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CUMBERLAND COUNTY COUNCIL

THE HEALTH OF CUMBERLAND 1972

REPORT OF THE COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON

THE HEALTH OF THE COUNTY

FOR THE YEAR 1972

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

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PREFACE

To the Chairman and Members of the County Council,

The year that has just passed is one in which several of the health statistics are the best ever recorded in Cumberland.

In the overall health picture, the risk groups, in this rural community, continue to be the mothers and young children, the physically handicapped, the mentally disordered and the elderly.

In the first group - mothers and young children - the infant death rate and the peri-natal death rate are both under national average for England and Wales and in considering this situation I feel that the community owes a great deal to the health services generally, to obstetricians and midwives acting as teams in hospitals, where all but two percent of mothers are confined, and to general practitioners with their domiciliary midwives.

What a change the picture is today compared with that painted only a dozen, or so, years ago. The infant wastage now is generally half of what it was then, and here again the expert care of the consultant paediatricians and their units, together with a good linkage with paediatric care in the community, brought about this happy state.

By using the County Council computer, children are now being routinely brought forward by their parents for immunisation procedures in their own family doctor's surgery and the procedure is usually carried out by an attached health visitor or nurse member of the family health care team. It is remarkable that some 91% of children are now so protected against some 70% in previous years and it is heartening to me that the protection against the commonest communicable disease is slowly bringing under control those widespread outbreaks of measles which we have suffered from every alternate year in this country in the past.

It is also an interesting side-light to realise that the same computer brings forward parents with their three year old children to see the dental officers in the County Council Dental Clinics and there is evidence that the fluoridation of public water supplies is already showing in the better condition of the teeth of the children coming from areas in which the water has its fluoride content adjusted to a dental optimum.

Having said all this, one must also point out that the year carries the lowest ever birth rate recorded in Cumberland and the natural increase is tending to diminish — facts which have great planning implications for the future.

The next group is the physically handicapped. In the county their care continues to be a combined Health and Social Services operation. On the health front, the primary medical team takes in the ongoing care mainly by the work of the health visitor and district nurse with increasing communication with social workers.

Then the care of the mentally disordered is in a state of great change, with increasing emphasis on community care both in respect of cases of subnormality and mental illness and the year has seen wide ranging multi-disciplinary discussions about the implementation of this policy.

Lastly the elderly - the total number of whom in Cumberland increases continually. It is critical that the number of very old (i.e. over 85 years) is increasing at almost four times the rate of those over 65 years of age.

The number of psycho-geriatric cases bears a direct relationship to the number of the very old in the population, which has more than doubled in the last twenty years, with a two to one preponderance of females over males. There is an increase in the number of such cases and also an increase in the family and community anxieties that they cause. I find that doctors, nurses, and social workers are increasingly frustrated in that adequate arrangements cannot from time to time be found for the care of some of the diagnosed cases.

In addition to the present plans for the development of provision for this group in the Health and Social Services Departments I would like to see an urgent and great increase in the provision of day hospital places, and an equally dramatic increase in the number of supported independency flats or bungalows in the county districts.

Turning now to the ambulance service - another service for which the authority is responsible - which is now geared for 1974, with the prospect of ever increasing work and responsibility. It is perfectly clear to me that the further development of the health service in a rural area such as Cumberland is dependent on the continuing efficiency of the functioning of the ambulance service, both for general medical transportation and acute emergency and accident work.

The implementation of the ambulance service productivity agreement which we have all been waiting for for so long has, unfortunately, been held up by the Government's anti-inflation measures.

The change that has been noted elsewhere in this report is also associated with the work of nurses in the community where the Mayston structure of nurse management was accepted by the Health Committee and introduced in May and should be completed in the near future.

Miss K.J. Hayes, Chief Nursing Officer, resigned in the year to take up a similar appointment in Berkshire, and during the time before the Director of Nursing Services, Mrs. P.M. Botting, took up duties at the turn of the year, Miss J. Reid, Southern Area Nursing Officer, acted up as Director of Nursing Services in a most capable manner.

I have found the nursing service to be one in which change is well accepted. It is to the nursing staff whose fine work in the county is universally respected and the family doctors who are working as a team, that we must look to and thank for the very high standard of primary medical care that we enjoy in this country. This is equalled only by the similar high standards in the hospital and specialist service.

The problems of reorganisation have been constantly before our minds during the year and all change tends to bring forward feelings of inadequacy and uncertainty but I have been supported by staff at all levels on the occasions when I have met them as groups or individuals and explained to them the detailed situation.

Another important factor in minimising anxiety has been the increase in attendance of officers at local and national courses on management, even although the attendance of so many at one time has caused some difficulty in maintaining the service.

The change to the new reorganised health service is one which will bring opportunity for an even better service, for a system of delivery of health care that is better than we have at the moment, a system that will meet contemporary community needs better, where the results can be monitored and where positive health can be attained for the Cumbrian.

Progress must be allied to continuity, and advances must be equated with tradition and action on these fronts must be with the agreement of all concerned. These principles

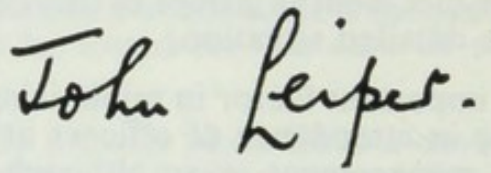
are embedded deeply in the new reorganised National Health Service management. It is to the very important planning element of management that we look to make tomorrow different to today in the National Health Service. A difficult task indeed as all the professions in the service exist to meet basic needs of society, which itself is changing so fast.

As I have said in previous Annual Reports it is now clear that this report will be the penultimate written by me as County Medical Officer of Health. The new Area Authority may well decide to continue this type of report for Cumbria. There is no doubt, however, that the information in these reports has proven of great value to the work of the National Health Service Joint Liaison Committee for Cumbria, which is collating a health profile for the new Shadow Health Authority.

My thanks go to Mrs. E.G. Cain, O.B.E., J.P., the Chairman of the Health Committee of the County Council for her support in such a difficult year of change, and especially as during the year the local authority health service is clearly moving away from local government, a situation which is indeed one that brings mixed feelings to all the staff.

To my staff for their continued loyalty and superb effort goes my appreciation.

I have the honour to be, Sir,
Your obedient Service,



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., F.F.C.M., D.P.H., Q.H.P.

Deputy County Medical Officer of Health:

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

Area Medical Officers:

J. Connolly, M.D., M.F.C.M., 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., M.F.C.M., 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., M.F.C.M., 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:

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

Dental Auxiliary:

Miss F. M. Brydon.

Consultant Psychiatrists seconded from Newcastle upon Tyne Regional Hospital Board:

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

Director of Nursing Services:

Mrs P. M. Botting, S.R.N., S.C.M., H.V.Cert., N.Admin Cert.(P.H.)

Area Nursing Officers:

Miss J. M. Bailey, S.R.N., S.C.M. (Q.N.), H.V. Cert., N.D.N. Cert., Northern Area.
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.

Nursing Officers:

Miss C. M. Bannan, S.R.N., S.C.M., H.V.Cert., Western Area.
Miss B. Knibbs, S.R.N., S.C.M., Q.N., H.V.Cert., Northern Area.
Miss R. Sheppard, S.R.N., S.C.M., Q.N., H.V.Cert., Southern Area.

Chief Chiropodist:

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

Chiropodists:

R. Darke, M.Ch.S., L.Ch., 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.

Orthoptists:

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

Physiotherapists:

Mrs. C. M. Blair, S.R.Ph.
Mrs. P. P. Bratt, M.C.S.P.
Mrs. V. K. Freebairn, M.C.S.P.
Miss M. Sivewright, M.C.S.P.

Screening Assistants:

Miss M. Bell.
Miss D. Kidd.
Miss L. P. Graham.

Senior Speech Therapist:

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

Speech Therapists:

Miss A. Bainbridge, L.C.S.T.
Miss E. B. Moon, 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 1972

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. R. Hassan Dr. A. M. Brown, Alston	Mrs. E. M. Walton Mrs. D. Boulton (Relief) Mrs. A. Davidson (Aux.)	Mrs. E. M. Walton	Mrs. D. Sanderson
Dr. E. K. Rankin Dr. A. M. Rankin, Aspatria	Mrs. H. R. W. Williams Mrs. J. Dickinson (Relief) Mrs. S. Wilkinson (Relief)	Mrs. H. R. W. Williams	Mrs. J. Eelbeck (H.V. Assist.)
Dr. A. C. Beeby, Aspatria Dr. J. R. Rose, Aspatria	(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 Mrs. M. Forster Mrs. F. Gaskin (Relief) Mrs. K. M. Bell (Relief) Mrs. T. Wight (Relief) Mrs. D. Pearson (Relief) Mrs. P. Alexander (Aux.)	Mrs. M. Dobson Mrs. M. Forster	Mrs. M. Whitson Mrs. D. Lazenby 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. Dickinson Dr. A. R. Waygood, Dalston	Miss K. Winter Mrs. M. I. Jones Mrs M. Faulder (Relief)	Miss K. Winter Mrs. M. I. Jones	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. MacDonald Dr. R. A. Maxwell, Kirkbride	Miss A. A. Cockton Mrs. M. Bendle (Relief)	Miss A. A. Cockton	Mrs. D. Lancaster (Group Adviser)
Dr. R. A. Forrester, Longtown Dr. G. M. Ingall, Longtown	Mrs. M. Asbridge Mrs. A. M. Slade (Relief) Mrs. A. Nixon (Relief)	Mrs. M. Asbridge	Miss M. Butler (Group Adviser) Mrs. J. B. Armitage (H.V. Assist.)

(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 Dr. A. Reed, Penrith	Mrs. E. J. Relph Mrs. M. Judson Mrs. M. M. Osborne (Relief)	Mrs. M. Judson	Miss K. Rigby Miss M. Tarr
Dr. G. H. Kilgour Dr. C. H. Thomson, Penrith	Mrs. V. M. Lamb Mrs. M. Hammersley (Relief)	Mrs. V. M. Lamb	Mrs. D. Willan
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) Mrs. N. Thorneley (Part-time H.V.)
Dr. H. Hutton Dr. R. M. Yule, Silloth	Miss G. Jobson Mrs. N. Reay Mrs. M. C. Johnston (Relief)	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. A. Lawson (Relief) Mrs E. Lightfoot (Aux.)	Mrs. A. Addison	Mrs. M. Hedworth Mrs. J. R. Denmark (Part-time H.V.)

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. K. Gillow Dr. T. Mooney Dr. T. Gardner Dr. G. Raitt Dr. J. Haworth Dr. R. A. Frizell, Carlisle	Mrs. E. M. Stafford (Surgery Nurse)		
All Carlisle Practices except the practice of Drs. Simpson, Roy, Spencer and Allan.	Mrs Y. J. Johnston Mrs E. Yeomans Mrs. M. Kennedy (Relief) Mrs. D. Jefferson (Relief)		Miss E. A. Lockhart
Dr. P. Delap, Appleby	Mrs. E. J. Woodhall	Mrs V. M. Lamb	Mrs. D. Willan
Dr. D. M. C. Ainscow, Temple Sowerby	Mrs. E. J. Woodhall	Mrs V. M. Lamb	Mrs. D. Willan

SOUTHERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER 1972

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. Sumner Frizington and Cleator Moor	Miss H. Spencer Miss M. Proctor Mrs. J. Niles (Relief)	Miss M. Proctor	Mrs. P. Fitzgerald Miss E. Miller (Geriatric Visitor)
Dr. W. T. Hunter Dr. J. W. Veitch Dr. I. W. McAndrew Dr. J. W. Strain Egremont and Cleator Moor	Mrs. A. Gell Mrs V. Wrightson Mrs M. Toole Mrs. A. Rea Mrs. D. Adair (Relief)	Mrs V. Wrightson	Miss M. Gibson Mrs. A. Donald Mrs. S. Miller
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. Gallantry (Surgery Nurse) Mrs. A. Brightman (Relief Surgery Nurse)	Miss D. James Mrs. M. Marshall	Miss D. James (Group Adviser) Mrs M. Marshall
Dr. A. M. Smith Bootle	Mrs. J. Capp Mrs. M. Beaumont (Relief)	Mrs M. Marshall	Mrs. M. Marshall
Dr. A. E. Jackson Dr. M. J. Leverton Dr. A. J. Todd Dr. I. C. C. Matheson Millom	Miss M. Beattie Mrs. I. Booth Mrs. M. Wilson Mrs. S. Troll Mrs. M. Fazakerley (Relief) Mrs. M. R. Fowler (Surgery Nurse) Mrs. V. Armstrong (Aux.)	Miss M. Beattie Mrs. I. Booth	Mrs. I. E. Bowe (Group Adviser) Miss M. M. Robinson
Dr. R. A. Galloway Dr. M. C. Nicolson Dr. B. T. Higgins Dr. R. H. Pearson Whitehaven	Mrs. I. Routledge Mrs. B. Tinnion Mrs. F. D. Clarke (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 (Relief)	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. MacLeod Whitehaven	Mrs. E. Brannon Mrs. D. Cameron (Relief)	Mrs. A. King	Mrs. M. Ainsworth Miss E. Miller (Geriatric Visitor)

WESTERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER 1972

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. T. Fletcher Dr. E. R. Herd Dr. D. E. Holloway, Cockermouth.	Miss A. I. Kirk Mrs. J. M. Brown Mrs. V. Sherwood Mrs. E. Swindle (Relief) Mrs. J. Thomas (Relief)	Miss A. I. Kirk (for all Cockermouth practices) Maryport Midwives relieve.	Mrs. M. Lythgoe Miss A. Dixon
Dr. A. G. Abraham, Cockermouth	Mrs. K. Lytollis Mrs. W. Sharp (Relief)		Miss M. Reynolds
Dr. R. J. M. Irvine, Cockermouth	Mrs. M. E. Dobson Mrs. M. 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 Miss D. Parsons (Relief) 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 Mrs. J. E. Barnes (Relief)	Miss S. M. J. Iliffe	Mrs A. E. Campbell
Dr. J. D. H. Bird Dr. A. W. Rattrie Dr. K. Longstaff Dr. B. J. Havard Dr. F. W. Clark Dr. C. M. Yule Dr. K. M. A. Slinger, Maryport	Mrs. S. A. Blackman Miss O. Pickering Mrs. J. Bacon Mrs. E. Foster Mrs. J. Volkaerts (Relief)	Miss O. Pickering Miss A. Chadwick Mrs J. Bacon	Mrs. A. Conway Mrs. L. Messenger Mrs. A. Irving (Geriatric Visitor) Miss S. Hart
Dr. R. E. Fletcher Dr. P. R. H. Fletcher Dr. A. Craig, Workington	Mrs. L. Daniels Mrs. M. B. White Mrs D. Messenger (Relief)	*Mrs. M. K. Tunstall Miss J. Cunliffe (Ante and Post Natal Care for all Workington doctors)	Miss A. Jackson Mrs J. A. Graham
Dr. D. N. Fitzgerald, Workington	Mrs. M. I. Lowis Mrs K. Walker (Relief)		Mrs. M. Hewitson
Dr. N. McKerrow Dr. P. I. Rutherford Dr. K. A. Sugathan Dr. A. W. B. Lawson, Workington	Miss M. Young Mrs. D. Fisher Mrs. M. K. Tunstall Mrs. D. Harrison Mrs. M. J. Spedding (Relief)		Miss E. J. Surtees Mrs. A. M. Wandless

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

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

ADMINISTRATION

The administration of the department has settled down again after the re-organisation consequent upon the transfer of welfare and mental health functions to the social services and education departments, although there had to be further adjustment to introduce nurse management in accordance with the recommendations in the Mayston report. The fact that there was no Director of Nursing Services in post for a considerable part of the year necessitated a temporary adjustment of some of the administrative arrangements but the appointment of Mrs P.M. Botting to the post at the end of the year gave hope that normal arrangements could be resumed early in 1973.

The administrative organisation of the department is basically one of decentralisation. There are three area offices - in Carlisle, Workington and Whitehaven, each dealing with the day-by-day management of services under the overall direction of area medical officers. The population of each of the areas is roughly equal at around 75,000 but the problems posed frequently varies from area to area because of the geographical factors. The Northern area, based on Carlisle, is the most rural in character and is, at 612,000 acres, much larger than the other two combined. The Western area, based on Workington, is the most urban.

Matters relating to the ambulance service and to policy, training and finance covering all other aspects of the local authority health and school health services are dealt with at the headquarters office.

There is only one committee and it has no standing sub-committees. Policy decisions can, therefore, be passed through the committee stage quickly. The sole committee does, however, have on it representation of the Cumberland Executive Council, which appointed two general practitioners, and the Special Area Committee of the Regional Hospital Board, while I, or my deputy, are able to attend meetings of the Special Area Committee, the West Cumberland Hospital Management Committee, the Garlands Medical Advisory Committee and Cumberland Local Medical Committee. My deputy is a member of the Garlands Hospital Management Committee.

The Local Maternity Liaison Committees which have been active for many years continue to serve a most useful purpose. My deputy acts as secretary to both.

Close links are maintained with the environmental health services of the county district councils through the area medical officers, who are also medical officers of health to the district councils in their areas. The only exception is Alston Rural District, where the medical officer of health is a part time medical officer in department on the county staff. He is also a general practitioner and provides the medical care at the local hospital. Nominally, the area medical officers spend half their time on district duties but this assessment was based on the assumption that each would have a deputy who would spend one third of his time on district matters. Unfortunately, it has not been possible to fill the posts of deputy latterly and in view of impending reorganisation no attempt is being made to fill them. The two thirds of the deputies' posts which were for clinical duties are filled by the part time appointment of general practitioners and others but cover for the district duties does pose a problem. Undoubtedly the area medical officers frequently have to spend more than half their time on district matters.

There has been no difficulty in the recruitment of medical staff for part time clinical work and during the early part of the year there was a full complement of dental officers. Unfortunately, there were two dental vacancies before the end of the year. The chiropody service has probably suffered more than any other because of staffing problems. The Northern area was without both its full time chiropodists for a substantial part of the year, which meant a serious disruption of the service and an adjustment of staffing in other areas to give even a minimal service in parts of the Northern area.

Almost throughout the year an increasing amount of time has been spent on planning for the national health service re-organisation on 1st April, 1974. Before Joint Liaison Committees were officially brought into being I had, with my local health authority colleagues in Carlisle, Barrow, Westmorland, North Lancashire and the Sedbergh area of the West Riding, set up joint working parties to look at the existing arrangements, identifying points of difference which might cause problems on integration and make recommendations as to how the problems might be overcome. The groups which we set up covered administration, nursing, ambulance, adult and child health and dental service. Much of the information collected and the work done by those groups will undoubtedly be of value to the working groups of the Joint Liaison Committee created officially at a later date.

The groups demonstrated that there is a keen desire among the staff of all the constituent local health authorities in what is to be Cumbria to work together with the common aim of the most efficient service possible after integration.

GENERAL STATISTICS AND SOCIAL CONDITIONS OF THE AREA

Comparison of the Registrar General's mid-year estimates of population for 1972 — 219,410 and 1971 — 219,270 shows an increase of 140 in the population of the county. The natural increase of births over deaths was in fact 153, therefore, the net migration out of the county is calculated at 13 persons.

This figure may indicate a balanced migration but recognition must be taken of the fact that the Registrar General is still making adjustments to the mid-year estimates based on the 1971 census, and it must be viewed together with the high outward migration figure of 4,341 persons calculated for 1971.

The changing pattern of the age group structure in the community is illustrated in the following table. The effects of the recent low birth rates since 1964 can be seen in the 0 - 4 year group and the high rates between 1957 - 1964 can be seen to have their effect on the 5 - 14 group. The migration of the younger working age groups and the more stable growth of the older working age groups are evident in their respective groups. Elderly are on the increase and in particular the numbers in the over 75 group have gone up by 45% in two decades.

It is interesting to note the decrease in the ratios of females to males in the 65 - 74 age group, which was 121.6 per 100 males in 1951, 138.1 in 1961, and 132.0 in 1971. However, in the 'over 85' group the ratios continue to increase and the figures are 100 males to 163, 202 and 205 females, respectively.

CUMBERLAND ADMINISTRATIVE COUNTY

SHOWING EACH GROUP AS PERCENTAGE OF TOTAL

Age Group	1951 Males No.	%	1951 Females No.	%	1951 Total No.	%	1961 Males No.	%	1961 Females No.	%	1961 Total No.	%	1971 Males No.	%	1971 Females No.	%	1971 Total No.	%
0 - 4	10,014	9.3	9,578	8.8	19,592	9.0	9,756	8.8	9,047	8.0	18,803	8.4	8,680	8.0	8,265	7.4	16,945	7.7
5 - 14	16,111	14.9	15,243	13.9	31,354	14.4	18,716	16.9	18,007	16.0	36,723	16.5	18,750	17.3	17,475	15.6	36,225	16.4
15 - 44	48,112	44.4	45,517	41.7	93,629	43.0	45,621	41.3	43,342	38.4	88,963	39.9	42,545	39.2	40,945	36.5	83,490	37.9
45 - 64	23,710	21.9	25,865	23.7	49,575	22.8	25,972	23.5	27,244	24.2	53,216	23.8	26,700	24.6	27,855	24.8	54,555	24.7
65 - 74	7,281	6.7	8,852	8.1	16,133	7.5	7,013	6.4	9,684	8.6	16,697	7.5	8,115	7.5	10,715	9.6	18,830	8.5
75 plus	3,064	2.8	4,193	3.8	7,257	3.3	3,427	3.1	5,373	4.8	8,800	3.9	3,675	3.4	6,885	6.1	10,560	4.8
TOTAL	108,292		109,248		217,540		110,505		112,697		223,202		108,465		112,140		220,605	

Vital Statistics

Births

This year has seen the lowest ever number of births in the county — 3,036 and also the lowest ever 'crude' birth rate — 13.8 births per 1,000 total population. The national rate is also decreasing and the rate of 14.8 is the lowest recorded in post-war years.

The table and graph on pages 32 and 33 shows the comparison of the county adjusted birth rates (crude birth rate X Registrar General's comparability factor for the area) with the rates for England and Wales since 1948.

An interesting phenomenon of recent research is the relatively high rate of male live and stillbirths per hundred live and stillborn females. Indeed since 1917, there have only been four years when total female live and stillbirths exceeded males. This interesting phenomenon is, however, almost certainly associated with several factors, both environmental and social, e.g. parental attitudes to family size and composition. See graph on page 30.

There have been 39 stillbirths giving a rate of 12.7 stillbirths per 1,000 live and stillbirths. This compares with the previous rate of 12.2 for 1971 (the lowest recorded in the county) and also with the national figure of 12.0.

The perinatal and infant mortality figures are very encouraging and the perinatal mortality rate of 21.1 stillbirths or first week deaths per 1,000 live and stillbirths is the lowest ever recorded. So indeed is the infant mortality rate where 44 deaths were recorded giving a rate of 14.5 infant deaths per 1,000 live births.

Maternal Mortality

One death was recorded as being associated with pregnancy and child birth, and gives a rate of 0.3 deaths per 1,000 total live and stillbirths.

Mortality

The number of deaths has risen this year to 2,883 — a crude death rate of 13.1 deaths per 1,000 total population. This has shown a departure from the fairly consistent figures of the past four years and is the highest rate since 1951.

The table and graph on pages 34 and 35 shows the comparison of the adjusted death rate for the county (crude death rate X Registrar General's comparability factor for the area) with the rates for England and Wales since 1948.

The increase in the number of deaths was mainly in the malignant disease group where there was an increase of 62 deaths noticeably in the causes — stomach, intestine, lung/bronchus, breast and uterus. Also an increase in diabetes mellitus from 25 to 37 deaths, heart diseases — 14 more ischaemic and 34 more 'other forms' of heart disease, and from pneumonia where there were 29 more deaths than in 1971.

It is, however, pleasing to note that the number of deaths from bronchitis — 88 shows a slight improvement on the 100 for 1971, and maintains the fairly constant level of the past three years.

Analysis of the place of death since 1960 shows a marked trend towards fewer deaths in the community as the following table shows:—

Place where death occurred

	Domiciliary %	Institutional %
1960	64	36
1961	64	36
1962	62	38
1963	60	40
1964	57	43
1965	54	46
1966	52	48
1967	51	49
1968	52	48
1969	48	52
1970	52	48
1971	50	50
1972	45	55

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County — 967,054
Rateable Value (April 1st, 1972) — £8,122,836
Estimated Product of 1p Rate (1972-73) — £78,145
Population (Census 1951) — 217,540
Population (Census 1961) — 223,202
Population (Census 1971) — 220,605
Population (1972 Mid-Year Estimate) — 219,410

Live Births — Number	3,036
Rate per 1,000 population	13.8
Illegitimate Live Births per cent of total births	7.4
Still Births — Number	39
Rate per 1,000 total live and still births	12.7
Total Live and Still births	3,075
Infant Deaths (Deaths under 1 year)	44
Infant Mortality Rate —	
Total Infant Deaths per 1,000 total live births	14.5
Legitimate Infant Deaths per 1,000 total legitimate live births	13.9
Illegitimate Infant Deaths per 1,000 total illegitimate live births	22.3
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	11.2
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births)	8.6
Perinatal mortality rate (Still Births and Deaths under 1 week combined per 1,000 total live and still births)	21.1
Maternal Mortality (including abortion) —	
Number of Deaths	1
Rate per 1,000 total live and still births	0.3

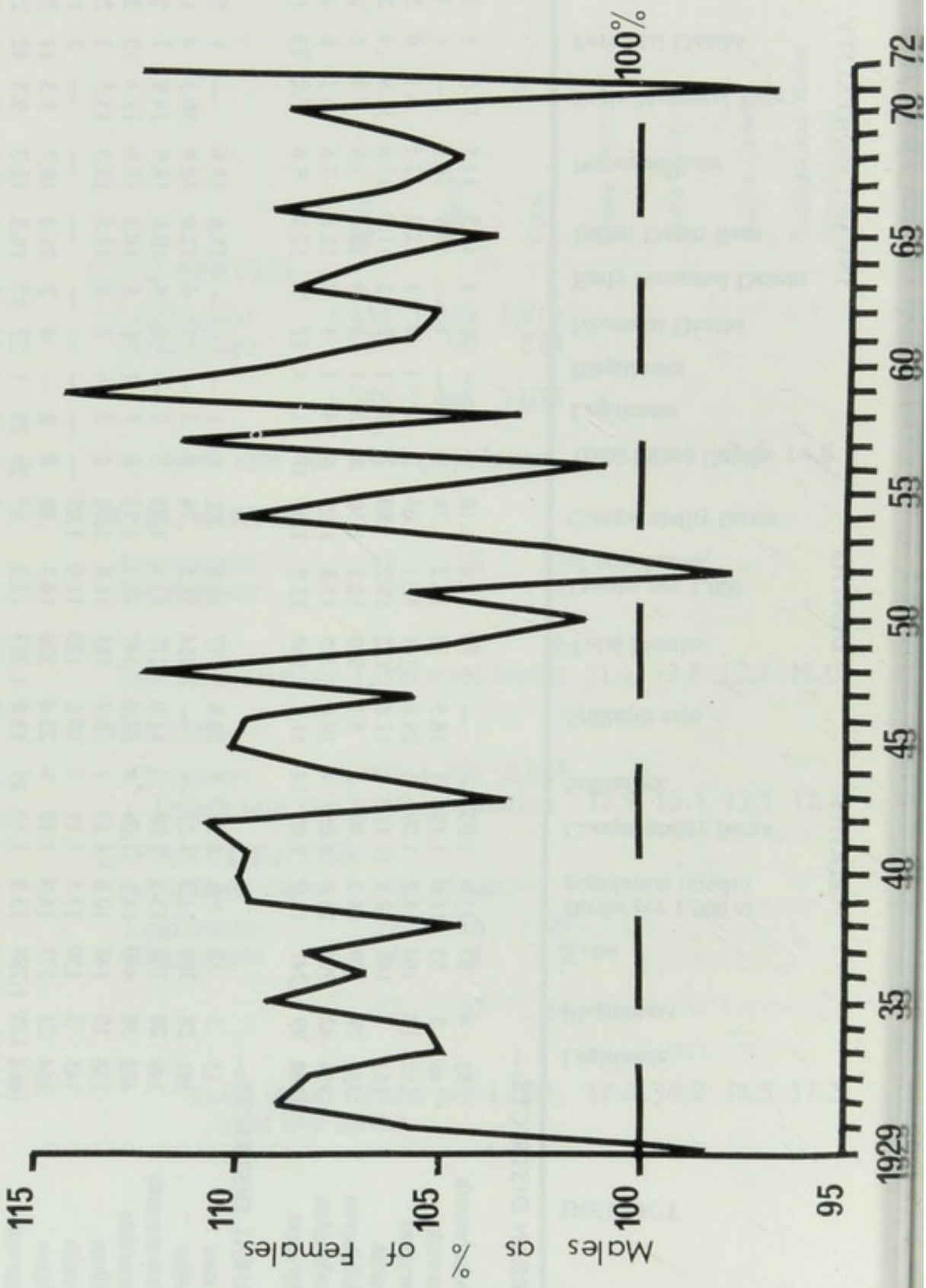
A more detailed analysis of the above figures is given overleaf.

	Male	Female	Total	Urban Districts	Rural Districts	Admin County	England and Wales (Provisional)
LIVE BIRTHS —							
Legitimate	1,454	1,358	2,812				
Illegitimate	134	90	224				
	1,588	1,448	3,036				
Birth rate per 1,000 population				13.9	13.8	13.8	14.8
STILL BIRTHS—							
Legitimate	19	18	37				
Illegitimate	2	—	2				
	21	18	39				
Still birth rate per 1,000 total births				11.1	13.8	12.7	12.0
DEATHS —							
All causes	1,485	1,398	2,883				
Death rate per 1,000 population				12.9	13.3	13.1	12.1
INFANT DEATHS —							
All infants under 1 year of age:—							
Legitimate	23	16	39				
Illegitimate	4	1	5				
	27	17	44				
Total infant deaths per 1,000 total live births				12.0	16.2	14.5	17.2

BIRTHS, DEATHS, INFANT MORTALITY AND POPULATION IN THE YEAR 1972

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	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	Estimated Mid-Year Population
URBAN DISTRICTS:—																					
Cockermouth	83	4	87	13.6	1.03	—	—	73	11.4	1.10	1	1	—	1	1	11.5	11.5	11.5	1	11.5	6420
Keswick	48	5	53	11.0	1.19	1	18.5	78	16.2	.78	1	1	—	1	—	18.9	18.9	—	1	18.5	4820
Maryport	152	12	164	14.1	1.09	5	29.6	141	12.1	1.03	2	1	1	2	1	12.2	12.2	6.1	6	35.5	11610
Penrith	161	7	168	14.5	1.11	2	11.8	153	13.2	.80	2	1	1	2	2	11.9	11.9	11.9	4	23.5	11610
Whitehaven	350	29	379	14.3	.99	2	5.2	320	12.1	1.10	4	3	1	3	3	10.6	7.9	7.9	5	13.1	26460
Workington	354	42	396	13.8	1.05	4	10.0	395	13.8	1.05	5	4	1	3	2	12.6	7.6	5.1	6	15.0	28700
Aggregate	1148	99	1247	13.9	1.05	14	11.1	1,160	12.9	1.01	15	11	4	12	9	12.0	9.6	7.2	23	18.2	89620
RURAL DISTRICTS:—																					
Alston	15	3	18	9.6	1.22	1	52.6	37	19.8	.88	1	1	—	1	—	55.6	55.6	—	1	52.6	1870
Border	361	28	389	13.3	1.21	—	—	454	15.5	.74	5	5	—	5	4	12.9	12.9	10.3	4	10.3	29300
Cockermouth	249	20	269	13.2	1.08	3	11.0	275	13.4	1.03	5	5	—	4	4	18.6	14.9	14.9	7	25.7	20450
Ennerdale	402	38	440	14.1	1.08	8	17.9	347	11.1	1.13	8	7	1	6	5	18.2	13.6	11.4	13	29.0	31230
Millom	138	10	148	10.8	1.13	1	6.7	161	11.8	1.11	2	2	—	2	2	13.5	13.5	13.5	3	20.1	13660
Penrith	145	5	150	13.5	1.11	3	19.6	123	11.0	1.05	—	—	—	—	—	—	—	—	3	19.6	11140
Wigton	354	21	375	16.9	1.10	9	23.4	326	14.7	.89	8	8	—	4	2	21.3	10.7	5.3	11	28.6	22140
Aggregate	1664	125	1,789	13.8	1.12	25	13.8	1,723	13.3	.95	29	28	1	22	17	16.2	12.3	9.5	42	23.2	129790
Admin. County	2,812	224	3,036	13.8	1.09	39	12.7	2,883	13.1	.97	44	39	5	34	26	14.5	11.2	8.6	65	21.1	219410

Percentage of Male to Female Births
Cumberland 1929-72



BIRTHS AND DEATHS STATISTICS

Year		Estimated mid-year population	Births: Number	Rate	Deaths: Number	Rate	Excess of births over deaths
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
1972	...	219,410	3,036	13.8	2,883	13.1	153

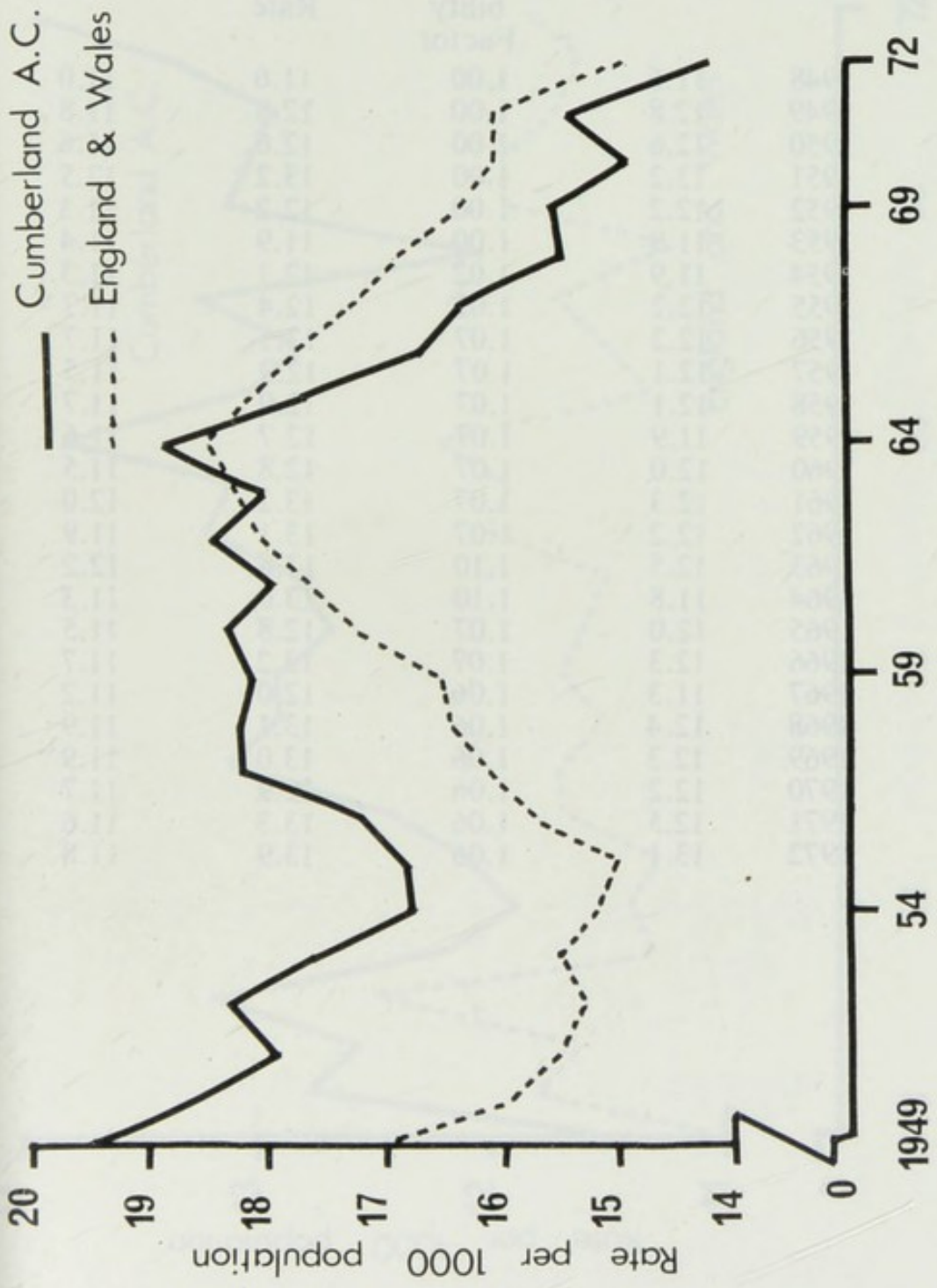
BIRTH RATES

1948 - 1972

Cumberland Administrative County and England and Wales

Year	Cumberland Crude Rate	Administrative Comparability Factor	County Adjusted Rate	England and Wales
1948	19.4	1.06	20.6	18.1
1949	18.4	1.06	19.5	16.9
1950	17.8	1.05	18.7	15.9
1951	17.0	1.05	17.9	15.5
1952	17.4	1.05	18.3	15.3
1953	16.8	1.05	17.6	15.5
1954	16.4	1.02	16.7	15.2
1955	16.5	1.02	16.8	15.0
1956	16.9	1.02	17.2	15.7
1957	17.8	1.02	18.2	16.1
1958	17.8	1.02	18.2	16.4
1959	17.7	1.02	18.1	16.5
1960	17.9	1.02	18.3	17.2
1961	17.7	1.01	17.9	17.6
1962	18.2	1.01	18.4	18.0
1963	17.6	1.02	18.0	18.2
1964	18.4	1.02	18.8	18.5
1965	17.3	1.02	17.6	18.1
1966	16.3	1.02	16.6	17.7
1967	16.0	1.02	16.3	17.2
1968	15.1	1.02	15.4	16.9
1969	15.2	1.02	15.5	16.3
1970	14.6	1.02	14.9	16.0
1971	15.1	1.02	15.4	16.0
1972	13.9	1.02	14.2	14.9

Live Births
Cumberland (Adjusted Rates) and
England and Wales 1949-72



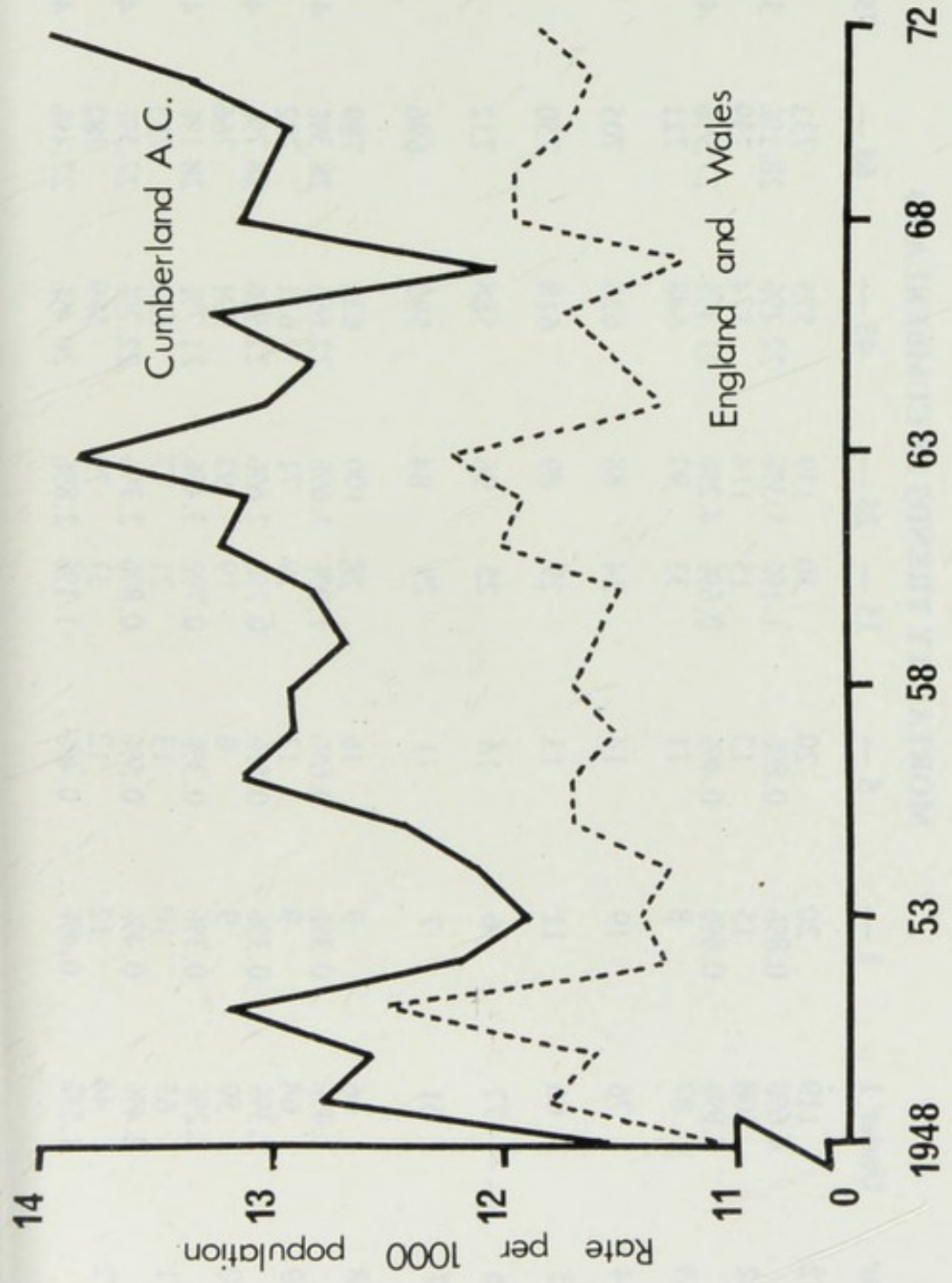
DEATH RATES

1948 - 1972

Cumberland Administrative County and England and Wales

Year	Cumberland Crude Rate	Administrative Comparability Factor	County Adjusted Rate	England and Wales
1948	11.6	1.00	11.6	11.0
1949	12.8	1.00	12.8	11.8
1950	12.6	1.00	12.6	11.6
1951	13.2	1.00	13.2	12.5
1952	12.2	1.00	12.2	11.3
1953	11.9	1.00	11.9	11.4
1954	11.9	1.02	12.1	11.3
1955	12.2	1.02	12.4	11.7
1956	12.2	1.07	13.1	11.7
1957	12.1	1.07	12.9	11.5
1958	12.1	1.07	12.9	11.7
1959	11.9	1.07	12.7	11.6
1960	12.0	1.07	12.8	11.5
1961	12.3	1.07	13.2	12.0
1962	12.2	1.07	13.1	11.9
1963	12.5	1.10	13.8	12.2
1964	11.8	1.10	13.0	11.3
1965	12.0	1.07	12.8	11.5
1966	12.3	1.07	13.2	11.7
1967	11.3	1.06	12.0	11.2
1968	12.4	1.06	13.1	11.9
1969	12.3	1.06	13.0	11.9
1970	12.2	1.06	12.9	11.7
1971	12.5	1.06	13.3	11.6
1972	13.1	1.06	13.9	11.8

Deaths
Cumberland (Adjusted Rates) and
England and Wales 1948-72



MORTALITY TRENDS IN CUMBERLAND

Year	Under 1	1 —	5 —	15 —	25 —	45 —	65 —	75 plus	Total
1952	119	20	20	30	139	575	732	968	2603
	4.6%	0.8%	0.8%	1.1%	5.3%	22.1%	28.1%	37.2%	Rate 12.1
1962	108	15	13	15	114	574	759	1125	2723
	3.9%	0.6%	0.4%	0.6%	4.2%	21.1%	27.9%	41.3%	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
									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
1972	44	12	12	31	79	589	782	1334	2883
	1.5%	0.4%	0.4%	1.1%	2.8%	20.4%	27.1%	46.3%	Rate 13.1

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	2,883	73	78	141	153	320	395	1,160	37	454	275	347	161	123	326	1,723
B4 Enteritis and Other Diarrhoeal Diseases	2	—	—	—	—	—	1	1	—	—	—	—	—	—	1	1
B5 Tuberculosis of Respiratory System	4	—	—	—	—	1	1	2	—	2	—	—	—	—	—	2
B6(1) Late effects of Respiratory T.B.	2	—	—	—	1	1	—	2	—	—	—	—	—	—	—	—
B18 Other infective and Parasitic Diseases	2	—	—	—	—	1	—	1	—	—	—	—	—	1	—	1
B19(1) Malignant Neoplasm, Buccal Cavity, etc.	8	1	—	—	1	—	2	4	—	3	—	—	—	—	1	4
B19(2) Malignant Neoplasm, Oesophagus	17	—	1	—	1	2	6	10	—	3	1	1	—	—	2	7
B19(3) Malignant Neoplasm, Stomach	77	—	1	3	3	11	22	40	—	12	7	7	—	2	9	37
B19(4) Malignant Neoplasm, Intestine	84	1	4	3	4	13	18	43	1	7	7	11	3	1	11	41
B19(5) Malignant Neoplasm, Larynx	3	—	—	—	—	—	1	1	—	1	—	—	1	—	—	2
B19(6) Malignant Neoplasm, Lung, Bronchus	118	4	2	9	5	13	21	54	1	14	12	13	7	4	13	64
B19(7) Malignant Neoplasm, Breast	45	2	1	2	3	4	6	18	—	5	3	8	1	1	9	27
B19(8) Malignant Neoplasm, Uterus	22	1	—	4	2	3	—	10	—	9	1	—	—	—	2	12
B19(9) Malignant Neoplasm, Prostate	18	1	—	1	—	3	4	9	1	3	—	3	—	1	1	9
B19(10) Leukaemia	18	—	1	3	—	—	2	6	—	5	2	1	—	2	2	12
B19(11) Other Malignant Neoplasms	127	6	5	5	6	10	15	47	3	17	14	14	12	5	15	80
B20 Benign and Unspecified Neoplasms	5	—	—	—	2	—	—	2	—	1	—	1	—	—	1	3
B21 Diabetes Mellitus	37	1	—	1	2	5	5	14	—	4	5	7	3	—	4	23
B22 Avitaminoses, etc.	1	—	1	—	—	—	—	1	—	—	—	—	—	—	—	—
B46(1) Other Endocrine etc. Diseases	9	2	1	—	—	1	—	4	1	1	1	1	—	—	1	5
B23 Anaemias	8	—	—	—	—	3	—	3	1	—	1	1	1	1	—	5
B46(3) Mental Disorders	3	—	—	—	—	—	—	—	—	1	—	2	—	—	—	3
B24 Meningitis	1	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
B46(4) Multiple Sclerosis	4	—	1	1	—	—	1	3	—	1	—	—	—	—	—	1
B46(5) Other Diseases of Nervous System	28	1	1	2	—	2	2	8	—	7	6	1	1	—	5	20
B26 Chronic Rheumatic Heart Disease	20	—	—	—	2	2	3	7	2	2	2	1	—	—	6	13
B27 Hypertensive Disease	33	3	—	2	—	4	1	10	1	13	—	2	2	1	4	23
B28 Ischaemic Heart Disease	889	21	23	43	51	91	125	354	6	135	96	101	52	43	102	535
B29 Other forms of Heart Disease	150	4	8	2	9	15	20	58	2	24	11	17	8	11	19	92
B30 Cerebrovascular Disease	433	9	12	19	32	40	50	162	7	78	39	41	33	17	56	271
B46(6) Other Diseases of Circulatory System	146	4	1	8	5	11	19	48	1	23	14	29	9	9	13	98
B31 Influenza	27	1	1	—	4	4	3	13	2	7	2	2	—	1	—	14
B32 Pneumonia	141	2	2	7	5	25	18	59	1	21	15	27	2	3	13	82
B33(1) Bronchitis and Emphysema	88	2	1	6	3	12	15	39	2	10	8	12	3	5	9	49
B33(2) Asthma	8	—	—	1	1	1	—	3	—	3	—	1	—	1	—	5
B46(7) Other Diseases of Respiratory System	26	1	1	2	2	1	5	12	2	1	3	4	1	1	2	14
B34 Peptic Ulcer	11	—	—	1	—	—	2	3	1	2	2	1	—	1	1	8
B35 Appendicitis	2	—	—	—	—	—	—	—	—	1	1	—	—	—	—	2
B36 Intestinal Obstruction and Hernia	4	—	—	1	—	1	—	2	—	1	—	—	—	1	—	2
B37 Cirrhosis of Liver	10	—	—	—	1	1	3	5	—	2	—	1	—	1	1	5
B46(8) Other diseases of Digestive System	29	1	1	2	1	5	4	14	—	4	—	5	3	2	1	15
B38 Nephritis and Nephrosis	9	1	1	1	—	—	1	4	—	1	—	1	1	1	1	5
B39 Hyperplasia of Prostate	4	—	—	—	—	—	—	—	—	2	—	—	—	1	1	4
B46(9) Other Diseases, Genito-Urinary System	17	—	3	1	—	1	—	5	—	2	4	2	3	—	1	12
B46(10) Diseases of Skin, Subcutaneous Tissue	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1
B46(11) Diseases of Musculo-Skeletal System	20	1	1	—	—	1	1	4	—	3	—	1	6	2	4	16
B42 Congenital Anomalies	17	1	1	1	—	2	1	6	—	2	5	2	—	—	2	11
B43 Birth Injury, Difficult Labour, etc.	10	—	—	—	2	1	—	3	—	1	1	2	1	—	2	7
B44 Other Causes of Perinatal Mortality	9	—	—	—	—	1	1	2	—	2	1	3	1	—	—	7
B45 Symptoms and ill defined Conditions	33	1	—	2	1	18	6	28	—	2	—	2	—	1	—	5
BE47 Motor Vehicle Accidents	37	—	1	4	—	6	5	16	—	5	5	5	4	1	1	21
BE48 All other Accidents	47	1	—	3	2	1	4	11	—	9	4	8	3	2	10	36
BE49 Suicide and Self-Inflicted Injuries	9	—	2	—	1	2	1	6	1	1	1	—	—	—	—	3
BE50 All Other External Causes	10	—	—	1	1	1	—	3	1	1	—	5	—	—	—	7

PERINATAL DEATHS 1957 — 1972

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
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
1972	39	26	65	12.7	12.0	21.1	21.7

CUMBERLAND COUNTY PERINATAL DEATHS

(locally compiled figures)

Analysis of Causes of Perinatal Deaths during 1972

Cause of Death	Stillbirths Pre-mature	Stillbirths Full-time	Deaths during 1st Week	Total
Toxaemia	1	—	—	1
Ante Partum Haemorrhage	3	—	1	4
Placental Insufficiency	6	1	—	7
Complications of Rhesus Factor				
— Antibodies present	2	—	—	2
— Hydrops foetalis	—	—	1	1
Prematurity	5	—	9	14
Congenital Malformations	6	—	6	12
Tentorial Tear	—	—	2	2
Asphyxia				
— Cord round neck	3	1	1	5
— Intra Uterine	7	3	—	10
Atelactasis	—	—	5	5
Malpresentation	—	1	—	1
Baby's Body found discarded	—	—	1	1
Total:	33	6	26	65

INFANT MORTALITY

Cause of Death	Age in Weeks Under 1	1 to 4	4 to 52	Total
Antepartum Haemorrhage	1	—	—	1
Complications of Rhesus Factor — Hydrops Foetalis	1	—	—	1
Prematurity	9	1	—	10
Congenital Malformations	6	4	—	10
Tentorial Tear	2	—	—	2
Asphyxia	1	—	—	1
Atelactasis	5	—	—	5
Pneumonia and Bronchitis	—	2	7	9
Baby's Body found discarded	1	—	—	1
Accident	—	1	—	1
Cot Death	—	—	2	2
Perforation of Ileum	—	—	1	1
	26	8	10	44

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales for 1962 to 1972 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
1972	14.5	17.2

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 SERVICE

Several changes have affected the Nursing Service during the year. Miss K.J. Hayes, Chief Nursing Officer, since 1969, resigned in May to take up a similar appointment in Berkshire.

The outline of a new nursing administrative structure based on the recommendations of the Mayston Report was accepted by the Department of Health and Social Security early in the year and approved by the Health Committee in May. Stage 1 of the scheme, the appointment of the three Area Nursing Officers and the appointment of three of the Nursing Officers, has been completed. The introduction of a further three Nursing Officers to complete the new structure will take place next year. The alignment of nursing management in the community and the hospital services will enable the forthcoming unification of the profession to be effected with greater ease. See diagram opposite.

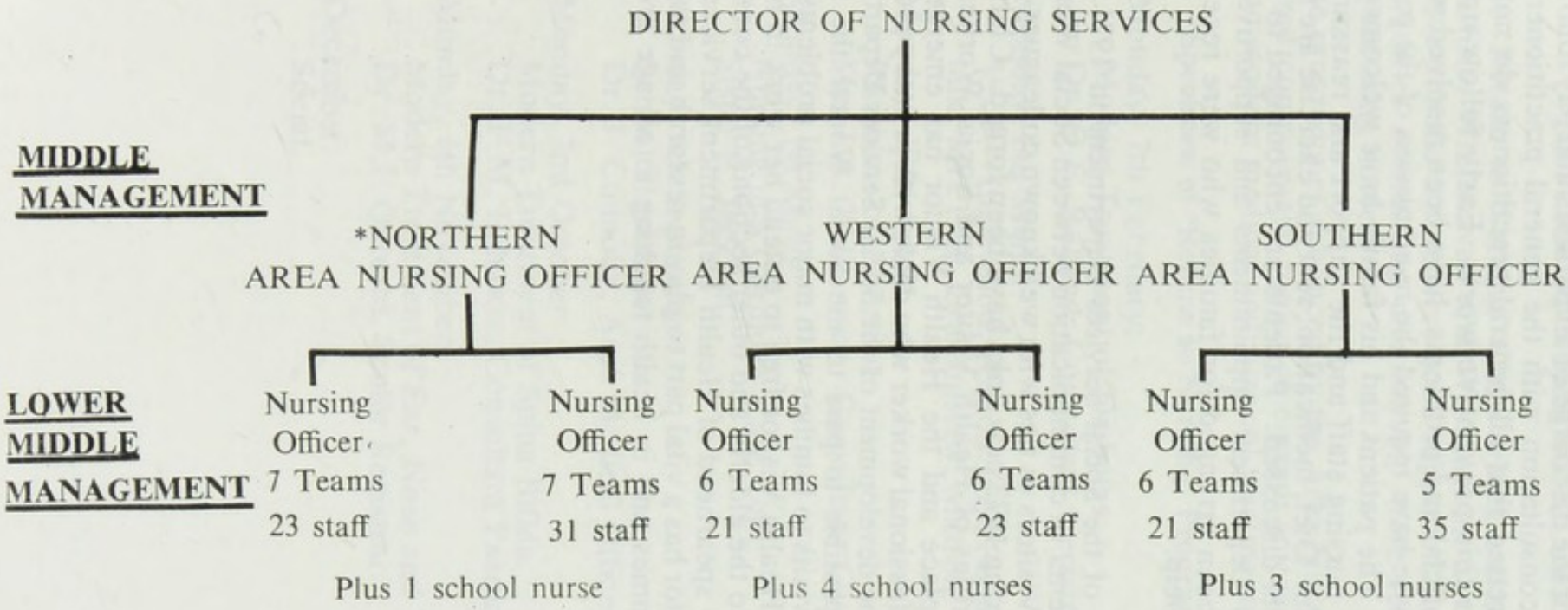
Stronger links have been forged between hospital and community services with the introduction of paediatric liaison at the Cumberland Infirmary. Miss B. W. Knibbs, Nursing Officer, writes:—

"Paediatric liaison commenced in June 1972. Weekly ward rounds are made with Dr. Elderkin, Consultant Paediatrician, and his team, the Ward Sister and the Medical Social Worker. Much useful information is discussed which benefits the patient during his period of hospitalisation and provides continuity of care on his return home."

Discussions also took place between senior nurses in the community and their hospital colleagues to improve nursing services for the mentally ill and the mentally handicapped. Plans for liaison have been made and a programme of in-service training for staff working in both spheres is in the course of preparation.

In 1971, following the publication of 'Home from Hospital', the report of the Dan Mason Research Committee, an attempt was made to organise a scheme which would enable all patients to be visited by a member of the community nursing staff on discharge from hospital. A scheme has now been established with the co-operation of nursing staff at the West Cumberland Hospital. Nurses in the community

PROPOSED STRUCTURE



* Services to 9,000 county patients of Carlisle doctors to be the special responsibility of the Northern A.N.O.

are notified of the discharge of all patients and pay follow-up visits after consultation with the general practitioner. It is to be regretted that all general practitioners do not see the need for this preventive work. Early follow-up has proved beneficial and problems have been resolved which might otherwise have required the re-admission of the patient to hospital. The patient and his family have welcomed the visits of the nursing staff and the support and reassurance these provide. Diet, medication, rest and exercise are some of the aspects discussed. Patients are encouraged to keep Out-Patients Department appointments and supportive services have been arranged for families who were receiving inadequate help.

The birth of the Social Services Department in 1971 gave rise to problems of communication between Social Workers and Health Visitors as ties with well known colleagues were broken. During 1972 new links have been forged. Clarification of the roles of Health Visitor and Social Worker has also taken place and the Health Visitor has emerged as the only professional worker who deals with primary prevention. With the development of the Social Services Department it may be possible to pass to the Social Worker the time-consuming visits to families with major social problems thus leaving the Health Visitor free to extend her work in health promotion to the elderly and other sections of the community. As the spearhead of Health Department services, the Health Visitor has a vital part to play in research and screening programmes and in health teaching to all age groups.

'RETURN TO NURSING' CLUBS

The 'Return to Nursing' Clubs which are held monthly at Carlisle, Whitehaven and Workington, have continued to prove popular and receive good support. During the year 73 enquiries concerning membership were received from non-practising nurses.

The programmes produced by the Area Nursing Officers covered controversial topics of current interest and highlighted modern medical and surgical treatments.

Specimen of 'Return to Nursing' Programme.

Monday, 7th February:
Modern Treatment of Diabetes.
Dr. C.F. Rolland, Consultant Geriatrician.

Monday, 6th March:
Visit — Inglewood, Wigton. (Old People's Home).
talk: Mrs P.B. Grahamslaw, Matron.

Monday, 10th April:
Problems of Abortion.
Mrs J.A. Williamson, Consultant Gynaecologist.

Monday, 1st May:
Nursing in a Coronary Care Unit.
Sister E. Jackson.

Monday, 4th September:
School Health Service.
Dr. J. Connolly, Area Medical Officer.

Monday, 2nd October:
Modern Treatment of Spina Bifida.
Dr. F.M. Elderkin, Consultant Paediatrician.

Monday, 6th November:
Modern Treatment of Ear, Nose and Throat.
Dr. M.I. Qureshi, Senior Registrar.

December:
Social.

The clubs have been a means of recruiting four nurses to the staff during the year, giving a total of 51 nurses employed since 1966. In addition three nurses joined the Marie Curie Day and Night Nursing Service and two others took employment with the Social Services Department.

Total number enrolled 174

(152 State Registered Nurses —
0.69 per 1,000 population of administrative County)

(22 State Enrolled Nurses —
0.10 per 1,000 population of administrative County)

Average attendance at 'Return to Nursing' meetings .. 63

HOME NURSING

During the year district nursing staff have continued their vital work of nursing patients in the community. All district nurses are now working as members of primary health care teams with medical guidance from their general practitioner colleagues.

Although the total number of treatments given by the nurses has shown little change from last year, subtle changes in the demands placed upon the staff have become evident. An increase has occurred in the number of treatments carried out in surgeries and local authority clinics which follows the trend for early ambulation, rehabilitation and the well recognised need to encourage those patients who may become socially isolated, to leave their homes and meet other members of the community even though this contact takes place in their doctor's waiting room.

Staff are undertaking nursing procedures in a clinical setting which would be difficult to carry out in the patient's home. Some of these procedures such as ear syringing and venepuncture were undertaken formerly by the general practitioner. The increasing appreciation of nursing skills has resulted in improved teamwork and a better service to the patient. In many parts of the county district nursing sisters are in attendance for part, if not the whole, of the general practitioner's surgery session. It is regretted that the lack of adequate premises and the delay in the health centre programme prevents the extension of this facility to all group practices.

The increase in the number of patients who attend surgeries for treatment has brought a slight decline in the number of patients nursed at home. It is these patients, however, who require skilled nursing care and occupy the majority

of the nurses' time, frequently requiring the attendance of more than one nurse at each visit. The increased use of ripple mattresses indicates that more severely ill patients suffering from chronic or debilitating conditions are being nursed in the community.

As the pattern of nursing changes it is essential to review the composition of the nursing teams. The introduction of State Enrolled nurses and Nursing Auxiliaries has enabled each team member to use her skills to the greatest advantage thereby obtaining more satisfaction from her work.

Towards the end of the year a District Nurse Training Course was held at the Postgraduate Centre, West Cumberland Hospital, the fifth course arranged in the county. Twenty-one students undertook the training giving a total of 96 district nurses trained by the County Health Department since 1968. All participants were existing members of staff and due to the large number it was not possible on this occasion to offer vacancies to staff from neighbouring authorities.

The programme of studies was arranged by the course tutor, Miss J.M. Bailey, Area Nursing Officer, Northern Area, on a day release basis and covered a period of 16 weeks. Lectures were given by consultants, medical officers, general practitioners, a hospital chaplain, social workers, public health inspector, physiotherapist, nurses and others and included the following subject matter: Central and Local Government, Local Authority Services, Insurance Benefits, Work of the Public Health Inspector, Social Services, National Health Service Act, Paediatrics, Cardiac Disease, Gravitational Ulcers, Diabetes, Modern Problems of Gynaecology, Implications of the Abortion Act, Chest Diseases and Tuberculosis, Mental Subnormality, Mental Disease, Mental Disorders seen in General Practice, Care of the Elderly, Diseases of the Central Nervous System, Vascular Disease, Terminal Care, Family Planning, Unmarried Mother, Rehabilitation, Drugs in Common Use, Storage etc., Nutrition, and Home Accidents.

In addition to the lectures, tutorials and visits of observation, clinical tuition was provided by the Practical Work Instructors. All the students were successful in the examination and obtained the National Certificate of District Nursing. Although it is not a statutory requirement for nurses working in the community to hold this qualification, it has been the aim in this county to have a totally trained nursing service.

I am pleased to report that 64 (100 per cent) full time district nurses, and 10 (60 per cent) part time district nurses are now fully qualified.

Mrs Y. Johnston, S.R.N., N.D.N., comments:

"The National District Nurse Training Course I attended together with twenty other district nurses commenced on 8th September 1972, in the Postgraduate Centre, West Cumberland Hospital, Hensingham, Whitehaven. During this 16-week course a wide range of lectures was given together with several tutorials. I felt that the general consensus of opinion was that although the lectures themselves were both interesting and informative, greater future emphasis on tutorial groups with a bias towards practical instruction on home management of the patient, could possibly be more helpful.

I was particularly impressed during the course by the insight we gained into the workings of the Social Services Department and its multifarious activities. My overall impression of the course is that it is most worthwhile for it teaches the trained nurse to adapt her professional hospital skills to the needs of sick patients and their families within the context of the community."

Miss Bailey, Course Tutor, comments:

"At the outset of the course some members found difficulty in adjusting to study after a long absence from text books but soon adapted themselves. The course provided good opportunity for group discussion and a high standard of work was reached especially in the individual projects of the students. I am indebted to the Practical Work Instructors for their help with the supervision of the students' clinical work and to the visiting lecturers who helped to make the course an interesting and successful one."

The recently completed district nurse training course will be the last under the present syllabus. The new programme of training which comes into effect next year has extended the theoretical content of future courses to a total of 20 days during the 16 week training period in order to include knowledge of technical procedures to be undertaken either in the home, surgery or health centre and an introduction to teaching and management skills increasingly necessary for the modern district nursing sister.

The training proposed will equip the district nurse to undertake the more sophisticated treatments required of her.

District nursing has been for too long the Cinderalla of the profession and is the only branch of nursing in which staff may be trained by unqualified tutors. Negotiations are now taking place at national level to rectify this anomaly by establishing a training scheme for a new grade of district nurse tutor.

Credit must be given to administrative nursing staff who have hitherto undertaken this teaching in addition to their other duties and have achieved an extremely high standard of service.

Cross boundary arrangements with neighbouring local authorities have continued.

Table I

No. of visits of Cumberland nursing staff to Northumberland	273
No. of visits of Northumberland nursing staff to Cumberland	50
No. of visits by Roxburghshire nursing staff to Cumberland	642

Table II

Number of Nursing Visits

	1968	1969	1970	1971	1972
Over 65's visits	130,979	146,107	156,503	149,746	149,179
Other groups	46,381	51,483	51,204	47,785	48,125
Total No. of nursing visits	177,360	197,590	207,707	197,531	197,304

Table III

Surgery Treatments

1968	1969	1970	1971	1972
23,935	37,639	44,721	47,799	54,614

CONGENITAL MALFORMATIONS

During the year there were 37 reported cases of babies born with congenital malformations, including one baby with five deformities who died when four days old of circulatory failure and meningocele.

Congenital malformations in this context are the abnormalities noted at birth and recorded on the birth notification card by the midwife who attended the delivery. My thanks are again due to the midwives on whom I rely for obtaining this most important information.

Since official records began in 1964, 478 babies were born in the county with congenital malformations, i.e. 390 live births and 88 stillbirths.

The table shows the classification of malformations in 1972 which again fall mainly under two headings — those of the central nervous system and limbs, talipes accounting for five cases of limb abnormalities.

	Males		Females		Total	Total
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Central Nervous System	3	1	5	5	8	6
Eye, ear, etc.	—	—	—	—	—	—
Alimentary System	1	—	2	—	3	—
Heart and great vessels	—	—	—	—	—	—
Respiratory system	—	—	—	—	—	—
Uro-genital system	2	1	—	—	2	1
Limbs	5	—	6	—	11	—
Other skeletal	1	—	—	—	1	—
Other systems	—	—	1	—	1	—
Mongolism	—	—	3	—	3	—
Other malformations	1	—	—	—	1	—
Totals:	13	2	17	5	30	7

MIDWIFERY

During 1972 we have continued with the difficult task of providing a domiciliary midwifery service to cover, with safety, those mothers who still wish to be confined in their own homes.

The year has shown a further steep drop in the number of births taking place outside the hospital setting, the latter accounting for only 2 per cent of the total births in the county.

Table I

Number of deliveries conducted by Domiciliary Midwives.

16 midwives delivered	Nil
12 midwives delivered	1
5 midwives delivered	2
2 midwives delivered	3
1 midwife delivered	6
1 midwife delivered	9
1 midwife delivered	15
domiciliary births	Total: 58

The Workington Agency Scheme:

In addition there were three domiciliary deliveries conducted by the midwives of the Workington Agency Scheme, thus totalling 61 domiciliary births in 1972. This compares with a total of 117 in 1971.

It is interesting to note that this also reflects the pattern of a falling number of domiciliary confinements.

1969	7 deliveries
1970	9 deliveries
1971	4 deliveries
1972	3 deliveries

Table II

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

Area	Total No.	At *Risk by Age, Parity and/or Obstetric History	Complicating Factors
Southern	23	13	1 Mother waited until baby was born before sending for assistance.
			7 B.B.A.s★ (4 were hospital bookings)
Western	9 (includes 3 by Agency	5	1 Baby born in Ambulance.
			1 Concealed Pregnancy
			3 B.B.A.s Hospital Bookings.
Northern	29	13	1 Undiagnosed twin pregnancy Transferred to hospital.
			1 Baby with multiple congenital malformations. Died aged one week.
			1 Mother had a Haemorrhage.
			1 Twin pregnancy. Transferred to hospital.
			1 Mother refused ante-natal care.
			2 Precipitate labours. Mothers and babies transferred to hospital.
			1 Unbooked case.
			4 B.B.A.s.
			2 Births in Ambulances.
	61	31	28

*Age — Over 35 years or under 18 years.
Parity — primipara or fourth and subsequent pregnancy.
★B.B.A. — 'Born before attendance' of midwife or medical practitioner.

In 1971 there were 117 deliveries at home, 46 of which were "At Risk" by the same criteria.

In spite of the fact that the total number of home confinements has decreased, the proportion of that total who come into the "At Risk" category is still high. We are continuing with our efforts to persuade all these mothers to agree to hospital confinement.

Table III

Total number of mothers seen as first attendances by midwives at ante-natal sessions held in G.P. surgeries		971
Number of mothers booking after the fourth month of their pregnancy		518
Number of mothers attending classes in psychoprophylaxis and mothercraft:		
Booked for hospital confinement	347)	356
Booked for home confinement	9)	
Total attendances at classes		1,411

During 1972, the midwives have increased their efforts to see more mothers whether booked for home or hospital confinements, at the G.P. surgery ante-natal sessions. They also try to pay at least one home visit to all mothers. It is disappointing to see that there is an increase of 62 in the number of mothers booking for ante-natal care after the fourth month of their pregnancy. This means that during the important early months they are without medical supervision. The reason for this is not clear. The midwifery staff are investigating the possibility that working mothers are unable or unwilling to take time off to attend surgery. Psychoprophylaxis and mothercraft classes continue to be held at twelve centres in the county. The number of new mothers attending during the year shows an increase of 135 over last year, although the total attendances has fallen. Because the majority of the mothers will be confined in hospital, Local Authority and Hospital staff take care that conflicting advice is not given. Health visitors from the county staff are invited to speak at the Hospital classes, and also visit the mothers in the post-natal wards to talk on various subjects, including Family Planning.

Midwifery Visits

Because of the revision of nursing returns, the information given in the following table differs in form from that given in previous years.

Table IV

Year	Ante-Natal Visits to Mothers at Home (Domiciliary and Hospital Bookings)	Post-Natal Visits to Mothers Delivered at Home
1970	5,853	3,253
1971	5,406	2,404 Post-Natal Visits to Mothers Delivered at Home, or Delivered in Hospital and transferred Home.
1972	4,330	6,466

Table V

Early discharges from Hospital

Year	No. of Mothers discharged within 48 hours	No. of Mothers discharged within 2-8 days	Total No. of Visits to Mothers discharged within 10 days	No. of Cases discharged within 8 or more days
1970	162	1,028	4,361	—
1971	190	1,186	5,553	—
	No. of Cases discharged within 2 days	**No. of Cases discharged within 3-7 days**		
1972	61	939	—	563

Due to the altered form of the information, accurate comparison between this year and previous years in the number of mothers being discharged within 48 hours is difficult. These cases are always very carefully planned, and happen only on the request of the mother who for personal reasons wishes to return to her home and family as soon as possible after delivery. Some mothers are persuaded to accept hospital confinement on the understanding that they can return home to the care of their domiciliary midwife within 48 hours. The preparations made for the care of the mother and baby are as detailed as if she was being delivered at home.

It is encouraging to see that the mothers themselves are now more readily accepting that they should stay in hospital for longer than two days confinement and the availability of hospital beds has always allowed of this in the Western part of the county.

MIDWIFERY TRAINING

The integrated training scheme for pupil midwives has continued throughout the year, the pupils coming from the City Maternity Hospital, Carlisle, and the West Cumberland Hospital, Whitehaven. The City Maternity Hospital students spend six weeks in Carlisle with the city midwives, and six weeks with the Cumberland County Council midwives. The West Cumberland Hospital pupils spend the two six-week periods with midwives in the county.

Ten Teaching Midwives in the county have been responsible for the supervision of the Community Care Training of 29 students compared with 26 in 1971.

Study days are held alternately at the two hospitals, and are arranged and run by Miss M. Moore, Health Visitor Superintendent, City of Carlisle, and Miss J. Reid, Area Nursing Officer, Southern Area, Cumberland County Council.

A "spin-off" of these courses is the very close links being forged between the nursing staff of both hospitals and the staff of the two Local Authorities.

Miss B. Cox, the Central Midwives Board Nursing Inspector, visited the West Cumberland Hospital Group in October, and expressed satisfaction with the way in which the integrated training course is being run. During her visit, she met some of the domiciliary staff, and discussed the training with them.

Seven midwives attended Statutory Refresher Courses during the year. In spite of the decline in the number of home confinements, it is still very important that all midwives attend these courses at least every five years.

Number of Midwives on Roll in 1972

In the community service	35
In the hospital service	68
	103

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				
		Died				Died				Died			
	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	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	6	3	2	—	—	—	—	—	—	—	—	—	6	1
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	10	3	—	1	—	—	—	—	—	—	—	—	6	—
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	31	5	1	—	—	—	—	—	2	—	1	—	5	—
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	39	2	1	—	1	—	—	—	1	—	—	—	1	—
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	97	—	—	2	—	—	—	—		—	—	—	3	—
6. Total	183	13	4	3	1	—	—	—	3	—	1	—	21	1

HEALTH VISITING

Students

From January to September, 1972, we sponsored three students for training, two at Durham Technical College and one at Robert Gordon's School of Technology, Aberdeen. The two at Durham were nominees from outside the county staff: one was from the hospital field and one had previously worked for a short time in the Medical Centre at the Steel Works, in Workington. The male trainee, at Aberdeen, had been a District Nurse for a number of years in Workington.

All three were successful in their examinations and are now working within the county. We now have our first Health Visiting Officer and apart from pre-natal work he undertakes the full range of duties. He is interested in a population group so far unexplored in this county, i.e. the middle aged men. Towards the end of 1972, in conjunction with Dr. A. Hargreaves, Area Medical Officer, Western Area, the late Dr. C. B. Robinson, General Practitioner, and Miss J. M. Crossfield, Area Nursing Officer, the details of a medical/social screening survey for this group were planned with Mr. Holmes, H.V.O., and he will commence the interviewing early in 1973.

In September, 1972, two students commenced training and should qualify in September, 1973, one at Durham Technical College and one at Glasgow College of Technology.

With students training at different centres, all outside the county, we have little or no contact with the training schools and it is sometimes difficult to ascertain if we are providing the correct experience for them when they come to us for short periods during training and for the three months prior to certification.

Miss J. M. Crossfield, Area Nursing Officer, Western Area, who has delegated responsibility for health visitor training has had two meetings with the Principal Tutor from Manchester, and hopes to meet and discuss the students' progress with tutors at other training centres.

Family Planning

Forty-five health visitors attended a two-day course run by the Family Planning Association on our behalf, to enable them to give meaningful advice on this subject.

A cassette tape and film were supplied to each Area in the County and are in regular use in antenatal classes, schools and mothers' clubs.

It is important that staff are fully aware of the facilities offered at clinics run by the Family Planning Association throughout the county on an agency basis. The insight gained enabled the staff to identify, through a survey, the need for a domiciliary service in the county. Plans to provide a directly operated domiciliary family planning service are now well advanced.

Developmental Assessment

Health visitors throughout the county have carried out developmental screening of pre-school children at regular intervals. The procedure introduced in the Western Area last year has been extended this year to other areas of the county.

Screening is undertaken at three monthly intervals either in the home or at a clinic and an assessment is made of progress in the main areas of development, i.e. locomotion and posture, vision and manipulation, hearing, language and speech development, and social development. The findings are charted and returned to the Area Offices where a medical officer reviews the progress of each child.

Nursing Officers

The appointment of a nursing officer to each area in 1972 has meant that more support is readily available to the staff. This is especially valuable in the induction of newly trained health visitors and the nursing officers have had regular meetings with them to offer practical advice and guidance and to introduce them to the particular working methods of this county.

Generally the nursing officers have been able to offer more clinical assistance to staff, to assist in planning health education programmes, and to undertake liaison with hospitals, particularly in the geriatric field, and to follow the progress of discharged patients.

The nursing officers play an important rôle in maintaining harmonious working relationships between general practitioners and the nursing members of the family health care teams.

They are actively engaged in the promotion of even closer team work amongst the nurses, to avoid duplication of effort, to enhance communications, and to ensure that each member

is employed in work commensurate to her status and to the best advantage for the community and the harmony of the team.

With a second nursing officer this work could be more consistent and of greater depth and the quality of care more closely examined. We should be able to look for areas of need not yet fully provided for and plan accordingly.

General

Throughout the year health visitors continued to work closely with the Social Services Department and although experiencing some difficulty as the new Department became established, as the year progressed members of both staff got to know each other and communications became easier and definite channels established. Regular meetings between field workers are now in being in some areas and are increasing in number, social workers are also attending group practice meetings and the picture is one of increasing involvement with understanding and appreciation of each other's rôle.

During the fuel crisis early in 1972 the two departments worked together to assist persons in need and the fact of it being a crisis caused both teams to integrate their work which provided a good basis for further work.

Table 1

Table of Cases and Visits for 1972

	Cases	Visits	
Born 1972	3,785	15,054	
Other children under 5 years ..	10,779	25,715	
Persons between 5 - 16 years .	1,093	(8,916	
Persons aged 17 - 64 years	2,923	(	
Persons aged 65 and over	6,208	18,762	
Visited for Tuberculosis	108	229	
Other Infectious Diseases	337	727	
Any other reason	2,201	9,200	Treatments in GP surgeries
	27,434	3,701	Interview and advice
Mentally handicapped	103		
Mentally ill	181	750	Mentally disordered
Total:	27,718	83,054	

Table II

Total Number of Visits

	1969	1970	1971	1972
Visits to babies and children under 5 years	44,836	40,599	40,084	40,769
Visits to other age groups	5,829	7,181	7,516	8,916
Visits to patients over 65 years	17,925	18,146	19,835	18,762
Visits to patients with mental disease	885	810	682	750

HEALTH EDUCATION

The promotion of health through health teaching is one of the prime functions of a health department. The majority of health teaching is undertaken by health visitors on a friendly and informal basis when visiting families in their own homes and is tailored to meet individual needs. This may range from guidance on home safety, hygiene or tuition to the more complex aspects of mental health.

During the year, health visitors sought additional opportunities for group teaching and the number of formal sessions increased by approximately 100 (792 compared with 689 in 1971). It is during group sessions that the modern health hazards of obesity, smoking, drug dependency and sexually transmitted disease can be aired and discussed.

The national rise in the incidence of sexually transmitted diseases, especially amongst young people, has caused concern.

Mrs. Parkinson, Health Visitor, Egremont, who has incorporated the subject in a series of talks comments:

> "During the year I was invited to help with mothercraft classes at Wyndham School — the group, 14 years old, particular reference Family Planning and Immunisation.
>
> After discussions with the teacher and in view of the present statistics, it was decided to include a talk on sexually transmitted diseases in the family planning talk.
>
> I contacted the late Dr. Bell who was very pleased that sexually transmitted diseases were to be discussed with this group — he provided some very useful material including booklets which had been produced for this age group. These were provided for use in class one week before the talk. Permission was requested from

parents for their daughters to attend the class. It was interesting to note that there was only one refusal — this for a girl who lived with grandparents. The project was a success and the discussion group which followed showed that, not only had the information been needed but it had been understood.

This session was repeated at a later date with a larger, younger mixed group. I felt this was not successful, the children were too young to realise the social implications of sexually transmitted diseases and were too shy to join in any discussion. It was decided that in future the group should be smaller and not mixed."

In all parts of the county, head teachers have again welcomed the assistance of health visitors and in many areas health education programmes are being incorporated into the school curriculum at an earlier stage.

Mrs. L. Messenger, Health Visitor, Maryport, comments on her work during the year:

"After discussion with the Deputy Head of Netherhall School, and the Departmental Head concerned, it was decided to begin the programme of health education at an earlier stage than before, i.e. to introduce it into the third year classes instead of the fourth year. It was felt that the pupils were mature enough at this stage to be interested in such topics as personal hygiene, menstruation, conception, childbirth, personal relationships, sexually transmitted diseases, child development and the dangers of cigarette smoking.

The pupils have been found to be very keen and besides asking countless questions they discuss the topics further with their parents who, in turn, react very favourably by asking, 'Why didn't we get the opportunity to discuss such topics as these when we were at school?'

A Mother and Baby Club was started in Maryport last August. We meet every Tuesday afternoon. Mothers enjoy a varied programme, see page 64, of health education and social afternoons whilst their babies and toddlers are cared for in a separate room. Ten fourth year girl pupils from the school attend and help to look after the children. The teachers have been most co-operative in this venture, the girls learn quite a lot about child care and the value of play. Afterwards they discuss with their teacher the various activities in which they have been involved.

Another new venture started recently at the suggestion of the Area Nursing Officer. It is to explain to all the first year girls (about one hundred) the value of Rubella vaccination; it is hoped that this will promote a better response when the School Medical Officer visits the schools to do the vaccinations."

Throughout the county the problem of obesity is prevalent in all age groups but most notably in the middle-aged and the schoolchild. In the latter age group the development of 'tuck shops' in schools is undoubtedly a contributory factor. Concern for the health of those who are overweight has given rise to the growth of four new obesity clinics in one area of the county.

Miss B. Knibbs, Nursing Officer, Northern Area, writes:

"A further four groups of health visitors at Brampton, Penrith, Silloth and Wigton, are running obesity clinics, giving an opportunity for Health Education to this mainly middle-age group. Approximately fifty patients are involved at one time, referral being through the general practitioners. Most groups follow the carbohydrate unit system recommended by Professor Yudkin, one follows the calorie count system.

Vital statistics are taken at the first visit and at some groups photographs are taken.

The groups are informal — recipes being exchanged. One clinic demonstrates simple cooking recipes on the carbohydrate unit diets, where room allows exercises are performed to music.

The groups mainly consist of housewives. One evening group is being run.

Six to eight men and six to seven school children have been referred and are being supervised.

One lady of 28 stone has lost three stone in three weeks. The average loss is 3 - 4 lbs. per week. The length of attendance varies according to loss of weight need."

Mothers' Clubs have flourished during the year. These clubs, run under the guidance of health visitors, provide excellent opportunities for informal and formal health teaching. A typical programme is set out below.

"Maryport Mother and Baby Club.

To be held on Tuesday afternoons at 2.0 p.m. in the Town Band Rooms, Lyalls Place, Netherton.

Programme of Future Events:

January 9th	Health Visiting.	Mrs. L. Messenger
January 16th	'Glamour' the High Speed Way.	Gas Board Official
January 23rd	The Comprehensive School	Mrs M. Black
January 30th	Holiday Abroad Slides	Miss A. Robinson.
February 6th	Speech Therapist.	Mrs. M. Blacklock
February 13th	Heinz Baby Foods.	Miss J. Stoker
February 20th	Marriage Guidance.	Mrs. B. Gratton
February 27th	Talk about Shoes.	Mr. J. Pattinson
March 6th	Physiotherapist.	Mrs Freebairn
March 13th	Flower Arranging.	Mrs. Bennett
March 20th	N.S.P.C.C.	Mr. Longley
March 27th	Baby Clothes and Toy Sale.	

Evening Meetings:

February 5th	Film about Spastic Children.
March 6th	Demonstration in the Electricity Board Showrooms, 18 Lowther Street, Whitehaven. Transport provided.

Committee for 1973:

President:	Mrs. McClure.	Vice President:	Mrs. Gartland.
Secretary:	Mrs. White.	Asst. Secretary:	Mrs. McCracken.
Treasurer:	Mrs. Roach.	Health Visitor:	Mrs. Messenger.
Committee Member:	Mrs. Shimmings.		

All Mothers are welcome to attend with their Pre-School Age Children."

Health visitors and midwives have continued to hold group sessions for pre-natal mothers at 12 centres in the county. The series of talks includes: The developing foetus, nurtition relating to the needs of the mother and her unborn baby, breast and artificial feeding, and family planning. A film on the birth of a baby is shown and demonstrations are given on bathing the baby, preparation of bottle feeds and sterilisation of equipment. Relaxation exercises follow each talk. Health visitors from the county are invited to speak at the classes run in hospital. They also visit the post natal wards and talk on various subjects including family planning.

Total sessions during 1972 were as follows:—

Schools	179
Clinics	101
Antenatal classes	339
Mothers' Clubs	45
Other Organisations	54
Surgeries	66
Hospital	8
Total sessions:	792
Total attendances:	9,270

Training

In-Service Training and Refresher Courses:

We are greatly aware of the need to draw the attention of nurses working in the community to current trends in medical and nursing practice and social change which affects their work.

The following interesting programme of monthly lectures was arranged from topics suggested by the staff.

CUMBERLAND COUNTY HEALTH DEPARTMENT

NURSING STAFF LECTURES

1972

NORTHERN AREA

Tuesday, 18 Jan.	Sexually transmitted diseases. DR. H. J. BELL, Consultant Venereologist.
Wednes. 16 Feb.	Occupational Therapy. MISS M. PARKIN, Occupational Therapist. (Venue - Salkeld Hall, C.I.C.)
Tuesday, 21 March	Radioactive substances in use in medical practice. DR. T. G. GIRDWOOD, Radiologist. (Venue - Salkeld Hall, C.I.C.)

Monday, 17 April	Psychiatric problems in childhood. DR. J. WOOD, Consultant Child Psychiatrist. (Venue - Salkeld Hall, C.I.C.)
Wednes. 24 May	Coronary Care. DR. T. C. STUDDERT, Consultant Physician.
Wednes. 28 June	Modern treatment for conditions of the eye. MR. W. E. PATTISON, Principal Tutor, W.C.H.
Wednes. 13 Sept.	Ethics of Euthanasia. DR. P. CHIN, Consultant Geriatrician.
Wednes. 18 Oct.	Emergency Midwifery. NURSING OFFICER.
Wednes. 22 Nov.	Side effects of steroids. DR. P. C. MITCHELL, Consultant Dermatologist.

SOUTHERN AND WESTERN AREAS

Monday, 10 Jan.	Occupational Therapy in Rehabilitation. MR. M. J. BOOY, Rehabilitation Officer. (Venue - Rehabilitation Centre, Whitehaven Hospital, Flatt Walks).
Wednes. 9 Feb.	Emergency Midwifery. MISS J. REID, Area Nursing Officer. (Venue - Park Lane Clinic).
Thurs. 23 March	Radioactive substances in use in medical practice. DR. G. B. SCHOFIELD, Senior M.O., Windscale and Calder Works. (Venue - W.C.H.).
Friday, 28 April	Psychiatric problems in Childhood. DR. J. WOOD, Consultant Child Psychiatrist. (Venue - W.C.H.)
Tuesday, 16 May	Coronary Care. DR. C. B. WILLEY, Consultant Physician. (Venue - W.C.H.).
Tuesday, 13 June	Modern treatment for conditions of the eye. MR. W. E. PATTISON, Principal Tutor. (Venue - W.C.H.).
Thurs. 14 Sept.	Problems of Euthanasia. DR. J. KAMINSKI, Consultant Geriatrician. (Venue - W.C.H.)
Tuesday, 10 Oct.	Psychiatric Care. DR. A. W. DRUMMOND, Consultant Psychiatrist. (Venue - W.C.H.).

Monday, 13 Nov. — Multiple Sclerosis. DR. D. S. WILSON, Consultant Physician. (Venue - W.C.H.).

Once again colleagues from the hospital service joined the community nurses at sessions of interest to them. Staff working in the community were invited to join the series of Study Lunches arranged at the Cumberland Infirmary, Carlisle, and during April/May and October/November an average of eight staff attended on each occasion.

The lectures and lunchtime sessions have enabled contact on a semi-social level between nurses in hospital and in the community. This has resulted in a deepening understanding of each other's rôle and problems.

A Study Day on Stoma Therapy and Care of the Patient was arranged for District Nursing Sisters at the West Cumberland Hospital in July. The 42 members of staff who attended found the day beneficial. All gained knowledge of up to date surgical techniques and modern appliances for patients with stoma which will be of help in the aftercare of these patients.

In June, 45 health visitors attended a two-day Family Planning Appreciation Course held at West Cumberland Hospital. This was arranged by the County Health Department in conjunction with the Family Planning Association. The seven health visitors who were unable to attend joined a similar course arranged by Carlisle City Health Department in December. All members of the Health Visiting staff are now better equipped to offer advice and guidance to the families they visit.

Six members of staff attended one-day courses on specialised topics and management training continued. Miss Bailey, Area Nursing Officer, attended Part I of a Middle Management Course, at Stannington, and Miss Simpson and Mrs Conway, Health Visitors, attended a two-week First Line Course held at Workington in the West Cumberland College of Technology and Science.

Seven midwives attended statutory refresher courses during the year.

Hospital Students and Pupils:

In addition to the 29 student midwives who undertook part of their training in the county, 65 student and pupil

nurses from the local hospitals spent a day observing the work of nurses in the community. The short time spent in the community by nurses in training, although inadequate, does provide insight into the multiplicity of nursing duties carried out in the home.

Visitors:

Three senior nurses from overseas visited the county during the year, Mrs Johansson, Mrs Olsson, both from Stockholm, were particularly interested in aspects of child health. Mrs R. Gordon, W.H.O. Fellow, from Israel, visited the county as part of a tour of England and Scotland, during which she was studying nursing administration in relation to family care in a rural community.

In February, Mr Maclean and Mr Loughran, Consultant Surgeons, met members of the nursing staff when spending a day in the Department.

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

Once again I gather here reports on a variety of services which wholly or mainly affect the health of mothers and their young children. The pre-school child health clinic continues to develop more towards a system of developmental screening of young children with the health visitors continuing the basic advisory services increasingly in, and from, general practitioners' premises and with the support of their general practitioner colleagues. It is also pleasing to be able to record encouraging early results from developments in the dental services.

CHILD HEALTH SERVICES

The table below gives some indication of the numbers of attendances at Child Health Centres, conducted in local authority premises on the one hand, and in group practice premises on the other. The shift of emphasis from the former to the latter is apparent for recent years.

Attendances at Pre-School Child Health Centres

	No. of L.A. centres provided at end of year.	Total attendances during year at L.A. centres.	No. of separate G.P. practices providing well-baby sessions at end of year.	Total attendances during year at G.P. well-baby sessions.
1969	29	31,018	9	4,364
1970	27	20,720	21	11,048
1971	26	18,651	21	14,656
1972	22	16,361	23	14,303

The greater part of the work carried out in the group practice centres is advisory and educational in the child health and welfare field, while progressively more of the attendances at local authority clinic premises are for more detailed, planned developmental testing of pre-school children by specially trained medical officers of the County Health Department. Both types of activity are vital and their parallel development begin to provide a more comprehensive advisory and developmental screening service for young children. The pattern of the advisory service given by health visitors, now more and more, as I have indicated,

given in group practice premises in conjunction with the family doctor, is very familiar to all concerned. Less clear will be the picture some have of the developmental clinic work, and I give below fairly full accounts of this by the medical staffs of the areas, commencing with reference to the very important regular panel meetings now held in each area where medical and other specialists discuss with health department doctors and nurses selected children with a real or potential handicap, or with a serious developmental problem.

The year 1972 saw the establishment on an area basis of regular Panel meetings involving health, education and social services departments to consider and co-ordinate the care of pre-school children who showed signs of suffering major handicaps, mainly in the area of mental development. These have continued successfully and it is already apparent that they will probably in future provide an equally suitable forum for discussion of severely handicapped children. It is very interesting and encouraging to see from the reports below of the medical officers working in developmental testing of young children, how this latter work is tying in with the Panel discussions of individual children and in due course with the continuing medical, psychological and educational care of handicapped children in school. The growth of pre-school developmental testing of children is a notable feature of child health services generally on the current scene and fully satisfactory methods of evaluating it are not yet available. While this is so and the future will no doubt hold a more sophisticated approach to this aspect of the work, I think there is wide consent that the elucidation of both frank and more minor handicaps before school entry can only be to a child's benefit even if the medical or educational means are not at hand to correct or ameliorate the problem.

The classical example of the young child with minimal brain damage who presents as a 'clumsy' child is much more likely to receive the required consideration and special help if it is appreciated by teachers and all concerned that his difficulty is of physical developmental origin. Only in time will techniques of special help and possibly equipment for such children be developed. The elucidation of the character of the problem must come first.

It was necessary to review the medical staff establishment in the light of all of this developing work and provision has been made for a further full time medical officer or

part-time equivalent in the financial year 1973/74. This by no means satisfies the wishes of the area medical officers who organise this work but will help forward the service to some extent. Similarly, additional screening assistant time has been provided for to the extent of one full-time assistant.

I now give below the report from the western area on the growth of some of the activities mentioned above. This is provided by Dr Marshall, Medical Officer in Department, who writes:—

"The developmental testing of pre-school children in Workington is now settling down and beginning to work smoothly. The Medical Officer sees all At Risk and Handicapped children at suitable intervals and all the children at 6 months and 3 years of age; the Health Visitors complementing this work at key ages and referring the children into the clinics where necessary. The mothers are becoming increasingly aware of the service and its advantages and many are beginning to regard it as a step forward in community medicine.

The attendance rate is around 60%, the younger the children the higher the numbers attending. The defaulters are visited by the Health Visitors to encourage clinic attendance, but, in the event of a second failed appointment, the General Practitioner is informed. In this way most children are covered.

During 1972 a comprehensive filing system started at the Area Health Office, combining Health Visitor Records, Medical Officers' Developmental Clinic Notes, and any Specialist Reports including the Paediatrician Reports as the baby leaves the Maternity Department. These files are sent to the various clinics as the children are seen, and the Medical Officers' remarks made available to the Health Visitors before being filed on return.

Throughout the year liaison has been very good between the various sections of people concerned with the health and welfare of the children. There have been held throughout the Area during the year a number of multi-disciplinary panel meetings concerned with pre-school handicapped and potentially handicapped children, which as well as revealing facts of the environment, health and circumstances of the children discussed, thus enabling really constructive efforts to solve their problems, have ironed out a number of apparent difficulties between the services concerned. They proved immensely helpful in getting a full picture of the children

concerned and helping them in the best possible way. This included passing on observations of the pre-school child to those who would be involved in education and to the Educational Psychologist. It became apparent that many of these discussed had delay in language development, and in particular the more retarded children. These the Educational Psychologist hoped to investigate before or soon after school entry. Once again, one could not help feeling how valuable a diagnostic nursery class would prove in helping to assess the difficulties of these children and to provide stimulation often lacking in their homes. Attached to a developmental assessment centre, such a class would be a great help.

It was agreed to refer any deafness found in pre-school children to the Medical Officer in Department specially trained in audiology, who would pass them on to the hospital E.N.T. Department where necessary, informing the General Practitioner of the action taken. Eye defects would be directly referred from the developmental clinic to the hospital, as before. Any delay in language development would be referred to the Speech Therapist by General Practitioner, Medical Officer or Health Visitor. The General Practitioners preferred any behavioural difficulty to be referred to them prior to any consultation at the Child Guidance Clinic. They also felt it would be more useful to inform them directly of any developmental abnormality picked up on routine examination, avoiding using the parent as an intermediary.

Although the number of 3 year olds attending the developmental clinics is only 60%, we feel that the school entry medical examination will eventually be foreshortened and facilitated as a result; only 40% requiring a full medical examination at that stage. Already, the observations made at the more leisurely 3 year old examination are proving most helpful to the School Medical Officer. Any minimal physical or psychological defect which may give an educational disadvantage have been located and allowances can be made at school entry."

In the southern area 1972 has seen the commencement of a real effort to establish the beginnings of a pre-school developmental assessment scheme. Dr. McMillan, Medical Officer in Department, gives the following account of this:—

"1972 has been concerned primarily with the preparation of a regular system of developmental assessment of pre-school children in the Southern Area.

I attended a brief but intensive course on Developmental work in Edinburgh early in the year which was very useful.

It was decided to initiate a programme of developmental assessment based on the 'Milestone' reports of Health Visitors, done in association with the 'At Risk' Register, and the Medical Officer would see all such children for assessment at 3 years. This would then be enlarged to cover the whole 3 year population of the area. The choice of assessment at 3 years is a useful one from a School Medical Officer's point of view as at this age lesser degrees of hearing or visual defect or faulty speech can be picked up and dealt with before school. It also provides an opportunity to discuss future schooling with parents, e.g. the provision of special schooling for a severely handicapped child, or attendance at Nursery School of some children.

The information obtained on such assessments is of value in the cases of known or suspected slow development, and can be usefully relayed to the Paediatrician or General Practitioner looking after the child.

It is too early yet to assess the future value of this work as a screening procedure, as it is already apparent that the rate of attendance is very low, (less than 50% of children called up between September and December attended the clinic). The Health Visitors have largely been active in visiting mothers and explaining the purpose of the appointment, and in providing the milestone reports for the 'At Risk' children.

A small proportion of speech defects have been found and noted for action later, and several children have been recommended for nursery school attendance, including, with the co-operation of nursery school staff, several handicapped children.

In the northern area geographical problems make it even more difficult to establish developmental clinics. In addition in this area reliance has to be placed to a greater extent on part-time medical officer time and, in these circumstances, it is more difficult to secure the desired specialist training for the professional staff concerned. However, an important start has been made by Dr. Garland. Dr. Connolly, Northern Area Medical Officer, writes as follows:—

"In the Northern Area, a Developmental Clinic for children aged 0-5 years, was established in Wigton in January, 1972. Children seen are confined to those who

are patients of the local group practice (Drs. Dolan, Jones and Gray).

A register is maintained of children who qualify for examination and a record is kept of the outcome. Dr. J. E. M. Garland, a Senior Medical Officer, holds the clinics. She sees children of varying ages but particularly children of 6 weeks to 6 months, children of three years and 'at risk' children and also those children causing concern to a parent or family doctor. Examinations are carried out at the clinic in Birdcage Walk, Wigton, on alternate Tuesdays and on Thursday mornings.

The observations of the examining doctor are made on the health visitor's record card for the child, which includes the milestone assessments completed by the health visitor from time to time. All these documents are of considerable help to the doctor in her assessment of a child's development. Health visitors are involved to quite some extent in determining priorities of appointment and also, of course, because of their personal knowledge of the children, parents and home background.

It is not envisaged that there can be a comprehensive service of this kind for the whole area for some considerable time. The service has, and will, continue to be of a selective nature but it is hoped to extend the scheme to another practice in the area. With the knowledge and expertise which will have been gained in the examination of these children, we hope to have a useful specialist service which will cover children throughout the area, outside the particular practices in the scheme."

Dr. Garland writes as follows:—

"The Developmental Clinic held at fortnightly intervals in Wigton, has completed its first year — 165 appointments were sent out and 127 of these (77%) were kept. This is a very encouraging attendance rate and gives evidence that the service is appreciated. The referral rate from this clinic has been very low, mainly because many of the children are already under observation or treatment by the General Practitioner, a Paediatrician or at an Eye Clinic. Very few new defects have come to light; nonetheless, it appears that parents are anxious to bring their children to the clinic for a general developmental check, in addition to the care they are already receiving.

Vision testing is carried out with all children and it was found that approximately two thirds of the children could be tested adequately by letter-matching at the age of three

years. The other children were tested by toy-matching or other methods. No cases of severe myopia were found but two children were referred to the Eye Clinic in addition to four others who were already under treatment for squint.

A number of children will be reviewed after a period of some months or a year; the majority of these reviews are to recheck vision where letter-matching was not possible when first seen."

WELFARE FOODS

It is now more than a year since the removal of subsidies from Welfare Foods and the withdrawal of orange juice and cod liver oil. This change has not been without its effect on the sale and distribution of the foods as a whole.

Sales of orange juice and cod liver oil continued until stocks in the county were exhausted. Vitamin A and D tablets which, since the withdrawal of orange juice, have been issued along with Vitamin C tablets, will also disappear to be replaced by Vitamin A, D and C tablets. Also available are children's Vitamin Drops, in dispenser bottles, containing at least seven weeks' supply, for the cost of 5 pence per bottle, and issued free to families who receive supplementary benefits. These drops have the added advantage over orange juice in that they are not a potential dental hazard.

Issues of National Dried Milk have increased, free issues have also been higher by 248 packets during last year. The total number of packets issued free in 1972 was 2,904. The Women's Royal Voluntary Service continues to provide the use of one of their vans and a member driver for the delivery of foods to the rural districts of Penrith, Wigton and Border. About 28 of their members, living in villages, store a month's supply of National Dried Milk and Vitamins for issue on demand to the local mothers. Once a month the W.R.V.S. driver and a member of the Health Department staff call at the homes of each distributor, replenish stocks, and collect cash and tokens for all issues since their last visit.

This service was commenced in 1940 and has carried on ever since without a break, although numbers have fallen considerably.

I remain grateful for the help and co-operation of W.R.V.S. members.

Year	National Dried Milk (Packets)	Cod Liver Oil (Bottles)	Vitamin Tablets A, D & C	Vitamin Tablets A & D (Packets)	Vitamin Tablets C	Orange Juice (Bottles)	Vitamin Drops (Bottles)
1963	78,858	5,162	—	2,630	—	34,953	—
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	—	1,171	—	46,198	—
1970	47,359	3,330	—	1,198	—	48,635	—
1971	42,276	2,348	—	847	—	44,765	—
1972	43,806	469	214	213	12	13,007	4,017

DENTAL

This year has seen the commencement of a new departure in Cumberland — the examination of all three year old children. The children are called up by computer and this appointment is for for inspection only. If treatment is required, an appointment is made if the parent requests the work to be carried out by the county dental officers. So far the response has been exceptionally good and attendance has been 42.5% of the call up, which is about 30% higher than the national rate. By inspecting the three-year-olds one has the opportunity of advising parents on diet and oral hygiene.

A revised code of practice for safeguarding patients and operators from radiation during the taking of x-rays came into force in 1972 and this authority is meticulous in implementing the recommendations as laid down. Surgeries have been inspected by Dr G. Scott Harden, Consultant Radiologist and adviser to the Regional Hospital Board, to ensure that equipment, protective aprons and signs used when taking x-rays, were up to standard and that the operators were conversant with the code. For many years now only the dental officer and patient have been in the surgery whilst x-ray apparatus has been used, and both wear lead aprons. No expectant mothers are x-rayed and every care is taken to ensure safety.

For many years now there has been a decrease in the number of maternity and child welfare patients attending

the clinic. Although it is only rational that maternity patients should continue to attend their general dental practitioners, some concern must be felt regarding the small number of pre-school children who are never seen until their first inspection in school at the age of five plus. Many parents do not realise the importance of conserving the deciduous teeth and fewer realise that the clinics treat pre-school children. By sending appointments for examination to all three year old children it does enable the dental staff to explain to parents the importance of sound healthy first teeth and, if treatment is required, to arrange for them to be treated by the general dental practitioner or at the clinic. This is a big move forward towards a comprehensive preventive service. About sixty sessions per year are devoted to this and it is considered to be worth while when assessed as part of a comprehensive integrated health service.

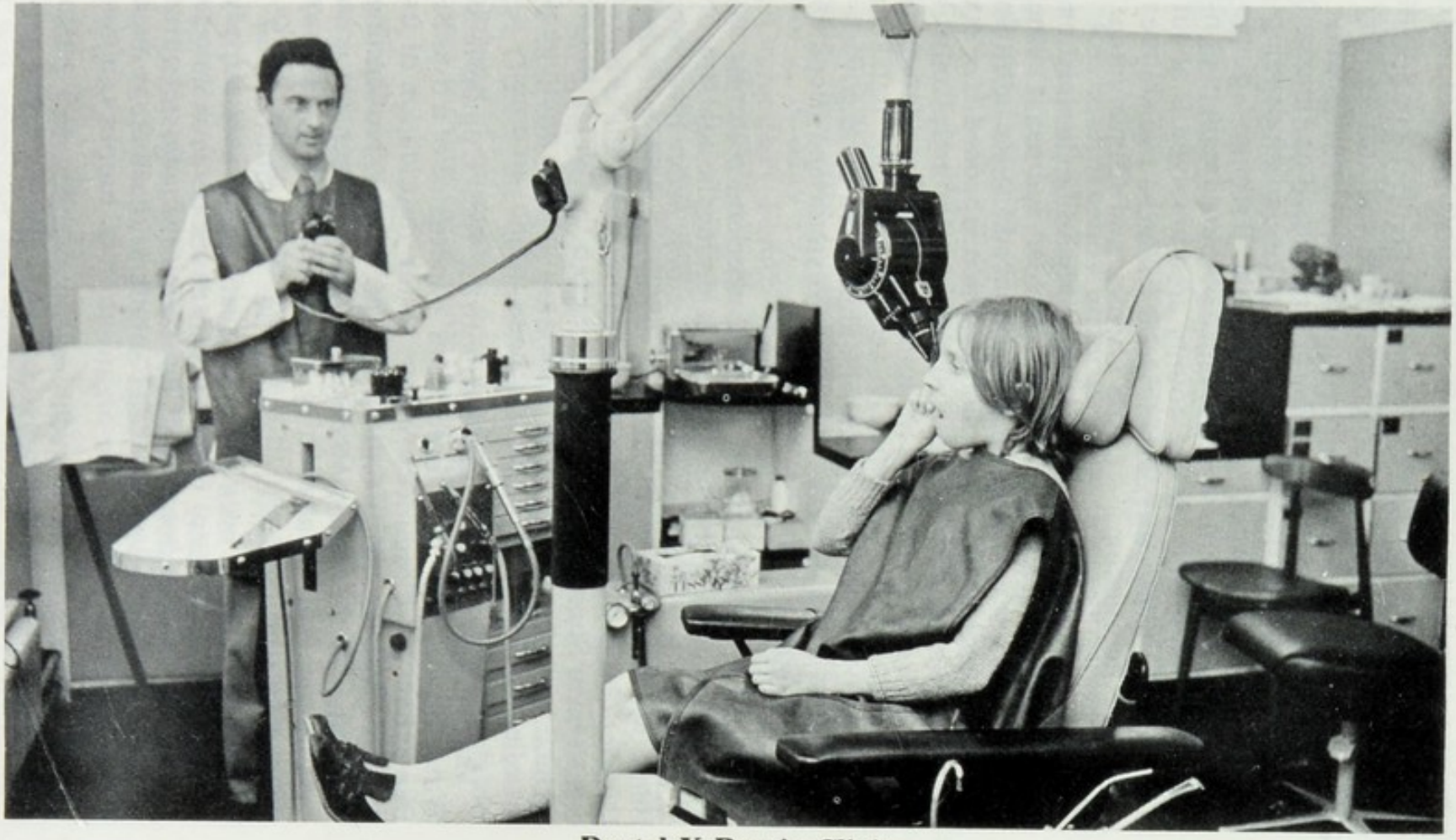
It is encouraging to note from those dental officers working on patients from fluoridated areas that there is an apparent reduction in the incidence of caries in permanent teeth and this, together with improved oral hygiene and less cariogenic substances sold in school tuck shops, is creating much healthier mouths.

Under the new integrated health service it is hoped that further resources for dental health education will be provided to work on a wide range of age groups, particularly teenage girls who are the mothers of the future, and instruct them in correct eating habits both for general and maternal health. So much could be done in the early years of a child's life to instil good habits and correct diet, which would prevent a great deal of suffering and ill health, including dental, in later life by educating parents to provide a good healthy diet.

FLUORIDATION OF PUBLIC WATER SUPPLIES

There was no extension of the fluoridation arrangements in the county during 1972.

About 107,000 people in three parts of the county have the benefit of fluoridation of the public water supplies; those living in the Whitehaven/Ennerdale areas and getting their water supplies from Ennerdale Lake; those living in the Cockermouth/Maryport/Workington areas served from Crummock Water and those in two parishes around Gilsland which are served from South West Northumberland. In



Dental X-Ray in Clinic

total this represents almost 50% of the population of the administrative county.

Agreement was reached some time ago about the fluoridation of the water supplies to Carlisle and the surrounding areas and work was to have begun in 1971. Unfortunately, this was deferred by Carlisle Borough Council on financial grounds and has not found a place in their capital development programme. At the end of 1972 the Borough Council did, however, re-affirm its acceptance of fluoridation in principle. 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 has been no change of opinion regarding fluoridation by the Eden Water Board, which decided against it some time ago and was undoubtedly influenced by the attitude of Westmorland County Council, which opposed it. As Cumberland County Council and Carlisle Borough Council have expressed themselves as agreeing with fluoridation in principle, it will be interesting to see what attitude is taken regarding the Eden Water Board's area when local government re-organisation takes place and Westmorland becomes part of Cumbria.

It has been hoped that the South Cumberland Water Board would get around fairly quickly to considering the adjustment of the fluoride content of the water supply from Baystone Bank, which is the main source of supply for Millom Rural District Council. That Council has expressed itself as anxious to have fluoridation of this source but the Water Board wanted to wait until the initial problems with the equipment installed at Ennerdale Lake had been fully overcome.

There is agreement in principle with the West Cumberland Water Board, which has three years' experience of a 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 or discussed as the intention is to synchronise the installation of fluoridation plant with any other improvements which may take place at the works.

There are very many small sources of water supply throughout the county where it will never be economic to undertake fluoridation. Any hopes for the adjustment of the fluoride content of the water supply to those areas must depend on the long term re-organisation of supplies.

Regular sampling of the fluoridated supplies goes on to ensure that the fluoride level is maintained between the per-

missible 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.

The dental examination of children when they attain three years of age began in 1972 and preliminary results indicate that fluoridation is having a marked beneficial effect on the children's teeth. Details of these examinations are given in the dental section of this report.

FAMILY PLANNING SERVICE

Research recently undertaken by the community nurses in Cumberland established the need in West Cumberland for a Domiciliary Family Planning Service. Over the last few years there has been a higher than county average birth rate in the more urban areas of West Cumberland, together with a higher than county average of infant and perinatal deaths.

Application was made to the Home Office for a grant, under the Urban Programme Non-Capital Projects, Circular No. 7, of May 1972. This has been given approval and a Domiciliary Family Planning Service will commence in this part of Cumberland during 1973.

This will be a directly run Service, in close co-operation with the Family Planning Association, who are agents, under Scheme 6, for the Cumberland County Council.

Members of the Social Services Department in West Cumberland can bring to the notice of the appropriate Area Medical Officer the families which might benefit from such a Service. Community nurses will also recommend suitable cases for referral as soon as the Service is operational.

The Domiciliary Family Planning Service will have close links with the Gynaecology Department at West Cumberland Hospital.

The recruitment of staff is now under way. Dr Ann Style, who has had gynaecological experience, has already been appointed and there has been a good response to advertisements for two part-time State Registered nurses. All these newly appointed members of the staff will receive specialist training.

With pressure building up throughout the country for family planning services to be made more readily available, it was proposed and resolved by the Health Committee,

that the County Council should change from Agency Scheme 6, where only medical cases are treated, to Scheme 5, a similar service, but one where non-medical cases could receive free consultations and advice, although they would still have to pay for prescribed supplies. It was expected that this change would come about in October 1973, and operate for the six months period prior to the Family Planning Association becoming part of the National Health Service. With the recent rapid development of the Government policy for family planning, and the phasing out of the Family Planning Association this may have to be revised, and discussions with the Health Committee held regarding the timing of these changes.

Family Planning Clinics are held regularly at Alston, Penrith, Keswick, Cockermouth, Workington, Whitehaven and Millom, where the County Council makes clinic accommodation and equipment available free of charge.

In Carlisle, the Borough Council also make accommodation available and allow the attendance of county residents from the surrounding area.

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

Arrangements for the call-up of children for vaccination and immunisation through the County Council's computer scheme continued satisfactorily throughout the year.

With the annual publication of the Community Health Immunisation and Vaccination Statistics by the Department of Health and Social Security concern was expressed by this authority that no account was taken of migration between authorities. Consequently, considerably lower results were being recorded for the county than was actually the case. It was stated that in the administrative county of Cumberland only 84% of those children born in 1969 were fully protected at the end of 1971. Computer records, on the other hand, confirmed that in fact 91% of those children born in Cumberland during the year were fully protected. It is hoped, however, that it will be possible to cope more efficiently with the problem of migration after 1974 on the basis of the new enlarged administrative areas.

As forecast in last year's report, it is now possible to confirm that the proportion of children born in 1970 who are at present fully protected according to the vaccination schedule set out below stands at 91%.

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 1972, the figures in brackets relating to 1971:—

Diphtheria Immunisation

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

Primary Courses—pre-school children	3,048	(2,597)
Primary Courses—school children	287	(192)
Reinforcing injections—pre-school children	—	(57)
Reinforcing injections—school children	2,628	(2,678)

Tetanus Immunisation

During 1972 the following numbers of children were immunised:—

Primary Courses—pre-school children	3,048	(2,598)
Primary Courses—school children	316	(204)
Reinforcing injections—pre-school children	—	(67)
Reinforcing injections—school children	4,167	(3,304)

Whooping Cough Immunisation

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

Primary Courses—pre-school children	3,048	(2,590)
Primary Courses—school children	18	(33)
Reinforcing injections—pre-school children	—	(46)
Reinforcing injections—school children	110	(333)

Poliomyelitis Vaccination

Primary Courses—pre-school children	3,075	(2,644)
Primary Courses—school children	332	(274)
Reinforcing injections—pre-school children	—	(26)
Reinforcing injections—school children	3,503	(3,121)

The increase in the numbers of children completing a primary course of vaccination and immunisation before starting school is most gratifying. No pre-school children were required to have a reinforcing injection.

Special point is given this year to these figures by the occurrence of several carriers of Diphtheria in the Northern Area of the county in November/December. An account of this is given by Dr. Connolly, Northern Area Medical Officer and Medical Officer of Health to the Border Rural District on page 22. From the point of view of immunisation figures the critical issue was the state of protection of the children attending the junior school concerned. It is highly gratifying that a close scrutiny of the immunisation records of the school population showed a fully up-to-date protection situation. Caution is always prudent in making claims in this field but it seems very reasonable to relate the early limitation of spread of this infection to the highly satisfactory protection state. The other message from the incident is more sombre. Diphtheria as a threat to child health and life is not dead and only the maintenance of a comprehensive immunisation level in the child community will justify confi-

dence in its limitation if introduced. The source of the infection in the carriers mentioned above was not discovered.

Measles

According to the current schedule of vaccination and immunisation procedures measles vaccination is recommended at 15 months of age. During 1972, 2,865 children were protected compared with 2,814 in the previous year. 93% of these children received their appointments through the computer call-up system.

During the year the possibility was raised of offering measles vaccination to 12 year old children in addition to the school entrants who have not already been vaccinated or have no natural immunity. In order to assess the need for such action it was agreed to conduct a pilot survey in the Cockermouth area of the county. Results showed that only 8% of the 12 year olds were at hazard and, therefore, it was decided to take no further action regarding vaccinating this age group on a county-wide basis.

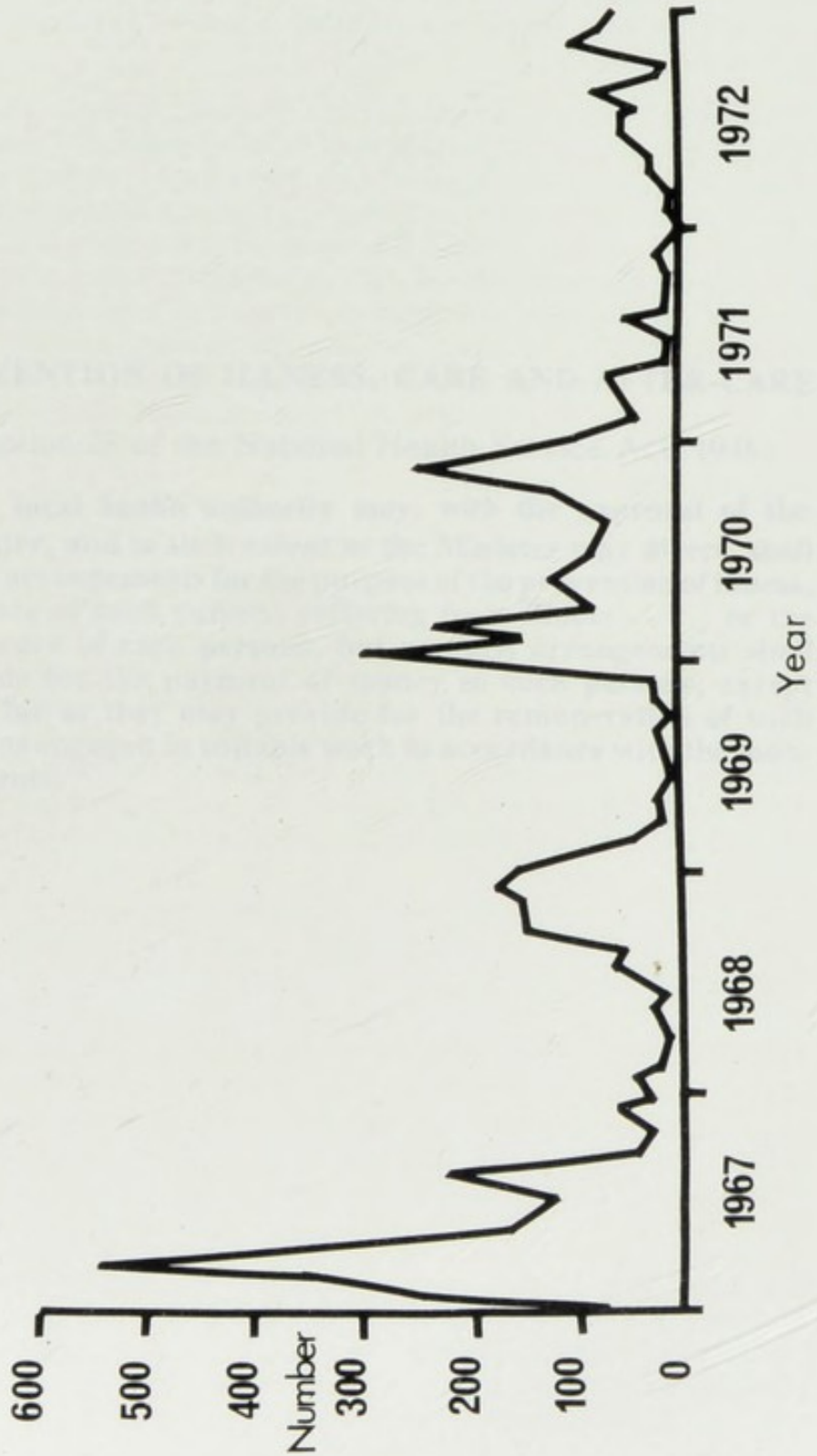
Rubella

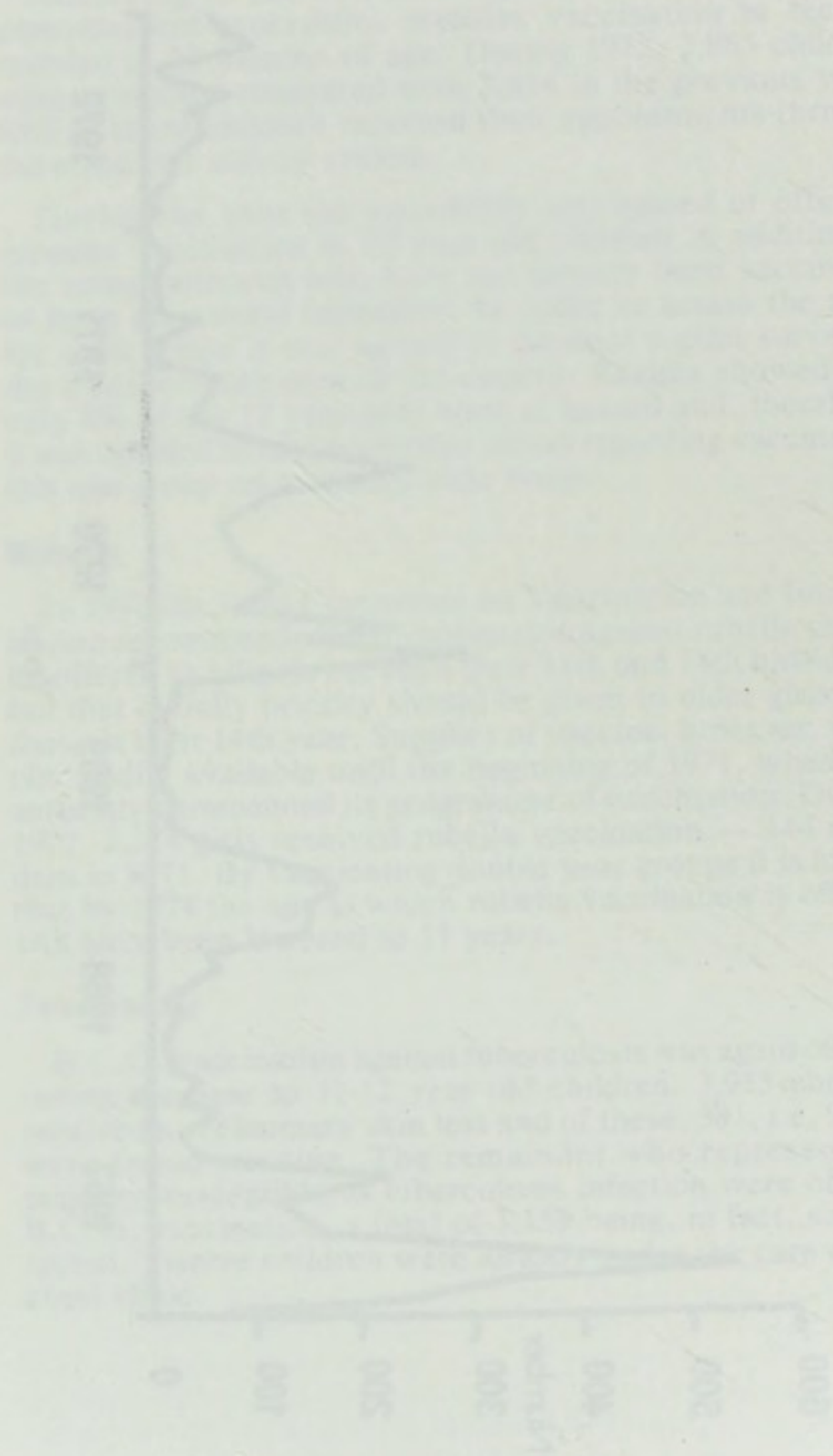
In 1970 the Joint Committee on Vaccination and Immunisation recommended that vaccination against rubella should be offered to all girls between their 11th and 14th birthdays, but that initially priority should be given to older girls, i.e. those in their 14th year. Supplies of vaccine, however, were not readily available until the beginning of 1971, when this authority commenced its programme of vaccination. During 1972, 2,378 girls received rubella vaccination — 144 more than in 1971. By vaccinating double year groups it is hoped that by 1974 the age at which rubella vaccination is offered will have been lowered to 11 years.

Tuberculosis

B.C.G. vaccination against tuberculosis was again offered during the year to 11-12 year old children. 3,915 children received a preliminary skin test and of these, 381, i.e. 9.7%, were found positive. The remainder who represent the majority susceptible to tuberculosis infection were offered B.C.G. vaccination, a total of 3,159 being, in fact, so protected. Twelve children were already under the care of the chest clinic.

Measles Notifications — Cumberland
Four-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

Among the services included under this heading are the chest services in East and West Cumberland. Although hospital based, these services are still of wide community importance and I am grateful to Doctors Hambridge and Southern for their reports which are printed in full as appendices to this report.

Another hospital based service of great epidemiological importance is that for the diagnosis and treatment of sexually transmitted diseases. Against an increasingly sombre international background, the position in Cumberland is not unduly alarming. The high worldwide prevalence of gonorrhorea in particular is not, fortunately, being mirrored here. A very severe loss to this service in Cumberland was the death of Dr. H. Bell, whose outstanding contribution in this field over many years will not be soon forgotten. He brought a lively, cultured mind to bear on all of the problems of prevention and treatment with a characteristic and unfailing enthusiasm.

CERVICAL CYTOLOGY

Cervical cytology examinations are carried out by local authority nurses at clinics in Carlisle, Cockermouth, Keswick, Longtown, Penrith, Whitehaven, Wigton and Workington. They also carry out examinations in general practitioners' surgeries throughout the county and the following table shows how the emphasis had swung towards this up to 1972. The figures shown relate to the whole of the Regional Hospital Board's Special Area and covers a population of 223,000:—

Period	Hospital Clinics	L.A. Clinics Cumberland County	Carlisle City	Family Planning Clinics	General Practitioners	TOTALS
1962/63	1,095	—	—	53	1	1,149
1964	2,137	—	—	254	1	2,392
1965	4,819	1,663	773	359	353	7,967
1966	6,940	4,116	1,383	418	567	13,424
1967	6,550	1,662	539	395	1,237	10,383
1968	7,114	1,249	400	512	2,485	11,760
1969	6,919	1,622	535	666	3,834	13,576
1970	6,626	1,411	473	671	4,040	13,221
1971	6,300	921	495	743	4,166	12,625
1972	6,020	1,588	965	936	6,178	15,687
Totals	54,520	14,232	5,563	5,007	22,862	101,184
1972						
Positive Smears	35	4	2	3	24	68
Total Positive Smears	332	60	33	19	139	583
Percentage of Positive Smears to Total Smears Examined	0.6	0.42	0.59	0.37	0.6	0.57

The number of positive smears detected in 1972 was 0.4% of all smears taken. The national average was 0.58% in 1969. A positive smear is one where an "atypical" or "abnormal" cell is found to be present, but does not include those showing an infection, which are reported separately.

Where a woman has several repeat smears which all prove positive, they are classified as a single positive smear, but the actual number of smears taken are included in the total of smears taken.

It is difficult to assess the benefit of this form of screening, but the following table shows that the number of deaths from cancer of the cervix has decreased considerably and over the past four years has levelled out to an average of 10 per annum:—

Deaths from Cancer of the Cervix Uteri

Year	Administrative County of Cumberland	England and Wales
1960	16	2,599
1961	14	2,504
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	2,315
1972	11	Not available

Miss E. Miller, Health Visitor Assistant, writes:—

"During the past year, sessions have been held in three factories in the area, and I found both the management and the workers very co-operative. The Directors of one factory expressed interest in the scheme, and hoped that their employees would take advantage of the service being offered to them.

During each visit, discussion sessions were held to explain the object of having the test carried out. Some of the women were worried about the results, but explanation and advice helped to relieve their anxiety.

In all forty-nine tests were taken, all of which were found to be negative. It is hoped that these sessions will become a regular part of the health care of women workers, and that other factories will take advantage of the service."

Five Year Recall

The recall scheme, using national request/record forms commenced in January this year and the lists prepared by the consultant pathologists in the area — were passed to the appropriate Executive Councils. Women who had died or left the area were deleted. The lists were then drawn up on a group practice basis and passed to the appropriate group practice team to check and eliminate from the list all women who are currently referred to gynaecologists or who otherwise should not have the examination. They were then returned to the Executive Council who in turn

passed them to the Local Health Authority who arranged appointments either at the practice surgery or the Local Authority clinics. The first list was received at the beginning of February and followed by monthly lists. 4,815 women were listed for recall up to the end of December. Of the 4,815 invited to attend 2,849 examinations actually took place, appointments are still in the process of being arranged for 67 and 1,899 were not examined for the following reasons:—

Medical	203
Left District	221
Had test previously	546
Refused	303
Elderly	26
Deceased	16
Other reasons	584

For statistical purposes three months have been allowed to arrange appointments and the above figures relate to the position at 28th February, 1973.

NURSING EQUIPMENT ON SHORT-TERM LOAN

Under the National Health Service Act of 1946, Section 28, it is the duty of Local Authorities to supply, on short term loan, any nursing equipment which will aid the patients' recovery.

In Cumberland I operate this service through an Agency with the British Red Cross Society whose members have done excellent work for almost ten years. The Council order all new equipment, replacing old and worn out articles with new and more up to date ones. The British Red Cross Society are in charge of all stocks and supplies and make the arrangements for getting the items delivered to the patients.

Last year, because of a considerable increase in the work involved and rising costs, an application was made by them for an increase in the grant. This was based on a sum of £15.00 for the running costs of each of the three depots. The Health Committee agreed to this and the grant was raised from £45.00 to £150.00 per annum. This was much appreciated by the British Red Cross Society.

The table set out below lists the larger items of equipment issued during the year, but also supplied were some 400 smaller articles. Into this category are included

64 bed pans, 46 urinals, 19 bath aids and rails, toilet seats and aids, 4 helping hands, 2 combs, knives and forks, and 2 "stocking putter-on's". The issues of ripple beds have increased from 36 in 1971 to 60 in 1972.

Table

Commodes	158
Crutches	33
Hoists, Hydraulic	4
Hoists, Penryn Lifter	1
Hospital Beds	11
Invalid Chairs, Adult	91
Invalid Chairs, Junior	1
Invalid Chairs, Car Type	37
Mattresses	11
Walking Aids	282
Ripple Beds	60
Total:	689

I again thank the British Red Cross Society for all the work they have undertaken during the year.

HAEMODIALYSIS

There are at the moment nine haemodialysis units operating throughout the county — four in the Northern Area, two in the Southern Area and three in the Western Area. One unit is to be completed in January, 1973, in the Southern Area, and discussions are taking place at the moment on a further unit in the Northern Area.

Ministry of Health Circular 2/68 authorises local authorities to carry out such adaptations as may be necessary, to provide accommodation for the installation of a haemodialysis unit in a patient's own home. In Cumberland, it was decided that as a kidney machine is life-saving medical equipment, full responsibility be accepted by the County Council for the cost of any alterations deemed necessary in particular cases. The machines are provided and maintained by the Regional Hospital Board, free of charge, and the Board pays for the extra cost of electricity used and rental of a telephone where this is necessary.

It is in this respect that a liaison officer has been appointed to the special renal dialysis unit at the Royal Victoria Infirmary, Newcastle. He is responsible as soon as the patient is considered suitable for training, for contacting the

appropriate Medical Officer of Health, Water Board, Electricity Board and, where necessary, the local housing authority.

A great deal of consideration and planning has been devoted to providing accommodation for the units, and in this respect the County Architect's department has done excellent work. Each one is usually located in a spare room or bedroom, but each case has its own individual problems. District housing authorities have been most co-operative and helpful in rehousing patients into suitable accommodation, and in making the necessary structural adaptations.

The usual requirements for the unit are a sink with hot and cold water supply, a formica topped draining board, a 30 amp electricity socket and three 13 amp sockets, together with storage space for large quantities of supplies which are delivered by the hospital authorities each time. In addition, the floor has to be made waterproof and the walls and ceiling crack free and washable.

The water and electricity authorities are very co-operative in maintaining services or giving advance warning of cuts. In the case of electricity cuts, mobile generators are kept on standby at the local hospital, and are issued as and when the need arises. During the fuel strike in February this system worked effectively and hospital engineers stood by at patients' homes during the period of the cuts. These engineers are to be complimented on the excellency of the service provided. They were also on call for any emergency that may have arisen.

Dialysis waste is disposed of at the local hospitals, special arrangements being provided for carrying it should the patient be unable to do this.

The ultimate aim of the hospital authorities, is to arrange a transplant operation; one, in fact, was performed during the year but, unfortunately, the donor kidney was rejected by the patient. Another case who had completed her third year of home treatment is due to be admitted in January, 1973, for a transplant operation.

DOMICILIARY PHYSIOTHERAPY

The limited extension of this service which I envisaged last year took place mainly in the western and southern areas and Dr. A. Hargreaves, Western Area Medical Officer, writes as follows:—

"In May it was decided to establish a limited physiotherapy service in Workington, using the services of Mrs. Freebairn, a part-time Hospital Physiotherapist. The establishment allowed for her to be employed for three sessions per week. The establishment of the service was discussed with some of the General Practitioners in the town and priority groups for treatment were to be 'stroke' cases and arthritics. The Physiotherapist would give treatment in people's own homes, particularly for early stroke cases, and if the case-load warranted it a room would be made available in Park Lane Clinic.

All the practices in the town were informed of the service and the doctors given a supply of simple referral forms giving details of the patient and his or her medical condition. The Physiotherapist reports the results of her course of treatment on the reverse of the form, together with any recommendations, and the form is returned to the General Practitioner.

During the six months of operation during 1972, 16 cases received treatment, all in their own homes, and 50% of these were stroke cases."

MENTAL HEALTH

With less direct involvement in some aspects of this service which are now in the field of social services, an area of work which has been explored during 1972 is that of co-operation between community nurses and hospital-based psychiatric nurses. A limited extension is envisaged of the work of the latter into the community in collaboration with the primary health care teams.

Dr. Connolly, Northern Area Medical Officer, makes the following comments on certain aspects of the mental health service:—

"In May, the Child Guidance Clinic for the portion of the county adjoining Carlisle, was transferred to the new suite of buildings at the Cumberland Infirmary. Although child psychiatry is now more closely integrated with the hospital services for children generally, there has been very good liaison during the year with the Northern Area medical staff and the Educational Psychologist.

The 'Cumbria Association for Mental Health' has again been active during the year, with various educational and practical voluntary efforts. This Association is mainly focused on the population within the catchment area of Garlands Hospital.

Services for the mentally handicapped and for the mentally ill have been under constant discussion during the year. Meetings have involved all the authorities and working groups caring for the mentally ill or mentally handicapped. A great deal of long term planning is involved and this can be expected to yield better facilities in the reorganised Health and Social Services.

Individual clinical and administrative problems which occur day to day are being satisfactorily dealt with by good liaison betwen all those concerned. During the year, Health Visitors made 750 visits to mentally ill or mentally handicapped persons.

DRUGS LIAISON GROUP

During the course of 1972 I had some discussion with the Chief Constable about the possibility of setting up a drugs liaison group in the county in order to bring together the various professional disciplines closely connected with the care and management of drug abuse, i.e. the drugs of habit formation and addiction. A meeting was called on Thursday, 30th November, 1972, at which representatives were present of doctors, the police, the Directors of Social Services and Education, the probation service and the pharmaceutical service. It was concluded that there would be benefit in such a group meeting regularly for a mutual exchange of appropriate information and the co-ordination of educational and other activities in this field, so that the various agencies concerned might be more mutually supportive in both prevention and treatment. At the meeting on 30th November, Dr. Terrell, Deputy County Medical Officer, was elected Chairman and Mr. N. V. Hutchin, Senior Probation Officer, as Secretary. The group is only concerned at present with the county of Cumberland since a very large body of people would have been involved if an attempt had been made to anticipate the whole Cumbria area, but clearly if the Committee proves helpful and generally successful it is anticipated that, in due course, it would be constituted on the basis of the Cumbria area which will be similar for local authority, health services, and police functions. I look forward to this group serving a most useful function in bringing together professional people with com-

mon areas of interest in this subject and yet with diverse responsibilities to the community and to individual persons. The legal responsibilities of the police and the personal care functions of doctors can readily come into some degree of conflict on this subject and I am sure that regular personal discussion of problems will be helpful here. It is already clear that the police in this area are deeply committed to preventive and remedial work in the management of drug offenders and a co-ordination of educational activities should prove very rewarding. At its second meeting, the group was honoured by the attendance of Judge R. R. Leech, judge of the Crown Court.

CONVALESCENCE

The number of patients sent for convalescent treatment this year was 27 — one fewer than in 1971. All were sent to the Silloth Convalescent Home and consisted of 13 cases from the Western Area, 10 from the Northern Area and 4 from the Southern Area of the county.

These cases are selected for their need for convalescent treatment and are in the main in the elderly age group. There are, of course, other referrals received from general practitioners, but where it is determined that the real need is a rest to enable patients to recoup their strength, it is suggested that they make application to the appropriate Area Social Services Officer for holiday bed vacancies in residential accommodation.

I am pleased to report that the doubt on the future of the Silloth Convalescent Home, which was raised in 1971 by the decision of the Newcastle Regional Hospital Board to end their contractual arrangement with the home, has been temporarily lifted. The Board had originally intended to end their arrangement from 30th June, 1972. However, following discussions between the Board's officers and the Department of Health and Social Security, and in consultation with a number of Medical Officers of Health in the region, it was suggested to the Board that in view of the pending reorganisation of the National Health Services on 1st April, 1974, a change in the arrangements was rather inappropriate, and that the matter should be deferred for consideration until reorganisation took place. The Board has agreed to this suggestion.

CHIROPODY SERVICE

For the second successive year the number of chiropody patients has increased by less than 1% — the actual increase being from 6,564 on the 1st January, 1972, to 6,615 on 31st December, 1972. Of the increase of 51, more than half were handicapped persons, bringing the number of handicapped on the patient lists to a total of 249. The number of handicapped persons being treated has more than doubled in three years.

Only four expectant mothers have been referred for treatment. It is interesting to note that since the inception of the service the annual number has varied between four and six.

During the year the number of treatments given was 26,844 compared with 28,502 in the previous year. The decrease is undoubtedly due to the fact that there have been two vacant posts in the northern area for most of the year. Arrangements were made for some of their work to be taken over by part time chiropodists and by transferring Mr. Gordon from the western area for one day per week. However, this does not enable a full service to be provided and resources are concentrated on those who need treatment most, although every effort is made to see all the patients in the northern area at least intermittently to assess their degree of need.

As the chiropody service is, for all practical purposes, a service to the elderly, it is no surprise that a substantial proportion of those referred for treatment are also certified by their general practitioners as being in need of domiciliary treatment. In 1972 it was, in fact, just under 30% of the total which is about the same as in 1971. It would seem that for planning purposes it can be assumed that almost one-third of the patients will have to be seen at home. These visits do, of course, involve a considerable amount of travelling time for the chiropodists, specially those serving the more rural areas, and in addition the chiropodists frequently have to give the treatment under very poor conditions. We are all grateful to volunteers who put their cars and services at our disposal so that those who can go to clinics for their treatment provided transport is available get it under the better conditions which prevail there.

The normal frequency of treatment is six times a year, although the individual chiropodists have discretion to increase or reduce the frequency as they believe necessary in each case. Unfortunately, there is some waiting for

patients before they can be seen for the first time. This is unavoidable when the chiropodists already have full case loads and make re-appointments well ahead but every effort is made to minimise this period although this has caused difficulties in the northern area because of the shortage of staff there.

The staffing establishment is nine full time chiropodists but at the end of 1972 there were only six in post. It has never been possible to get more than eight in post at the same time and consequently some of the chiropodists who work part time for the authority have been allowed to continue with case loads of over 300 patients. In addition to the full time staff there are thirteen who treat patients under the authority's scheme on a per capita or sessional basis. They can be regarded as the equivalent of three full time members of staff.

The recruitment problem, although Cumberland is probably better staffed with chiropodists than many authorities, has given rise to detailed consideration as to how chiropody as a career can best be brought to the attention of school leavers. The authority already has in operation a scholarship scheme under which students are paid higher than usual grants in return for an agreement to return to Cumberland to work for a period of not less than two years after qualification. There is already one student training under the scheme and it is hoped that another scholarship will be awarded in 1973. Unfortunately, the future of the scholarship scheme after National Health Service re-organisation is not clear and it was therefore thought best to concentrate on making careers teachers fully aware of the prospects in chiropody. To this end the authority's chief chiropodist, Mr. G. H. Thomas, will be speaking to careers teachers at a conference which is to be arranged in the county and is planning a publicity display which is suitable for exhibition in schools.

Together the full time and part time staff provide a service at the following places in the county:—

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

The staffing in the three areas would vary, even assuming a full establishment. Although the population of the areas is not significantly different the numbers of patients referred for chiropody does vary considerably for some reason which I have not been able to elucidate. In the western area there are 2,591 patients; in the northern area there are 2,075 and in the southern area 1,949. The number of patients needing domiciliary treatment fluctuates even more widely. 877 have to be seen at home in the western area; 609 in the northern area and only 434 in the southern area. As the western area has in general the better public transport service it is difficult to explain these differences.

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

The re-equipment of chiropody clinics is going ahead. By the end of 1972 new equipment had been installed at Whitehaven, Workington, Maryport, Cockermouth and Penrith. It is hoped to complete the programme for the major clinics in 1973, when Egremont and Millom will be re-equipped. The chief chiropodist, Mr. G. H. Thomas, says:

"There is no doubt that the new and greatly improved equipment is not only making our job much easier but is impressing the patients with its professional appearance. There is no doubt in my mind that smart clinical facilities produces, in turn, smart professional work. There can certainly be no excuse for anything but the highest standard of treatment in our new and improved surgeries.

There have been no outstanding developments in appliance techniques recently but we are continuing to produce ourselves a variety of appliances for patients with good effect. The Society of Chiropodists has recently produced a training syllabus for chiropody appliance technicians but the employment of such a technician would only be feasible if we were able to provide a central, purpose planned laboratory, which would entail considerable expenditure."

It is because the provision of a central appliance centre in this rural county is probably unrealistic at the present time that the authority has concentrated on providing appliance making equipment at selected points in each area of the county.

In April the department organised a three-day residential course attended by 30 chiropodists employed by local health authorities in England and Scotland. The course tutor was Mr. G. H. Thomas, Chief Chiropodist. Eight guest speakers covered a wide range of subjects from the relationship of the chiropodist to his medical colleagues; appliance work in chiropody and chiropody in the re-organised National Health Service. Adequate time was allowed for discussion and a considerable part of the course was set aside for group project work, ranging from the design of chiropody equipment and the planning of chiropody clinics, to the organisation of a chiropody service for our Area Health Authority. A visit was also made to a modern shoe factory. The object of the course was to stimulate discussion, to encourage active participation in the course by the members and to encourage the exchange of ideas.

As a result of this conference Cumberland has shown itself to be in the vanguard of local authority chiropody services in so far as standard of services provided and general working conditions and facilities are concerned. A leading equipment manufacturer has expressed interest in the design of a chiropody visiting case (one of the group projects), there has been an improvement in liaison between the shoe manufacturers and the department and an encouraging stimulation of interest in the service both by general practitioners and hospital consultants.

SEXUALLY TRANSMITTED DISEASES

This year eleven cases have been referred to the department from the physicians in charge of local treatment centres for the tracing of contacts. Nine were found, but two cases could not be traced — one in the western area, due it is thought, to a false trail, and one in the northern area where the address had been vaguely defined as "in the Carlisle area".

Ten of the cases referred were from the western area of the county, and from that area Miss E. J. Surtees, Health Visitor, reports:—

"During the summer of 1972 and late autumn I traced six contacts of V.D. — all were proved positive and treated. Only one girl required transport to the Clinic.

All girls were aged 17 - 24 years. Two were separated from their spouses. The last case, in October, was a girl addicted to drugs and on probation and also separated from her husband. A letter was received from the venereologist regarding his appreciation of the promptness of her arrival

at his clinic. All the girls appeared to at least appreciate the need for investigation and treatment.

Two girls arrived at the surgery, one married and living apart from her husband. Both were referred to the V.D. Clinic and received treatment.

There is a better appreciation of the serious consequences of venereal disease at the moment";

and Miss L. Tracey, Health Visitor, who also reports:—

"I have only been involved in this work since the end of June, 1972, during which time contact-tracing has been requested for four cases. Two of the referrals were from without the county.

Of these four, three were successfully traced and treated, but one of the local referrals proved a completely false trail, probably false information having been given.

Defaulting from follow-up appointments remains a problem, but has been resolved by transport of the patient to the clinic by the Health Visitor.

The need for contact tracing would appear to be less because more of the patients are willing to discuss the problem with their partner, and to bring the partner along to the clinic — probably a result of better Health Education."

AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness .... or expectant or nursing mothers from places in their area to places in or outside their area."

COUNTY AMBULANCE SERVICE

In 1962 the first steps were taken to replace the contractual arrangements with a directly provided service and this year, just over a decade later, has seen the modernisation of the service arising from the implementation of the recommendation arising from the Management Services Unit's review of the service. Central Control has been established in Carlisle, central workshops have been set up in West Cumberland, and a Staff Training Officer appointed. These items are referred to in greater detail below.

The target date for the introduction of Central Control was 1st June and, so that the controlling staff could be properly trained, they were appointed on 1st May. There was, however, a delay in the delivery of the new and essential radio equipment so that Central Control did not commence until the beginning of July. Advantage was taken of this delay for the control staff to undertake duties at both the East and West Cumberland controls, thus giving them first hand knowledge of the local situation and geography. That this was valuable experience for them is evidenced by the smoothness of the transition from area to Central Control. Not unexpectedly some problems arose but were soon resolved by consultation with the staff of the two main hospitals. General practitioners in West Cumberland expressed some concern about the new arrangements and in particular about the cost of telephoning from West Cumberland. A meeting was arranged with them and it was explained that the issue to them of pre-paid envelopes for sending in non-emergency requests for transport would go a long way towards minimising their extra telephone costs.

There is no doubt that the smoothness of the changeover was due, not only to the hard work and enthusiasm of the controllers, but also to the co-operation from all involved, especially hospital staff for which I am extremely grateful.

Mr J. Butler, Chief Controller, reports:—

"Central Control of the County Ambulance Service came into operation in June, 1972. The establishment of the control is seven controllers and one chief controller — the former work a twenty-four hour shift system including week-end work. The control is situated on the top floor of the County Health Department headquarters in Portland Square, Carlisle.

An improved network of radio communications has been installed along with two telex machines and a key and lamp system of telephone equipment.

Right from the earliest days of planning it was accepted that systematic and detailed procedures were necessary to ensure the ambulance service provided a satisfactory service to the patient. To this end much research was carried out to devise forms for:—

(1) requesting ambulance transport for non-emergency work;

(2) forms for advanced bookings and bookings by post;

(3) card index system for patients who travel regularly to social centres and old people's homes, etc;

(4) a vehicle allocation board to ensure controllers know exactly where vehicles are at a specific time.

Eventually as a result of amending our own forms, adapting forms and procedures recommended by the Department of Health and Social Security and liaison with other authorities who have already set up a centralised ambulance control, a system of control procedures emerged.

Well over three hundred telephone calls per day are received at the control, of which at least thirty are emergency or urgent calls. How these calls are dealt with and other operations of the controllers are as follows:—

(a) **To receive and record** calls for ambulance aid from members of the public, doctors, hospital staffs, other emergency services and other ambulance authorities.

(b) **Acceptance of calls.** In response to each call the controller must decide whether it is necessary to provide ambulance transport, or not; that is whether it is a proper call on the service within the terms set out in the National Health Service Act, 1946.

(c) **Priority of calls.** When calls have been accepted controllers then decide when ambulance aid should be sent. Emergency patients obviously need immediate help but for others, particularly those booked in advance, priorities have to be allocated in order to make the most efficient and economical use of our resources.

(d) **Planning and allocation of work.** The operational work arising from accepted calls is then planned into journey schedules which are allocated to ambulance stations or to individual crews.

(e) **General.**

(1) While ambulance crews are carrying out the planned work, control personnel must keep in touch with them to ensure punctuality, to deal with queries and to know when they can allocate additional short notice work.

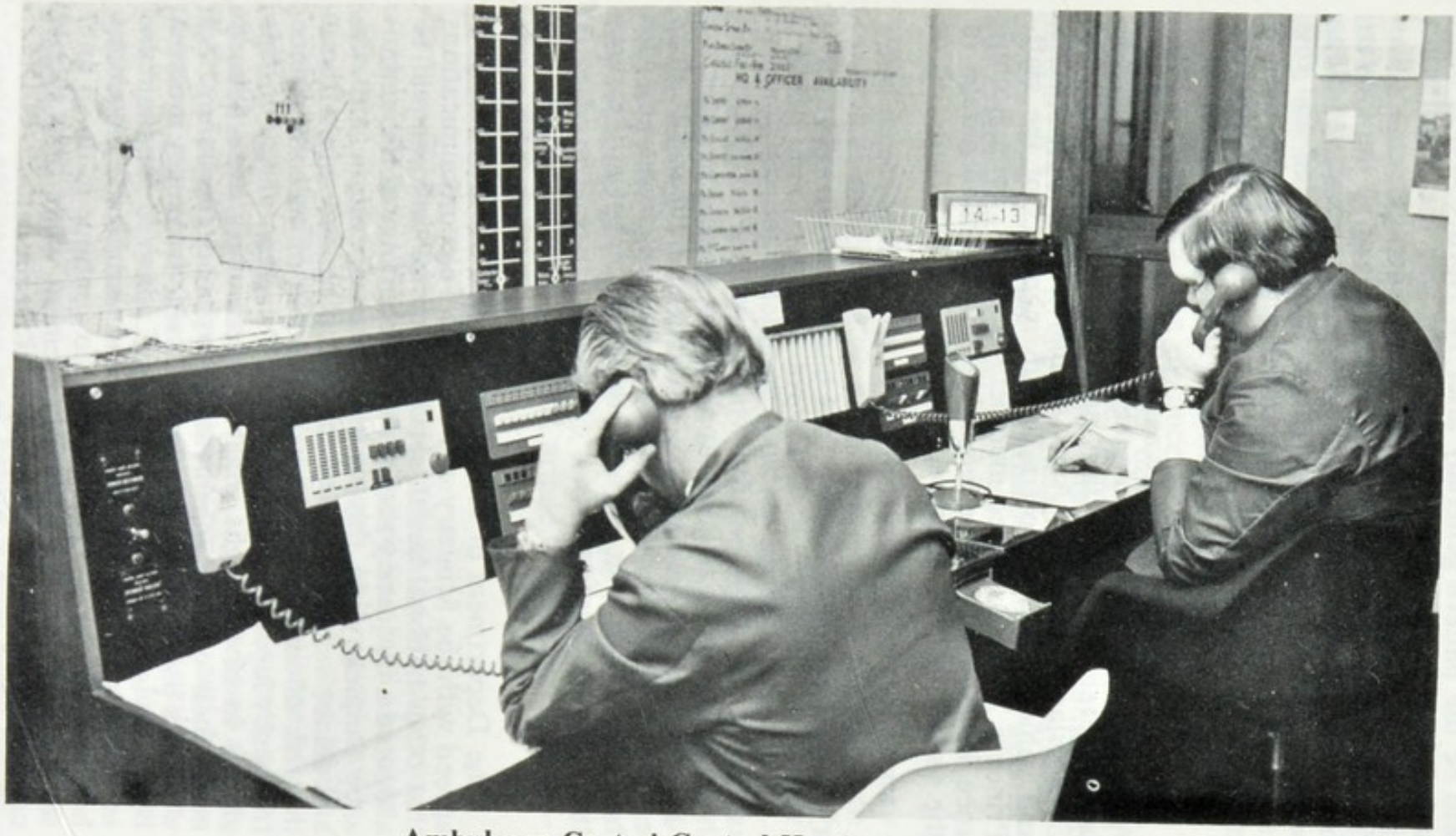
(2) They are responsible for keeping records and statistics for general planning, to ensure that an efficient service is constantly available within the county.

(3) Central Control is also an information and advisory centre for ambulance crews and those outside the service, including doctors and hospital staffs.

As a postscript, I would like to say that the degree of co-operation we have received from general practitioners, hospital staffs, the general public, and other emergency services has contributed much to the success of the system."

It had been hoped to establish central workshops at Maryport at about the same time but it was not possible as the premises were not acquired in time and consequently the obtaining of loan sanction for the necessary alterations was delayed. When it became clear that room would not be available at Maryport for some time it was decided, as a temporary measure, to operate the system from the Distington Station where some repair facilities exist. The new arrangements are working as well as can be expected but everyone is looking forward to the time when the planned accommodation and facilities are available at Maryport.

With the agreement and co-operation of the Trade Union representatives a Joint Consultative Committee has been established, giving both management and staff the opportunity of discussing problems of mutual concern. This is in line with the recommendations of Dr. McMarthy's Report, arising from his enquiry into the causes of industrial action taken in the area of certain ambulance authorities. The Committee met on three occasions during the year and the business was conducted in a spirit of mutual regard and trust and the emerging pattern of "consensus agreement", which



Ambulance Central Control-Headquarters, Carlisle

will be the pattern generally after 1st April, 1974, is most valuable. The most contentious item was the negotiation of the Productivity Agreement, which when agreement was finally reached, was unfortunately caught up in the Government's counter-inflation measures. It is not yet clear whether or not the scheme can be implemented and this is most frustrating for all concerned and is making the job of maintaining morale among the ambulancemen difficult.

The highlight of the year was the visit of H.R.H. Princess Anne to the Carlisle Ambulance Station following the stone-laying ceremony of the first part of the extension to the Cumberland Infirmary. After an inspection of the station and vehicles and a short talk with members of the staff, Princess Anne inspected members of the St. John Ambulance Brigade who were assembled in the main garage of the station for this purpose.

Communications

It had been hoped to have completed the replacement of the radio equipment for which financial provision had been made but again the supplier was unable to meet the delivery date. It is, however, expected that this will be done early in 1973. Other users of the ambulance frequency who had planned a replacement of their equipment at the same time were kept informed.

The Department of Health and Social Security has now agreed with the Ministry of Posts and Telecommunications that other national health service users of radio should be allocated a frequency within switchable range of the ambulance frequency. In this way radio co-operation with the ambulance service can be achieved, if desired, but without the risk of any impairment of the use of the ambulance frequency for ambulance purposes. Two general practitioner groups involving eight general practitioners have already made their own arrangements to use this frequency. All would-be users of the ambulance service frequency are now being advised to use the frequency reserved for their use in order to avoid overcrowding the ambulance frequency but existing users will be allowed to continue to do so until their equipment is due for replacement when they should consider transferring to this special frequency.

Operations

The demand on the service continued throughout the year; the number of patients carried increased by 12,392 (9%) and the number of miles travelled by 138,652 (10%). This extra demand has been due to the conveyance of patients to the kidney units in Newcastle and to the intensive physiotherapy centre in Chester-le-Street, Co. Durham, all necessitating long journeys. The amount of time spent by patients travelling long distances for treatment, with consequent fatigue and sometimes distress, is a matter of concern to me, especially those patients travelling for renal dialysis. Three years ago there were similar difficulties with patients travelling to the Artificial Limb and Appliance Centre, Newcastle, but as the result of action taken, a centre was established in Carlisle.

The increase in work is not confined to out-of-county journeys as more geriatric patients have been conveyed to clinics at West Cumberland Hospital and the Day Hospital at Whitehaven and the pressure on the service further increased with the development of the Intensive Rehabilitation Centre in Whitehaven. I wish I was able to report a possibility of a decrease in the apparently insatiable demand on the service. On the contrary, the fact must be faced that, with the impending development of the Psychiatric Day Hospital at Carlisle and the extension of geriatric care throughout East Cumberland, especially when adequate accommodation is available in Carlisle, the demand for transport will continue to grow.

Thirty-four incidents were dealt with on the M6 motorway without difficulty. This number included four fatal and eight serious accidents. Entonox (half oxygen, half nitrous oxide) was offered to patients, most of them injured in road traffic accidents, on twenty-one occasions and ambulance crews reported that, almost without exception, patients were afforded immediate relief from pain. There can be no doubt that this piece of equipment is most valuable and I was, therefore, extremely pleased to accept two such sets which were presented by the West Cumberland Lions for use in vehicles at the Distington Station.

Training

Greater emphasis than ever before is now being placed on training. At one time the ownership of a voluntary aid

society certificate in first aid was considered adequate but this is no longer sufficient, bearing in mind the continued increase in traffic and the increasing standard of service which the public is coming to expect and demand.

Training at Regional Centres now includes not only six weeks initial training courses but also regular two-week refresher courses designed for those who have already undertaken their initial training. At certain centres pilot courses on officer training in line with the recommendations of the Local Government Training Board are also being mounted. Driving training is also under consideration.

There is no doubt that supervisory training at all levels is of the utmost importance especially in these times of change and that it will receive greater emphasis in the years immediately ahead. It is essential that this should be so if everyone is to be able to carry out their tasks properly and the service to function efficiently in the re-organised Health Service. The need for this type of training is also recognised by the Trade Unions who are being given every assistance in making arrangements to send shop stewards on courses designed specifically for them. I have no doubt there is a case for joint supervisor/shop steward training and look forward to the day when this is introduced.

Mr. Corry, Staff Training Officer, comments as follows:—

"The objective of the training programme is to provide all members of the staff with the necessary knowledge and skills needed to enable them to carry out the full range of ambulance service duties. The programme must provide sufficient background knowledge to enable ambulance staff to make certain vital decisions with confidence and act accordingly, particularly to note changes in the patient's condition.

The need for training of ambulance staff has to be considered against a background of an expanding service, provided in a variety of ways to meet changing needs. All ambulancemen in Cumberland carry out the full range of duties and consequently a common basic training programme is needed.

As hospital facilities become centred on district general hospitals, and as Accident and Emergency Units are concentrated at fewer centres, special problems are likely to arise

during the longer journeys which will sometimes be necessary.

Ambulance crews require a thorough and intense training in first aid with substantial periods of practical work, but they also require training in additional subjects, both general and technical as well as para-medical, i.e.:—

Para-Medical Training

1. Medical nomenclature.
2. Care of seriously ill patients (surgical and medical).
3. Precautions in handling infectious diseases' patients.
4. Care of patients under drug treatment.
5. Care of mentally ill patients.
6. Care of out-patients.
7. Ambulance work when under medical instruction on direct supervision, e.g.:—
   (a) at the scene of an emergency incident;
   (b) making reports and conveying information to accident and emergency officers;
   (c) radiation hazards;
   (d) general ambulance nursing, hygiene, with particular reference to long distance journeys by road and rail.

Non-Medical Training

1. **Information**
   (a) National Health Service;
   (b) work of the ambulance service;
   (c) co-operation with other services.
2. **Communications**
   (a) 999 systems
   (b) Telex
   (c) Teleprinters
   (d) All aspects of radio telecommunications.
3. **Equipment**

   Use and care of all types of equipment.

4. **The Patient**

Professional conduct and relationships with patients and relatives.

5. Light rescue.

6. **Major Accidents**

(a) definition;
(b) co-ordination of plans.

7. **Driving**

To cover all aspects of advanced driving.

This training should be directed towards the various situations which ambulance crews are likely to face, and should emphasise the practical application of knowledge.

To enable ambulance staff to fulfil the demands made on them the following training programme has been introduced in addition to essential local training:—

Basic Training

Induction courses for new entrants to the service aim to provide a background knowledge of the work and organisation of the service, introduce them to the life saving techniques and generally prepare them for their attendance at the regional residential school. The period of stay at these schools is six weeks, at the end of which, subject to a satisfactory report, the new entrant receives an "Ambulance Service Proficiency Certificate".

On return to service the ambulanceman is given a period of training which takes place in hospital under the direction of the medical staff. Great importance is placed on this type of training, as first it enables the new entrant to see how a casualty is received in hospital. Second, he gains a better understanding of the effects of disease and injury and how to deal with them. This hospital experience, together with knowledge of the general practitioner services, enables him to see more clearly his place in the whole picture of patient care.

Fourteen new entrants to the service during the past year have been given induction courses. Thirty-five ambulancemen with less than two years' service have now all completed a six weeks residential course, and the first eleven longer service ambulancemen have attended the training school in order to complete a two weeks' refresher course which is designed to update and keep them abreast of new

techniques and developments. In addition to this, six ambulancemen have completed their period of 'in-hospital training'.

Officer training is also underway and is vital to the whole training programme. It is true to say that one of the duties of an officer is to train, to some extent, the men for whom he is responsible. To enable him to do this, specially designed courses have been made available to him and, to date, six out of ten officers have attended this type of course.

I am confident that the higher standards, to which the training programme contributes, will produce a uniform, efficient and highly trained service upon which ever-greater demands are being made. The prime task of the ambulance service is to transport patients to and from treatment centres without avoidable deterioration and without unnecessary delay, all the while ensuring their comfort and well-being.

With acutely ill or seriously injured patients, the crew of an ambulance must be competent to apply life saving measures. Ambulance staff have to strike a balance between doing too much or too little, moving too fast or too slowly, in circumstances in which calm is essential. Only a thorough training with a realistic and practical approach can produce the balanced attitude of mind which is necessary for acting wisely and accomplishing the demands of full ambulance duties.

The geographical position of Alston and the limited number of personnel engaged on ambulance work there presented training problems. However, with the assistance of Northumberland County Council these were resolved and arrangements were made for them to undertake training in Ambulance Aid at the Haltwhistle Ambulance Station. It is envisaged that this course will be followed at a later date with lectures in Advanced First Aid.

During the past year the ambulance service has provided instruction for numerous and various groups of people, i.e.:—

Social Services Department	—	Supervisory staff	—	Emergency treatment of casualties.
Dovenby Hall Hospital	—	Cadet nurses	—	The work and organisation of the ambulance service and treatment of casualties.
Whitehaven Technical College	—	" "	—	" " "
Workington Technical College	—	" "	—	" " "
Cumbria Constabulary	—	Police Constables	—	" " "
Women's Institutes	—	Members	—	" " "
Swimming Clubs	—	"	—	" " "
Boy Scouts	—	"	—	" " "
Girl Guides	—	"	—	" " "

This part of the work is important insomuch as it is informative and preventive in its aim."

Stations

The building of stations at Millom and Keswick has commenced and it is expected that the Millom station will come into use during May, 1973, and the Keswick station towards the end of the year. The staff at Millom are looking forward to the time when they can vacate the unsatisfactory premises from which they have had to operate since the end of 1963. It says much for their morale and devotion to duty that the service they provide has remained high throughout the period. It is very much appreciated by those who call on their services.

Accident and Emergency Scheme — Penrith

Co-operation with the general practitioners operating this scheme continued throughout the year and they have been called out on forty-four occasions involving eighty-eight

patients. Each month ambulance crews and doctors meet to discuss what lessons can be learned by both sides from situations dealt with during the preceding four week period. A happy relationship exists between doctors and ambulancemen, who work well together.

A meeting was held with representatives of the Local Medical Committee to consider a possible extension of the scheme in and around Carlisle. While it was appreciated that such a scheme had much to commend it in a rural area remote from an accident hospital, it was felt there would be little advantage in calling on a general practitioner in or near Carlisle and that the best way was to allow the highly trained ambulance crews, who are in constant radio touch with the accident and emergency department of the Cumberland Infirmary, discretion in deciding what action was necessary at the scene. It was also felt that if medical assistance was necessary it would be best provided from the accident and emergency department of the Cumberland Infirmary.

Emergency Services Liaison Committee

Four meetings of officers of the three emergency services continued throughout the year. Among other things they were asked to consider the question of major accident procedures in relation to the motorway and the call-out of doctors.

It was decided that the call-out of medical assistance and the alerting of designated hospitals should be the responsibility of the ambulance service and the major accident arrangements have now been amended accordingly. It is accepted by everyone that these periodic meetings are most valuable and should be continued at officer level after the reorganisation of the National Health Service in April, 1974.

Vehicles

During the year orders were placed for one traditional ambulance and six dual purpose vehicles. Delivery of the ambulance and four dual purpose vehicles, which were replacements for old vehicles, has been made but delivery of the remaining two dual purpose vehicles, intended for use at the new Keswick station and for which the order was placed later in the year, is not expected until late in 1973, by which time the new station there should be ready.

The Department of Health and Social Security issued details of the assessment by the Ambulance Service Advisory Committee of some commercial chassis currently in use for ambulances for consideration when ordering new vehi-

cles. There has been no need to change the type of chassis being purchased as those in use conform to the advice issued.

Hospital Car Service

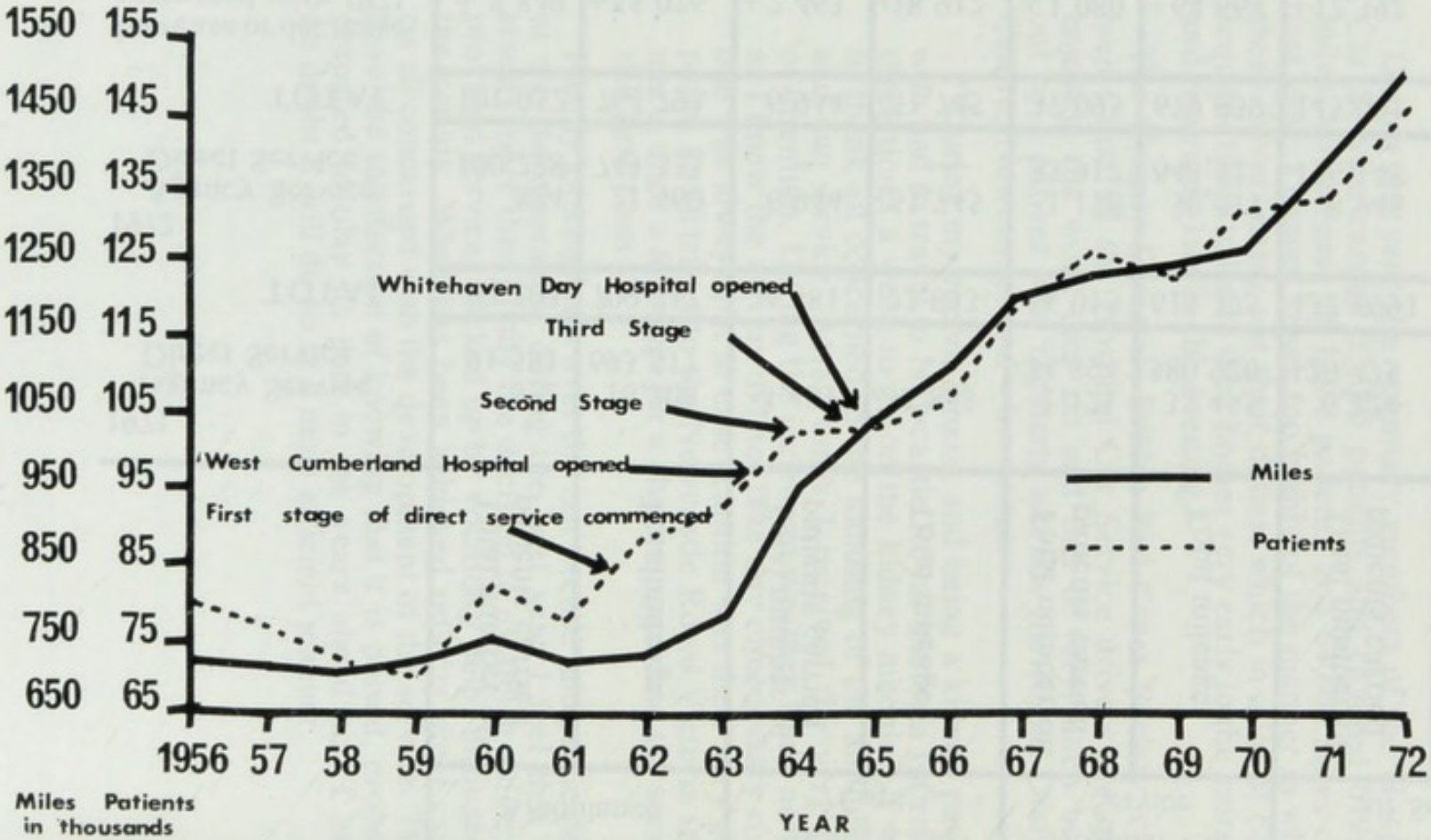
During the year the voluntary members of the Hospital Car Service carried 37,095 patients and covered 679,039 miles, an increase of 1,080 patients and 64,664 miles over last year. I cannot speak too highly of the manner in which these drivers carry out their duties, which in a lot of cases requires them to leave their homes very early in the morning and returning late in the evening.

The County Director, British Red Cross Society, comments that all the Hospital Car Service drivers are quite enjoying the work they do and this is very much borne out by a patient who regularly attends the Renal Dialysis Centre, Newcastle, and who writes:—

> "During my recent illness, and being a kidney patient who had to travel to Newcastle Royal Victoria Infirmary three times a week to go on the kidney machine, I wish to thank all concerned in the handling of the ambulance and car service. At all times I received the very best of attention. During the inclement weather I had no fear as I knew the drivers did not take any unnecessary risks; one was always put at ease, caution was their very good point. I still travel to the Newcastle Royal Victoria Infirmary, once a fortnight for a check-up and find the service still first class."

Finally looking back over the last decade and particularly at the developments during the past year I feel that the results more than justify the decision to establish a directly provided service, backed up by voluntary help, throughout the county. What has been achieved reflects great credit on all concerned with the development of the service. They have the satisfaction of knowing that it is poised, properly prepared to play its part in the years ahead and I have no doubt it will do so in a most efficient manner.

	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
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	132,6991	1,356,925
1972								
Agency Service	824	21,460	6,944	51,745	1,178	30,517	8,946	103,722
Direct Service	100,228	743,333	—	—	35,917	648,522	136,145	1,391,855
TOTAL	101,052	764,793	6,944	51,745	37,095	679,039	145,091	1,495,577
Increase or decrease compared with 1971	+ 8,849	+55,076	+2,463	+18,912	+1,080	+64,664	+12,392	+138,652



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 numbers of measles cases notified in the West Cumberland area naturally caused some concern. This proved on analysis to relate mainly to pockets of children in the school age group.

A publicity campaign was mounted in the local press on the free availability of measles vaccine. As yet, there is no tangible evidence whether this has had any effect on the take-up in this particular group.

There has been a fall in the number of cases of infective jaundice notified.

The northern area of the county had its full share during 1972 of activity in controlling threatened outbreaks of smallpox and diphtheria. The risk of the former is always before the minds of medical officers of health in view of the spread, and speed, of international travel. The occurrence of carriers of diphtheria is very uncommon now and such an occurrence provides a sharp reminder of the need for a continuing high level of protection in the child population. The full degree of protection of the children in the school community affected was highly gratifying.

Dr. J. Connolly, Northern Area Medical Officer and Medical Officer of Health to Border Rural District Council and Penrith Urban District Council, has kindly provided the following account of these events:—

"1972 has been an eventful and interesting year in infectious disease epidemiology. There were two major incidents, both involving school populations:—

(a) In January, 1972 there was a case of smallpox in a 12 year old boy attending Ullswater Secondary School at Penrith.

On Friday, 28th January, the disease was diagnosed by the family doctor in Penrith and confirmed by the Smallpox Consultant Langley Park Smallpox Isolation Hospital in Co. Durham was opened for the boy's immediate admission on that day. The disease had been contracted in Tunisia by a local boy on a short vacation, despite an up to date revaccination against smallpox. Apart from the usual family and community contacts, it was felt that the whole campus of pupils in the Ullswater (boys) and nearby Tynefield (girls) Secondary Schools were at risk as the boy was at school whilst highly infectious for smallpox.

On Saturday morning, 29th January, a large group of people — medical, nursing and educational, met at Penrith Clinic and this team stayed fully operational until two weeks later when the likelihood of secondary cases had disappeared. This was very much a joint exercise involving the Penrith Urban District, Cumberland and Westmorland Counties and Penrith Rural and North Westmorland Rural Districts. One doctor described it as 'Cumbria in action'. Family doctors including retired colleagues, gave a great deal of assistance and the exercise was marked by a cheerful willingness to work hard and efficiently outside normal hours and with a disregard for normal employment boundaries.

The Youth Centre was offered by the Director of Education as an Emergency Centre and, being on the school campus, this offer was gratefully accepted. The Centre continued in use for the full fortnight.

One thousand three hundred pupils were vaccinated in the Ullswater/Tynefield Schools. This was the entire school population. Teaching staff were also vaccinated. A large number of people, including all the second year boys, were placed under daily health surveillance and the Director of Education arranged for special transportation of these pupils on Saturdays and Sundays.

Two major problems during the fortnight were a large snowfall and the threat of electricity power cuts.

The end of the exercise coincided with the discharge from hospital of the smallpox patient. The boy was not seriously ill and made a good recovery and was re-integrated at once into school life.

(b) **Diphtheria:** Although there were no actual diphtheria cases, there was an incident in November/December involving five children, all carriers of diphtheria in the Houghton area, near Carlisle. Four of these were primary school children.

On the 14th November, a routine throat swab taken by a doctor showed the presence of the diphtheria organism in the throat of a girl aged 5 years. She was diagnosed a carrier of the disease. She attended the Houghton Church of England Primary School. Following the girl's admission to hospital and isolation of her family, one hundred and eighty children attending the school were examined and immunised against diphtheria. Swabs were taken from the nose and throat in each pupil. A similar procedure was followed with the school staff.

Ultimately, the eight year old brother of the girl and another eight year old girl at the school were also diagnosed as carriers along with a five year old girl and the sister of this 5 year old who was a pre-school child. Thus, a total of five children went to hospital, all as carriers of diphtheria and the three families involved went into temporary isolation.

The local village hall and the primary school, which is across the green, acted as centres for the swabbing and immunising work. The school staff and various voluntary workers who were involved at the village hall, provided tremendous assistance to the health team. It is a tribute to the work of local and more distant child health services that it was discovered that 100% of the children at the Houghton School had an adequate primary course of diphtheria immunisation. Especially so since this is, to some extent, a dormitory district for the City of Carlisle with quite a large movement of resident population. If this 100% protection had not existed, it is likely that under-immunised children might have contracted diphtheria with perhaps a fatal outcome.

Despite a great deal of investigation, no source of the diphtheria infection could be found."

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES 1972

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentery	Acute Encephalitis -Infective	-Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Food Poisoning	Tuberculosis-Respiratory	-Meninges and C.N.S.	-Other	Puerperal Pyrexia	Infective Jaundice	Erysipelas	Puerperal Sepsis	Acute Meningitis	Diphtheria
Urban Districts:																			
Workington	13	—	—	151	—	—	—	—	—	2	8	1	1	—	1	—	—	—	—
Whitehaven	3	—	—	161	—	—	—	—	—	—	4	1	1	—	9	—	—	—	—
Cockermouth	—	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Keswick	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport	9	—	—	18	—	—	—	—	—	—	1	—	—	—	22	—	—	1	—
Penrith	1	—	—	3	24	—	—	—	—	1	1	—	1	—	2	—	—	—	—
Rural Districts:																			
Alston	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	1	—	—	13	1	—	—	—	—	6	5	—	1	—	7	—	—	—	2
Cockermouth	4	1	—	52	—	—	—	—	—	1	6	—	—	—	11	—	—	—	—
Ennerdale	1	—	—	113	1	—	—	—	—	—	7	—	—	—	9	—	—	2	—
Millom	—	—	—	16	—	—	—	—	—	—	1	—	—	—	1	—	—	—	—
Penrith	1	—	—	1	6	—	—	—	—	3	—	—	—	—	6	—	—	—	—
Wigton	6	—	—	104	—	—	—	—	—	—	—	—	—	—	16	—	—	—	—
Total for Year	39	1	—	637	32	—	—	—	—	13	33	2	4	—	84	—	—	3	2
1971	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	—

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	424	333	91
Other Food	114	109	5
	538	442	96

Of the total samples obtained, 21.9% of the milk and 4.4% of other foods were unsatisfactory: 15 milk and 88 other foods being analysed by the Public Analyst. The milk samples submitted to the Analyst, in addition to compositional analysis, were tested for the presence of antibiotics but none were detected.

The average quality of the milk samples (excluding any sent to the Analyst) was 3.74% fat and 8.60% non-fatty solids, the presumptive standard being 3.0% and 8.5% respectively.

Informal tests were made on meat pies and sausage rolls, to ascertain whether the meat content was up to the required standard, and on spirits to check for the presence of added water.

This Authority participated in a further national scheme to determine the extent of pesticide residues in foodstuffs. Each authority was given a specific list of foodstuffs to be sampled during certain periods of the year and Cumberland's allocation consisted of butter, cheese, pears, lettuce, turnip mussels, lamb, suet, milk, white fish and oranges. The Analyst reported that although none of the samples contained residues in sufficient quantity to cause anxiety from a health viewpoint only three were completely free from detectable pesticides; these were butter, turnip and milk.

Unsatisfactory milk:

Eight of the milk samples submitted to the Analyst were unsatisfactory. Five were from one source and contained added water in amounts ranging from 3.3% to 11.0%. The farmer concerned was prosecuted and fined £20 plus £42 costs. At another farm milk from a bulk collecting tank contained 7.2% of water for which the producer was prosecuted and fined £25 plus costs of £25. Milk supplied to two schools by a producer/dairyman contained added water

and was also deficient in fat. The producer was prosecuted and fined £25 on each of four charges with total costs of £12.

The remaining 83 unsatisfactory samples tested by the sampling officers consisted of 3 deficient in fat and 80 deficient in solids-not-fat. The latter included 19 on which freezing point tests indicated the presence of extraneous water. Further samples taken later were mostly satisfactory but one or two again showed slight adulteration. In these instances it appeared that the adulteration was due to carelessness in draining the pipelines of the milking installations after cleansing. Suitable advice was given to the producers concerned. Where informal samples from wholesale dairies were adulterated, formal samples taken some days later at the supplying farms were found to be genuine. There is a strong possibility that some producers add water to the milk at sporadic intervals therefore such supplies have to be kept under observation. Deficiencies in samples, other than those containing added water, were slight and appeared to be due to natural causes, i.e. genuine milk but poor in quality.

Food other than milk:

The five articles of food upon which the Analyst reported adversely were yoghurt, cheese and a soft drink which were incorrectly labelled, beefburgers deficient in meat and ice cream deficient in non-fat milk solids. The attention of the packers concerned was drawn to the labelling infringements and to the deficiency of meat in the beefburgers. A prosecution was taken for the unsatisfactory ice cream but the case was dismissed. All these articles of food were of local manufacture.

Several complaints about unsatisfactory food were received from purchasers. One referred to a tin of peas which were alleged to be sour when opened but the contents of a number of other tins from the same batch were found to be wholesome therefore no further action was taken. The subject of a second complaint was a tin of pears in which there was a wasp. The danger of such insects being in fruit must be a particular hazard to canners and as this particular brand of pears had been canned in Italy the attention of the suppliers was drawn to the matter.

Further complaints concerned a loaf of bread and a meat and potato pie each containing an insect and frozen beefburgers containing a piece of hide. In each case the complainants

were most reluctant to attend Court to give evidence therefore the manufacturers were cautioned. A packet of baby food was found bearing a "shelf life" date which was well out of time and the matter was brought to the attention of the shopkeeper who immediately destroyed the old stock and refunded the complainant's money.

Milk (Special Designation) Regulations:

These Regulations govern the retail sale of milk and the infringements which came to light were very few. Occasionally suppliers of cartons of milk had to be reminded of the need to label cartons with their names and addresses.

HOUSING, WATER, SEWERAGE

Housing

The total number of occupied dwelling houses in the county increased this year to 75,325 against 74,298 in 1971, an increase of 1.4%, and gives an average of 3.0 persons per dwelling.

This increase has been brought about by the completion of 411 dwellings by or on behalf of district councils (including 60 for aged persons), and 626 private buildings, a total of 1,037 which compares with 861 completed in 1971.

Waiting lists have been affected by the increase and the current figure for the county is 4,631 a drop of 108 from 1971.

There has been a tremendous increase in the number of applications by private persons for improvement and standard grants — from 1,121 in 1971 (in itself double the figure for 1970) to 3,417. This has been reflected in an associated increase in the number of grants approved — 1,657 (991 in 1971) and those paid — 1,012 (763 in 1971). District councils themselves are making steady progress in the improvement or conversion of property and 71 houses were purchased or taken over for this purpose. In addition, a further 184 houses, both private and council owned, were improved by the councils — 178 with grant.

The housing programme envisaged for the ensuing year is slightly greater than for 1972, 1,637 dwellings in total. Of this 167 are for aged persons and 46 for aged persons with grouped welfare facilities.

Water

The County Council have approved 16 schemes under the Rural Water Supplies and Sewerage Acts 1944 — 71 during the year. Eleven of these were for the Eden Water Board with schemes at Alston (2), Dockeray, Ivegill, Nenthall — Middle Skelgill, Netherscales — Hutton End, Penruddock, Ainstable, Staffield, Skirwith and Threlkeld. The West Cumberland Water Board had four schemes at Branthwaite Road, Lorton, Sebergham, and Dearham. Carlisle Corporation also had a scheme approved for Cumwhitton.

Carlisle Corporation received a grant from the Department of the Environment for their Hill Head scheme. The Eden Water Board received grants for schemes at Linton Ghyll — Ivegill, Penruddock Station, Crossgill-Pasture Houses, Loaning House, Nenthall-Skelgill, Netherscales-Hutton End, Tyne Head-Garrigill and Threlkeld. The West Cumberland Water Board received grants for schemes at Whinfell, Branthwaite Road, Sebergham and Dearham.

The County Council made equivalent grants in all cases.

The water supplies throughout the area are generally regarded as adequate in quality and quantity and no great hardships were encountered during the drought conditions of the late summer.

Sewerage

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

The Border Rural District Council submitted a revised scheme to provide sewerage and sewage disposal facilities for Gilsland and Gilsland Spa and a scheme for sewerage and sewage disposal facilities at Burgh-by-Sands and surrounding villages.

The Wigton Rural District Council submitted a revised scheme to include the sewerage of Waverton and Park Gate in their Blencogo, Bromfield and Langrigg scheme, and also submitted a scheme to provide sewerage and sewage disposal facilities for Oughterby.

Schemes submitted by the Millom, Ennerdale and Penrith Rural District Councils related respectively to the provision of sewerage and sewage disposal facilities for Millom and Haverigg, Rowrah and Catterlen and Newton Reigny.

The Penrith Rural District Council received a grant from the Department of the Environment in respect of their Langwathby scheme, as did the Millom Rural District Council for their scheme at Holmrook.

The County Council made equivalent grants in both cases.

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 1972 there was again a slight fall in the number of known cases of tuberculosis on the Register in West Cumberland; and again there was only one death from known disease, although in three other cases death was considered partly attributable to tuberculosis.

Tuberculosis Register:

	Men	Women	Children	Total	
Respiratory T.B.	296	184	16	496	(518,
Non-Respiratory T.B.	26	32	4	62	(74)
Total	322	216	20	558	(592)

(Figures in brackets relate to comparable data for 1971).

Some 58 cases were removed from the Register for various reasons: of these 40 cases were removed deemed recovered (26 in 1971). Eleven cases were removed because of death from diverse causes deemed not tuberculous; and seven cases were transferred out or removed after reconsideration of the diagnosis.

New Cases

A total of 32 new cases were added to the Register during the year suffering from notifiable active disease: men, 21, women, 6; and 2 children. To these 29 must be added 2 posthumous diagnoses and one case transferring out during the year of diagnosis.

In summary there were 50 new cases of all types notified and not notified compared with 37 such cases in 1971. A

total of 19 cases drawn from the existing Register and new cases diagnosed during the year were infectious at the time of diagnosis (16 in 1971).

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 Out-patients, 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 again dispensed with.

A total of 116 contacts — children over 15 and adults — are known to have passed through the Static M.M.R. Unit, and from amongst these no cases of notifiable disease were found.

Of 48 familial contacts tested with 1/1000 O.T. four were found reactors.

B.C.G. Vaccination

A total of 122 infants and children, including new-borns were vaccinated during the year (177 in 1971; 244 in 1970).

The favourable trends mentioned in this annual report last year reflecting upon the low incidence of natural infection now being found amongst school children have continued and it is now comparatively rare for a school child aged 13 to be found to have sustained a natural tuberculous primary complex.

Static Mass X-ray Units

The work of the units is set out in tabulated form below, the comparative total figures for 1971 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	1162	7	838	3
Doctors' Cases	674	21	1005	40
Contact Cases	47	2	69	1
Out Patients	43	—	4	—
Firms	1194	4	393	1
Scholars	54	—	27	—
TOTAL	3174 (2962)	34	2336 (2383)	45

Combined Total: 5510 (5345)

Of those cases recalled for clinical examination whose 100 mm. films showed some significant abnormality, by far the highest proportion were originally referred to the Unit at the West Cumberland Hospital and Workington Infirmary by their family doctors — 61 cases in fact from a total of 79 abnormalities found.

Out-Patient Clinics

Out-Patient sessions totalling 108 in all have been held both at Workington Infirmary and the West Cumberland Hospital and at these a total of 384 new patients were seen with 908 old patients attending too. The total Out-Patient attendance at both centres was 1292 (1349 in 1971).

Inpatients

Admissions were again made to Homewood throughout the year, the proportion of tuberculous to non-tuberculous patients being shown in the discharge figures of 60/112, i.e. a total of 172 patients discharged compared with 150 in 1971; and compared with the tuberculous admissions of 39 for 1971, there is a clear indication of tuberculosis again requiring an increase in Inpatient care.

Pulmonary Neoplasm

The number of these cases diagnosed by the Mass X-ray Units during the year was 12. In all, 38 cases were dealt with by the Chest Service comprising 33 men and 5 women (28 men and 3 women in 1971). During the year 30 patients diagnosed either in previous years or during 1972 died of this disease, the prognosis of which remains depressingly poor despite quite a significant advance in treatment in other formers of cancer.

APPENDIX II

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

Introduction

There was again a fall in the total number of attendances at the Chest Centre in 1972, from 7090 in 1971 to 5698. New cases increased from 1195 in 1971 to 1300 in 1972.

A further call in total attendances is likely to be seen in 1973 because of changes in staffing and organisation. Following the retirement of Dr. Sargant on 22nd December, 1972, no senior staff appointment was made by the Regional Hospital Board so that for the six weeks period of leave, and any absences due to illness, there will be no Consultant or S.H.M.O. working at the Chest Centre. This may seem a less than ideal arrangement but it is one which already pertains in West Cumberland.

Partly as a consequence of the reduced level of staffing a decision was also taken to transfer the responsibility for the Mass X-ray Unit from the Chest Physician to the senior Radiologist. Although this is contrary to accepted practice throughout the country its manifest drawbacks are partly offset by some reduction in the load on the chest centre and the provision of holiday and sickness cover.

Tuberculosis

Table 1 shows the numbers of cases on the Tuberculosis Registers as on 31.12.72.

Table 1

	East Cumberland	Carlisle City	North Westmorland	Total
Respiratory	104 (114)	136 (138)	10 (12)	250 (264)
Non-Respiratory	10 (11)	22 (22)	1 (1)	33 (34)

During the year 18 cases were removed from the Registers, 11 through death; only one of these had active disease at the time of death.

Table 2 shows the number of new cases diagnosed during the year, the figures for 1971 being in brackets.

Table 2

	Respiratory				Non-Respiratory			
	M	F	Ch.	Total	M	F	Ch.	Total
East Cumberland	2	5	1	8 (7)	1	1	—	2 (1)
Carlisle City	9	6	—	15 (15)	2	—	—	2 (-)
N. Westmorland	—	—	—	— (1)	—	—	—	— (0)

Table 3 shows the number of beds available specifically for the treatment of respiratory disease. Owing to easier availability of beds in local Authority accommodation and a gradual reduction in the number of chronic respiratory invalids, the beds at Longtown have not been so fully utilised.

Table 3

Hospital	Beds available	No. discharged in 1972	No. discharged in 1971
Ward 18, C.I.C.	13	222	230
Longtown Hospital	26	67	86

It will be seen that the position as regards tuberculosis remains static in this area.

Examination of Contacts

A total of 757 new contacts were examined in 1972 compared to 1271 in 1971; three new cases of active tuberculosis were discovered as a result. There was only one case of a tuberculin positive child requiring prophylactic chemotherapy.

All Mantoux negative contacts were offered B.C.G. vaccination. Table 4 shows the number of B.C.G. vaccinations performed during 1972.

Table 4

East Cumberland	Carlisle City	North Westmorland
28	40	2

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

A recent follow-up of children given B.C.G. showed a protective efficiency of 78% over a 15 year period. The protection rate was 87% in the first five years but only 59% in the 10-15 year period. It has become apparent that a significant number of children given B.C.G. are Tuberculin negative if tested five years later. This does not necessarily imply that they are then no longer protected, but if they are exposed to any special risk of infection, revaccination is advised.

Carcinoma of the Bronchus

The number of cases of carcinoma of the bronchus diagnosed at the chest centre is almost unchanged in 1972. Of the 51 new cases diagnosed only 22 had survived to the end of the year. Of the 51 new cases 24 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 1972.

	Males	Females	Total	Suitable for surgery
East Cumberland	18 (20)	6 (4)	24 (24)	2 (0)
Carlisle City	14 (22)	5 (5)	19 (27)	2 (5)
North Westmorland	6 (2)	0 (0)	6 (2)	0 (0)
Dumfriesshire	2	0	2	1
	40 (44)	11 (9)	51 (53)	5 (5) *

* A further six patients were submitted to exploratory thoracotomy but were found unsuitable for potentially curative operations.

If all five cases who had successful operations are alive and well in five years, our success rate will be a little better than average. It is generally accepted that the

five year survival rate is only between 5—8%, which emphasises the over-riding importance of prevention in this condition. The anti-smoking campaign makes painfully slow progress. Rather more palliative treatment with cytotoxic drugs has been given during the past year and radiotherapy continues to play a useful part in alleviation of symptoms in some cases.

Mass Radiography

The attendances increased during 1972 after the decrease which followed the move from Brunswick Street to the City General Hospital, and the unit continues to perform a useful function.

Table 6 refers to the work of the unit during 1972 and the preceding 2 years.

Table 6

	1972	1971	1970
Miniature films	5538	5349	6674
Referred for clinical examinations	364	343	434
Active tuberculosis	4	8	17
Inactive tuberculosis	13	12	8
Bronchiectasis	6	7	3
Neoplasm	24	21	26
Pneumoconiosis	1	—	2
Sarcoidosis	1	1	1
Cardiac conditions	28	39	30
Doctors cases	2561	2402	3014
Contacts from chest centre	193	152	234
General public	1347	1722	2307
Works personnel	1250	1073	1117
Local Medical Officers of Health	197	—	—

No visits were paid to this area by the mobile unit based on Newcastle during 1972 although one was requested for examination of T.B. contacts in a Carlisle factory. As the unit takes some time to travel, even as far as Carlisle, and it is expected to return to its base each night, the number of hours it can actually operate is so limited as to be almost worthless. Anywhere further from Newcastle than Carlisle is out of range of the unit altogether, so this facility is not in fact available for a large part of Cumberland and North Westmorland.

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.
Aspatria	—St. Mungo's Park, Aspatria.	Child Health, Dental, Chiropody, Social Classes for Blind and other handicapped. Speech Therapy, Probation and Psychoprophylaxis.
Brampton	—Union Lane, Brampton.	Chiropody, Dental, Mothers' Club, Probation, Child Health, Mothercraft, Slimming and Hearing.
Broughton	—Nurse's House, Little Broughton.	Child Health.
Carlisle	—14 Portland Sq., Carlisle.	Cervical Cytology, Chiropody, Dental, Hearing, Ophthalmic, Orthoptic, Orthopaedic and Speech Therapy.
Cleator Moor	—Ennerdale Road, Cleator Moor.	Ante-Natal, Chiropody, Dental, Vaccination and Immunisation, and Speech Therapy.
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 and Psychoprophylaxis.
Egremont	—St. Bridget's Lane, Egremont.	Ante-Natal, Child Health, Chiropody, Dental, Speech Therapy, Vaccination and Immunisation, and Physiotherapy.
Frizington	—Council Chambers, Frizington.	Ante-Natal.

Centre	Address	Clinic Services
Houghton	—The Village Hall, Houghton.	Child Health.
Hunsonby	—The Village Institute, Hunsonby.	Child Health.
Keswick	—13 - 15 Bank Street, Keswick.	Cervical Cytology, Ophthalmic, Orthoptic, Psychoprophylaxis, Speech Therapy, Developmental Testing, Vaccination and Immunisation.
	—Cottage Hospital, Keswick.	Dental.
Longtown	—Burn Street, Longtown.	Cervical Cytology, Child Health, Dental, Psychoprophylaxis, Mothercraft, Physiotherapy, Playgroup, School Clinic, Hearing, Weight Reduction, Chiropody, Probation, Craft Class for Handicapped, O.P.W. meetings, and Blood Transfusion.
Maryport	—24 Selby Terrace, Maryport.	Ante-Natal, Child Guidance, Dental, Speech Therapy, Developmental Testing, Vaccination and Immunisation.
	—Cottage Hospital, Maryport.	Chiropody.
Millom	—18 St. George's Rd., Millom	Ante-Natal, Child Guidance, Child Health, Dental, Family Planning, Speech Therapy, Vaccination and Immunisation, and Chiropody.
Nenthead	—Overwater, Nenthead.	Child Health and Chiropody.
Penrith	—Brunswick Square, Penrith.	Cervical Cytology, Child Health, ChildGuidance,Chiropody,Dental, Family Planning, Hearing, Marriage Guidance, Mothers' Club, Physiotherapy, Orthoptic, Probation, Speech Therapy, Craft Class for Handicapped.

Centre	Address	Clinic Services
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, and Child Health.
Thursby	—The Church Hall, Thursby.	Child Health.
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, Health and Developmental Services, Chiropody, Dental, Probation, Mothercraft and Speech Therapy.
Workington	—Park Lane, Workington.	Cervical Cytology, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Speech Therapy, Developmental Testing, Vaccination and Immunisation, and Psychoprophylaxis.
Salterbeck	—Holden Road, Salterbeck, Workington.	Chiropody, Dental, Developmental Testing, Vaccination and Immunisation.