, Keswick	Dental.
Longtown —	Burn Street, Longtown	Cervical Cytology, Child Health, Dental, Mothercraft, Physiotherapy, Play-group, School Clinic, Hearing, Weight Reduction, Chiropody, Probation, Social Class for Handicapped, O.P.W. meetings, Blood Transfusion, Vaccination and Immunisation.
Maryport —	24 Selby Terrace, Maryport	Ante-Natal, Cervical Cytology (at surgery), Child Guidance, Dental, Obesity (at surgery), Speech Therapy, Developmental Testing, Vaccination and Immunisation.
	Cottage Hospital, Maryport	Chiropody.
Millom —	18 St. George's Road, Millom	Ante-Natal, Cervical Cytology, Child Guidance, Child Health, Dental, Family Planning, Speech Therapy, Vaccination and Immunisation.
Nenthead —	Overwater, Nenthead	Child Health, Chiropody and G.P. Surgeries.
Penrith —	Brunswick Square, Penrith	Cervical Cytology, Child Care, (Social Services Department), Child Health, Special Care Unit, Chiropody, Dental, Family Planning, Hearing, Marriage Guidance, Mothercraft, Mothers' Club, Physiotherapy, Orthoptic, Probation, Psychiatric, Speech Therapy, Social Class for Handicapped.
Scotby —	The Village Hall, Scotby	Child Health.
Seascale —	Gosforth Road, Seascale	Child Health, Dental, Chiropody, Physiotherapy, Vaccination and Immunisation.
Silloth —	G.P. Surgery, Silloth	Chiropody.
Thursby —	The Church Hall, Thursby	Child Health.

Centre	Address	Clinic Services
Wetheral	The Village Hall, Wetheral	Child Health.
Whitehaven	Flatt Walks Clinic, Whitehaven	Ante-Natal, Cervical Cytology, Child Guidance, Child Health, Chiropody, Dental, Family Planning, Hearing Therapy, School Speech Therapy, Vaccination and Immunisation.
Mirehouse	Dent Road, Mirehouse, Whitehaven	Ante-Natal, Child Health, Vaccination and Immunisation.
Woodhouse	Woodhouse, Whitehaven	Child Health, Mothercraft, Vaccination and Immunisation.
Wigton	Birdcage Walk, Wigton	Cervical Cytology, Child Health and Developmental Services, Chiropody, Dental, Probation, Mothercraft and Speech Therapy.
Workington	Park Lane, Workington	Cervical Cytology, Ghild Guidance, Chiropody, Dental, Family Planning. Hearing Therapy, Marriage Guidance, Speech Therapy, Developmental Testing, Vaccination and Immunisation.
Salterbeck	Holden Road, Salterbeck, Workington.	Cervical Cytology, Chiropody, Dental, Developmental Testing, Vaccination and Immunisation.

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