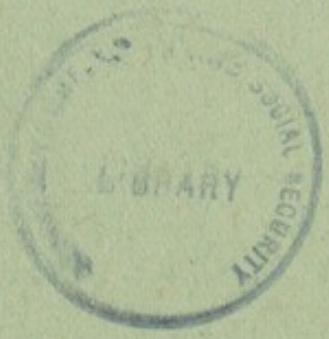
[Report 1968] / Medical Officer of Health and School Medical Officer of Health, Westmorland County Council.

wellcome collection

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

WESTMORLAND COUNTY COUNCIL



Annual Report

of the

County Medical Officer of Health

and Principal School Medical Officer

1. ~~Mr Muston~~ ~~B.415~~
2. ~~Mr Morley Parry~~ A.421
3. ~~Mr Perry~~ ~~A.405~~

1968

WESTMORLAND COUNTY COUNCIL

Annual Report

of the

County Medical Officer of Health

and Principal School Medical Officer

1968

CONTENTS

COUNTY OF WESTMORLAND

Health Department,
County Hall, Kendal.
October, 1969.

Mr. Chairman, Ladies and Gentlemen,

ANNUAL REPORT 1968

The Annual Report for the year 1968 is somewhat more voluminous than usual as the result of several changes in the nature of the committees and sub-committees and the work involved.

There has been a slight increase in population from 68,030 in 1967 to 70,340 persons living in the county. The situation in regard to births and deaths remains largely unchanged. The former is slightly above the average for the country whilst the latter is slightly below the national average. As in 1967 I am glad to report that there were no maternal deaths from pregnancy or childbirth. The three main causes of deaths were Heart Disease, Cancer and Cerebral Haemorrhage, in that order.

Perhaps the most important change during the year was the adoption of some of the Maud Committee's recommendations on the composition, numbers and function of the Health Committee. Further details appear later in the Report. As the result of the first year's experience it has been decided to continue the experiment for a further period. Comments on the other services are made at the beginning of the various sections.

The other services in the Health Department have functioned well and efficiently during the past year.

I have the honour to be,

Your obedient Servant,

JOHN A. GUY,

County Medical Officer of Health
and Principal School Medical Officer.

PUBLIC HEALTH OFFICERS OF THE AUTHORITY IN 1968

Name	Qualifications	Office	Whole or Part Time	Other Offices
John A. Guy	M.D., D.P.H.	County Medical Officer	Whole	Principal School Medical Officer
I. S. Bailey	M.A., M.R.C.S., L.R.C.P., D.P.H.	Deputy County Medical Officer	Whole	Deputy Principal School Medical Officer
R. Douglas Young	M.D., M.R.C.P.	Tuberculosis Officer	Part	Consultant Chest Physician
W. Hugh Morton	M.B., Ch.B., M.R.C.P., D.P.H.	Tuberculosis Officer	Part	Consultant Chest Physician
M. D. McGarry	L.D.S.	Principal Dental Officer	Whole	Principal School Dental Officer
D. J. Harrison (Resigned 31.7.68)	B.D.S.	Dental Officer	Whole	School Dental Officer
J. B. Millar	B.D.S., L.D.S.	Dental Officer	Whole	School Dental Officer
B. C. Tomlinson	L.D.S., R.C.S.	Dental Officer	Whole	School Dental Officer
A. Dunn (Commenced 1.8.68)	B.D.S.	Dental Officer	Whole	School Dental Officer
P. G. Holloway	Social Science Certificate	Mental Welfare Officer	Whole	———
A. Matthews	S.R.N., R.M.N.	do.	Whole	———
E. Nicoll	S.R.N., S.C.M., H.V.Cert.	Superintendent Nursing Officer	Whole	———
S. M. Head	Diploma in Institutional & Catering Managment	Home Help Organiser	Whole	———
E. Bland	S.R.Ch., F.R.S.H.	Chiropodist	Whole	———
H. M. Wrigley	L.Ch., S.R.Ch.	Chiropodist	Whole	———

STATISTICS AND SOCIAL CONDITIONS OF THE AREA

Area (in acres, land and inland water)	504,917
Population (Registrar-General's estimate of resident population, mid-1968)	70,340
Total Rateable Value as on 1st April, 1968	£2,477,556
Estimated product of a Penny Rate (General County) for the financial year 1968-69	£9,764

EXTRACTS FROM VITAL STATISTICS IN THE YEAR 1968

	Total.	Males.	Females.
Live Births—Legitimate	1,022	523	499
Illegitimate	83	50	33
	1,105	573	532

Birth Rate per 1,000 of the estimated resident population .. 17.9

Birth Rate, England and Wales, 16.9

Illegitimate Live Birth per cent of total live births, 7.5

	Total.	Males.	Females.
Stillbirths	15	8	7

Rate per 1,000 total live and stillbirths .. 13.4

Stillbirth Rate, England and Wales .. 14

	Total.	Males.	Females.
Total Live and Stillbirths	1120	581	539

	Total.	Males.	Females.
Deaths of Infants under 1 year of age ..	19	12	7

Death-rate of Infants under 1 year of age:

All infants, per 1,000 live births 19.0

Legitimate infants, per 1,000 legitimate live births .. 17.6

Illegitimate infants, per 1,000 illegitimate live births .. 36.1

Infant Death Rate, England and Wales, 18

	Total.	Males.	Females.
Neo-Natal Deaths (under four weeks) ..	10	7	3

Rate per 1,000 live births, 9.1

Neo-Natal Mortality Rate, England and Wales, 12.3

Early Neo-Natal Mortality Rate (deaths under one week):

Rate per 1,000 live births 6.3

Perinatal Mortality Rate (stillbirths and deaths under one week):

Rate per 1,000 total live and stillbirths .. 19.6

Deaths from Pregnancy, Childbirth or Abortions .. .. Nil

Rate per 1,000 total (live and still) births .. Nil

Maternal Mortality Rate, England and Wales, per 1,000 total (live and still) births, 0.24

	Total.	Males.	Females.
Total Deaths	918	467	451

Death Rate per 1,000 of the estimated resident population .. 10.8

Death Rate, England and Wales, 11.9

POPULATION

DISTRICT	Area in acres (Land and Inland Water)	Population: Registrar General's estimate Mid. - 1968
URBAN		
Appleby	1,877	1,890
Lakes	49,917	5,230
Kendal	3,705	19,800
Windermere ..	9,723	7,530
RURAL		
North Westmorland .	288,688	15,350
South Westmorland .	151,007	20,540
Westmorland ..	**504,917**	**70,340**

BIRTH RATE

Birth Rate per 1,000 estimated resident population.

District.	1966.	1967.	1968.
URBAN			
Appleby	15.7	26.2	13.7
Kendal	17.9	19.3	19.8
Lakes	12.8	11.3	12.3
Windermere	15.6	18.6	19.1
RURAL			
North Westmorland	16.9	18.8	19.0
South Westmorland	16.4	19.0	16.7
WESTMORLAND	16.6	18.6	17.9
ENGLAND AND WALES ..	17.7	17.2	16.9

The Birth Rates in the Table above are calculated using the comparability factor supplied for the purpose by the Registrar-General.

Live Births registered in the last five years were as follows:—

Year.	1964.	1965.	1966.	1967.	1968.
Number of births ..	1,096	1,045	992	1,121	1,105

DEATH RATE

Death Rate per 1,000 estimated population.

District.	1966.	1967.	1968.
URBAN			
Appleby	16.4	15.4	14.0
Kendal	12.0	12.1	11.6
Lakes	12.9	8.9	9.6
Windermere	10.9	8.8	6.7
RURAL			
North Westmorland	13.0	12.6	12.2
South Westmorland	11.0	10.1	11.7
WESTMORLAND	12.0	11.0	10.8
ENGLAND AND WALES ..	11.7	11.2	11.9

The Death Rates in this Table are calculated using the comparability factor provided for the purpose by the Registrar-General.

The chief causes of death in Westmorland in 1966, 1967 and 1968 in order of maximum fatality in 1968 were as follows:—

	1966.	1967.	1968.
Heart Disease	335	300	314
Cancer	164	173	188
Cerebral Hæmorrhage	126	143	146
Violence (including accident) ..	37	49	50
Other Circulatory Diseases ..	39	43	39
Bronchitis	38	28	32
Pneumonia	27	20	28

It should be noted that owing to changes in the International Classification of Diseases the analysis of causes of death supplied by the Registrar-General is not strictly comparable with the classifications hitherto used.

MATERNITY AND CHILD WELFARE
INFANTILE MORTALITY (Under 1 Year)

Rate per 1,000 Live Births.

District.	1966.	1967.	1968.
URBAN			
Appleby	—	23	—
Kendal	25.3	17.0	25.0
Lakes	15.9	—	—
Windermere	11.1	—	19.0
RURAL			
North Westmorland	21.6	16.0	11.0
South Westmorland	22.6	13.0	25.0
WESTMORLAND	21.2	13.0	19.0
ENGLAND AND WALES ..	19.0	18.3	18.0

The Infant Mortality Rates are now given by the Registrar-General and are shown as whole numbers only.

Causes of death during 1968 in Infants under 1 year of age:—

Congenital Anomalies	6
Bronchitis	3
Pneumonia	2
Malignant Neoplasm	1
Influenza	1
Birth Injury	1
Other Causes	7
	21

COMMENT ON VITAL STATISTICS

For several years it has been customary in this Report to comment on the Vital Statistics, always with the warning that figures relating to relatively small groups must always be viewed with caution, and the same warning applies to the comments below. As stated below the relevant tables on page 9 of this Report, the Birth and Death Rates, are calculated, using the Comparability Factor supplied for this purpose by the Registrar-General. This factor is designed to compensate for variations in the age and sex structure of the population of different areas, and to make the rates so calculated comparable to those of other areas and to the figures for England and Wales.

The number of livebirths during the year, 1,105, is only 17 less than in the previous year, but because of the higher estimated population the adjusted Birth Rate has fallen from 18.6 to 16.9. On the other hand although the deaths totalled 62 more than in 1967, the Death Rate fell to 10.8 for the same reason. Illegitimate births as a percentage of total births fell from 8.5% to 7.5%.

The stillbirth rate (13.4) rose, but remains below that for England and Wales (14). This rate being based on very small figures, is apt to fluctuate very considerably, but has, for the last four years, been below the national figure.

During the immediate post-War years the infant death rate fell rapidly, and during the last 15 years the rate for England and Wales has continued to fall, though more slowly. The figure for the County on the other hand has fluctuated from rates little over half those for England and Wales to rates slightly above the national figure. The Neo-natal Mortality Rate (deaths of infants under 4 weeks) though an increase on last year, (9.1 compared with 5.4) compares favourably with that for England and Wales (12.3), but this is another classic example of a rate which, being based on very small figures, is bound to fluctuate widely.

HEALTH COMMITTEE STRUCTURE

Arising from their consideration of the report of the Committee on the Management of Local Government (Maud Committee) the County Council, with the assent of the Health Committee decided

That

(a) for a temporary period, and continuing, subject to any further decision of the Council, until the end of the current triennium, an experiment be conducted in applying certain principles of the Maud Committee's Report to the organisation and procedure of the Health Committee and, to that end, the following pattern of organisation be adopted:—

(1) The Health Committee shall consist of the Chairman and Vice-Chairman of the Council, ex-officio. 10 Members of the Council. Not more than 5 members co-opted by the Committee from persons not being members of the Council.

(2) The Committee shall be authorised to appoint panels of members, primarily to consider and make recommendations on matters of policy, in respect of which preliminary and detailed consideration appears desirable.

(3) A panel may be authorised in a special case to exercise any power which has been delegated by the Council to the Committee.

(4) A panel appointed in respect of the Mental Health Service may be authorised to act as the managing body of the Mental Health Centre and, as such, to exercise any powers delegated to the Health Committee by the Council.

(5) The County Medical Officer and the Chief Fire Officer, as Ambulance Officer, within their respective spheres, shall be authorised, subject to the observance of the Council's Standing Orders in relation to contracts, to incur expenditure within the limits of the approved annual estimates on the maintenance of normal supplies and services and the acquisition and replacement of equipment, including vehicles.

(6) The County Medical Officer and the Chief Fire Officer, as Ambulance Officer, within their respective spheres, shall be authorised within the approved establishment and the approved annual estimates, to appoint all staff, save as may be prescribed by the Committee.

The newly constituted Committee held its first meeting on April 1st, 1968, when it appointed three Panels, Nursing, Mental Health and General Purposes, "to meet as and when particular matters might need detailed and prolonged consideration", each Panel consisting of the Chairman, Vice-Chairman, and four other members of the Health Committee.

Comprehensive reports, reproduced later in this Annual Report, have been submitted on the Ambulance, Mental Health, and Nursing Services, with shorter reports on the Councils' Vaccination and Immunisation functions and the Registration of Nurseries and Child Minders.

Whilst this Report was in course of preparation the Committee reviewed the operation of the new system over a period of some fifteen months, and subject to one or two minor observations, felt that its working had been an improvement on the old methods. From the point of view of the Chief Officer and his staff there can be little doubt that the new arrangements, coupled with new Financial Regulations adopted by the Council at the same time, have avoided some of the delays which would have occurred under the old system in dealing with a number of matters. The compilation of the new style of reports, intended to enable the Committee to subject various aspects of the service to a more searching review than was formerly possible, together with the research which their compilation involves, (though much of this is not immediately obvious in the end products) has certainly focussed the attention of not only the Committee members, but also the officers concerned, on points which may otherwise have escaped notice. It is however a time consuming task and has placed a not inconsiderable additional burden on the few senior members of the staff available and able to undertake such tasks.

NURSING SERVICES

The following is a copy of the report on the Nursing Services submitted to the Health Committee in March, 1969.

The general lines which this Report follows are:—

1. Historical
2. Present state of the Services
3. Housing
4. Transport
5. Trends
6. Statistics
7. Appendices — A. — Staff
   B. — Loan Equipment
   C. — Housing
   D. — Attachment to General Practices.

1. Historical

In writing a report on the Westmorland County Council Nursing Services, it might be appropriate to introduce a few extracts from the history of Nursing generally. There is no doubt that it is one of the oldest professions known. Thus St. Paul writes "I commend unto you Phoebe our sister which is a servant of the Church which is at Cenchreae; that ye receive her in the Lord as becometh Saints and that ye assist her in whatsoever business she hath need of you for she hath been a succourer of many and of myself also". The first mention of Midwives is even more ancient and appears in the Book of Exodus, Chapter 1; || Verse 15. "And the King of Egypt spake to the Hebrew midwives of which the name of one was Shiphrah and the name of the other Puah, || Verse 16. And he said when ye do the office of a midwife to the Hebrew women and see them upon the stools if it be a son then ye shall kill him but if it be a daughter then she shall live, || Verse 17. But the Midwives feared God and did not as the King of Egypt commanded them, || Verse 20. Therefore God dealt well with the midwives."

In 1725, we read, the Nurses of Guys Hospital were ordered to "attend the Butler at the ringing of the Beer Bell and suffer such patients as carry the beer not to embezzle it by the way".

Much more recently an impetus was given by Florence Nightingale (1820-1910) principally as the result of her experiences in the Crimean war. On return to England she founded the first nurses' training school at the St. Thomas's Hospital in London. The present system of District Nursing originated with William Rathbone of Liverpool who provided a trained nurse to look after the poor in Liverpool. The Queen Victoria Jubilee Institute was formed in 1887 for the education of nurses to tend the sick poor in their own homes and to promote the establishment of branches throughout the United Kingdom. In 1925 the name was changed to Queens Institute of District Nursing.

In Westmorland the County Nursing Association was formed in 1930 with Mrs. Gaddum, Honorary Secretary and the late Mr. J. W. Cropper, president. The whole of the County was covered by the Nursing Services and was divided into 18 districts.

The nurses then appointed were really "Sick Nurses". The first district in this County to have a nurse was Bowness. I am informed that the reason here was that William Rathbone, who was instrumental in starting the Nursing Services in Liverpool, had an interest in Bowness and it was probably his interest that caused a district nurse to be installed there.

In the beginning, few district nurses had cars and most of the work was covered by a nurse cycling to her patients, but the use of cars soon became usual.

When the National Health Service became effective, it became obvious that the subscription side of the finances would diminish due to the impact of the National Health Service Act, 1948 and the County Council decided to take over the service. One of the first tasks which the County Council undertook was an examination of the Nursing Districts. The result was the amalgamation of a number of Districts so that:—

Witherslack was united with Levens (pre 1948)
Bampton with Askham and Shap
Dillicar (formerly nursed by West Riding) was attached to Skelsmergh
Longmarton partly to Appleby and part to Kirkby Thore
Pooley Bridge with Askham
Langdale, Grasmere, Troutbeck with Ambleside
Ravenstonedale with Tebay
Patterdale nursed under agency arrangement with Cumberland.
Warcop (Soulby) split between Appleby, Brough & Kirkby Stephen.

Thus eleven districts were amalgamated with other districts with the consequent reduction of 5 nurses who were not replaced when they retired or left.

The present districts comprise:—

Ambleside
Appleby
Arnside
Askham
Bowness
Brough
Burneside
Burton
Crosby Ravensworth
Crosthwaite
Hutton
Kirkby Lonsdale
Kirkby Stephen
Kirkby Thore
Lakes
Levens
Milnthorpe
Morland
Preston Patrick
Shap
Staveley
Tebay
Windermere
Kendal (4 areas)

27 districts.

2. Present state of the Services

In a report of this nature a complete list of nurses, their qualifications, districts and duties is necessary and this is supplied in the form of Appendix "A" at the end of the report.

In brief summary these are:—

Whole time nurses	37
Part time nurses	12
Nursing Orderlies	5
Senior Health Visitor ...	1
Superintendent Nursing Officer	1

In the days prior to 1948 the nurses in the districts relieved each other as a rule and so made their own holiday and off duty arrangements. Since 1948 new holiday and off duty times have been negotiated centrally and the old arrangements have, of necessity, been discontinued. Each nurse is now entitled to 42 days annual leave and in addition works a 5 day week. This has occasioned the employment of part-time relief nurses. For some time past there has been a feeling throughout nursing circles that to use nurses to do simpler labours and time consuming work is uneconomical. Consequently the Ministry (Circular 12/65 and 32/68) recommended Local Authorities to:—

1. Examine their establishment to see whether and to what extent work could be done without loss of efficiency by partly or unqualified staff.
2. Recruit married women without professional qualifications and provide training facilities.
3. Provide equipment and ancillary assistance and ensure that working conditions are adequate.

With these objects in mind the County Council employ 5 Nursing Orderlies part-time who help in such tasks as bed bathing. These Nursing Orderlies are employed in Brough, Kirkby Stephen, Tebay, Kendal, Milnthorpe.

Courses

Each midwife must attend a 7 day Refresher Course at a centre approved by the Central Midwives Board every 5 years. In addition the Superintendent Nursing Officer arranges for nurses to attend courses from time to time on Health Visiting and General Nursing. Scholarships for Health Visitors and District Training are awarded as suitable candidates become available.

Nursing Loan Equipment

Following the take over of the Nursing Services by the County Council the question arose of providing items of equipment useful or

necessary to nursing. All nurses concerned with midwifery had been equipped with gas air machines for the relief of pain during childbirth. However the Ministry Circular gave power for the wider use of nursing equipment and such things as wheel chairs, air beds, commodes, walking frames and many other items of equipment were purchased and these were kept in a central store in County Hall and loaned out as required, whilst the nurses keep a supply of small articles. This service has proved a great boon to nurses and patients alike. A general list of equipment is provided in the Appendix "B".

Recruitment

It has been the custom in general for the County Council to recruit nurses who have the S.R.N., S.C.M. and H.V. qualifications so that one nurse is able to undertake general nursing, midwifery and health visiting. Unfortunately many nurses take the S.R.N. only or S.R.N. and S.C.M. qualification but comparatively few take the S.R.N., S.C.M. and H.V. qualifications. Consequently it is comparatively easy to find nurses who wish to undertake general nursing and perhaps midwifery but relatively few who are able to take on health visiting. Again nurses seem to like populated areas and it is easier to find nurses for Kendal and Windermere than for rural districts. Owing to this difficulty of recruiting nurses with the triple qualification the idea of finding nurses to undertake the three duties will have to be looked at again and the possibility of employing different nurses to undertake different duties examined. For example in the Appleby/Brough/Kirkby Stephen area, the Kirkby Thore/Morland area, and Windermere/Bowness area, one nurse does the health visiting and another the general nursing and midwifery.

3. Housing

Soon after the beginning of the Health Service it became apparent that houses were needed for the nurses especially in villages where suitable houses could not be rented and lodgings were either unsuitable or impossible to obtain. Consequently the County Council made a start by providing a nurse's house at Tebay and followed soon after by one at Crosby Ravensworth. Altogether the Council have built 18 houses and 4 more are projected. This will complete the housing programme for nurses. The employment of married nurses and other circumstances such as 2 nurses wishing to live together has resulted in some of the houses becoming temporarily redundant. There is no doubt that the provision of purpose built houses for the nurses was a good and progressive step forwards. If I am correctly informed Westmorland was one of the early Local Authorities to take such a step. Details are given in Appendix "C".

4. Transport

Nurses' cars at the present moment fall into two categories. Those using cars provided by the County Council and those owned by the Nurses. The figures are as follows:—

1. Those using County Council cars	14
2. Nurses' own cars	38
3. Nursing Orderlies' own cars	3

The newly registered nurse who has had little opportunity of saving often takes a County Council car to start with but later buys one of her own. This has the advantage in that the nurse can use her car whilst on holiday or at any time off duty. One slight disadvantage is that when any privately owned car breaks down or is unavailable for some reason then the nurse tends to look to the Department for a relief car and with the decreasing fleet of County Council owned cars this is not always easy. County Council cars are inspected at the Roads and Bridges Repair Depot once per year and on the advice of the examiner are taken out of service and replaced. Ordinary servicing is done at local garages, but major repairs are carried out at the Central Depot.

5. Trends

In dealing with the subject of Trends in the Nursing Services the use of short paragraphs is possibly the easiest way of coping with the task. The District Midwifery Service is one which illustrates a present day trend as well as any. The general consensus of medical opinion at present is that confinements should take place in Hospital. This opinion has been given the stamp of official approval and the Ministry of Health have suggested a target of 70% of births in hospital to be aimed at. In Westmorland this figure has been far surpassed and in this County in 1968, for example, 94.7% of all births occurred in hospital. In 1949, the earliest year for which figures are available, 332 births (31.5%) occurred in the patient's home. In 1968, 58 domiciliary births only occurred. I really doubt whether this small number (average less than 2 per nurse per year) is sufficient for the midwife to maintain her skill in spite of the refresher course taken at five-yearly intervals. Clearly a problem exists here. Another aspect is that the period in hospital has now been shortened in many cases to 48 hours with the result that the district midwife has missed the excitement of being present at the birth but has the duller routine nursing of the case during the following 14 days or so. It would be merely guessing if one were to surmise that the solution might be to take all midwives into one service and arrange for an interchange between district and hospital, suggested by the Cranbrook Committee. The administrative changes foreshadowed in the Green Paper, Seebohm Report and Royal Commission on Local Government

must be awaited and digested before this problem is solved.

Attachment to doctors' practices is now becoming general. The original idea was for health visitors in the first place to be attached to doctors' practices but in Westmorland many of the health visitors are also district nurses doing general nursing so that in fact when a nurse was attached to a practice, the whole range of nursing services was also attached. This arrangement has been uniformly welcomed by both nurses and doctors. There is now a feeling of integration and exchange of information which has been achieved. Details are given in Appendix "D".

Early Discharge from Hospital

The matter of hospital confinement and its effect on domiciliary midwifery has already been mentioned. There is another aspect to patients and their treatment in hospital. The lying-in period in Hospital following operation has been greatly shortened, e.g. appendix cases which half a century ago were kept in bed for from a fortnight to three weeks are now encouraged to get up and take walks a few days after the operation, leading to early discharge. This has been contributed to by improved surgical and hospital techniques and by the knowledge that early mobility following operation tends to prevent lung infection and other undesirable results.

All this tends to return the patient home sooner than was previously the custom but places an added strain on the nursing services.

Team Nursing

Scarcity of nurses especially in rural districts may lead to two things. In the first place nurses may have to cover larger districts. Secondly more unqualified nursing personnel may have to be recruited so that the nurse may find herself directing the work of several less qualified and possibly part-time helpers.

Health Visiting

Several aspects of this work are becoming increasingly important. The effect of mothercraft classes on expectant mothers which are largely run by Health Visitors has become recognised by the various maternity homes and hospitals in which the mothers are confined. It is said that a mother who has attended these classes is better prepared for labour and this makes the whole process of child bearing easier.

Again lectures and talks to secondary school children are being welcomed by secondary schools on such topics as general hygiene, smoking and allied topics. Evening talks to such bodies as Women's Institutes and the use of a slide projector are becoming increasingly popular.

In the Maternity & Child Welfare Clinics the use of Phenestix Tests has become general. This is a test which detects the presence

of abnormal metabolism in a few babies leading to mental subnormality. This test is likely to be replaced by the Guthrie Test, which is much more reliable, as soon as the Pathological Laboratories are able to cope with the specimens.

Play Groups and Child Minders — Creches

The provision of Creches where the care of young children was undertaken for profit has been a feature of Lancashire Cotton towns for many years. Factories often set up well equipped, staffed and managed creches, for the children of their female workers. Unfortunately child minding was undertaken by private persons in less desirable circumstances. This no doubt led to the passing of the Child Minders Regulation Act, 1948.

In Westmorland in the last year or two, childminders principally and a few creches have sprung up almost like mushrooms overnight and there are now 13 in Westmorland and applications are still forthcoming.

The existence of these undertakings calls for a measure of visitation and supervision and this will fall on the nursing services.

6. Financial and Statistical Considerations

In any critical review of the Nursing Services of the County, one cannot ignore the fact, frequently discussed by the Health Committee during the last 20 years, that the cost per 1,000 population of the service is higher in Westmorland than in any other county in England and higher by far than the average for all English counties, although it is, as will be seen from the Tables below, reasonably comparable with those Welsh Counties of similar population sparsity.

Except for the number of nurses per 1,000 population, the figures in Tables I and II below are extracted from the publication "Local Health Service Statistics, 1966/7" published by the Society of County Treasurers and the Institute of Municipal Treasurers and Accountants.

TABLE I

Costs per 1,000 *population* 1966/7

	Population	*Persons per acre*	*Midwifery*	*Health Visiting*	*Home Nursing*	*Total*
Westmorland	67,410	0.13	£90/12	£271/15	£543/9	£905/16
Av. English Counties	—	0.78	£186/13	£130/18	£252/15	£570/6
Welsh Counties of comparable sparsity.						
Brecon	54,470	0.12	£279/5	£214/7	£460/8	£954/0
Cardigan	53,410	0.12	£143/3	£111/3	£593/15	£848/1
Merioneth	37,750	0.09	£146/8	£294/18	£572/7	£1,013/13
Montgomery	43,700	0.09	£165/4	£155/16	£441/18	£762/18
Radnor	18,300	0.06	£192/9	£287/1	£350/16	£830/6

TABLE II

Unit Costs 1966/7

	Midwifery per case	*Health Visiting per visit*	*Home Nursing per visit*	†*Nurses per* 1,000 *population in* 1965
Westmorland	£24/15	11/8d.	11/2d.	0.59
Av. English Counties	£30/13	9/2d.	11/–d.	0.42*
Brecon	£90/10	14/8d.	9/11d.	0.60
Cardigan	£34/6	7/2d.	10/10d.	0.86
Merioneth	£71/1	17/8d.	11/10d.	0.56
Montgomery	£201/15	13/3d.	11/5d.	0.58
Radnor	£46/7	11/8d.	6/3d.	0.83

* Total England & Wales — English Counties alone not available.

† Extracted from the Revised Plans for Local Authority Health & Welfare Services submitted to the Minister in late 1965.

Because of the somewhat abitrary methods of apportioning the total cost between the three branches of the Nursing Service, there would be little point in discussing differences under the three separate headings, (although it may be observed that the 95% institutional confinement rate in Westmorland must keep down the midwifery costs) and comment is therefore based on the overall figures.

Despite the high cost per 1,000 population shown in Table I it will be observed that the unit costs given in Table II are reasonably comparable to the average for English Counties and to those of the Welsh Counties quoted. The logical conclusion from these two sets of figures is therefore that in Westmorland more visits are paid per 1,000 population than is the case in the rest of the country.

This then raises the question as to the extent to which local circumstances may or may not account for such a situation. Clearly a shortage of General Medical Practitioners does not, as the average number of patients per G.P. in Westmorland is well below the national average.

It is well known that the proportion of persons over 65 years old in the population of this county is high — in 1966 our proportion of elderly was 21.6% more than the national average, on the other hand our quota of children under 5 years was 16.5% below the figure for England and Wales. Taking into account these factors in the age structure of the population together with the very small number of domiciliary confinements, and the fact that the actual (crude) birth rate in the county is only 89% of the national figure, it would be reasonable to expect that the burden on the Midwifery and Health Visiting services would be lighter, but that on the Home Nursing Service, where the great majority of the work (roughly four-fifths)

is among the over 65's, would be heavier than in the country generally.

Trying to balance the pros and cons of this argument, it would appear that slightly over half of the cost of the service is likely to be affected adversely by reason of the local conditions mentioned above, and nearly half is likely to be affected, to a slightly less extent, in the opposite direction, leaving only sparsity and the frequency of visitation to account for the greater part of the higher cost per 1,000 population.

An analysis of the cost of the Nursing Service, based on the 1969/70 Estimates, shows that the total net expenditure arises as follows:—

TABLE III

Employees — salaries, superannuation, national insurance, laundry allowances, pensions & uniform	75%
Transport — cars & car allowances	12%
Nurses' housing — rents, rates, loan charges & maintenance	6%
Equipment — Nurses' instruments, dressings and loan equipment	1%
Establishment Charges — Printing, telephones, insurance, central & departmental charges	6%
	100%

It is therefore clear from Table III that 93% of the total cost is directly proportional to the number of Nurses employed, and could only be reduced by a reduction in staff, which in turn must lead to a reduction in the range, quality and/or quantity of services at present being afforded to the population of the County.

In July 1968 a two-day conference on the National Health Service convened by the Minister of Health was held in Church House, Westminster "not only to mark a notable anniversary, but also, more importantly, to help to shape and fit the Service for the tasks ahead". Among the many papers presented was one by Dr. H. Yellowlees, Deputy Chief Medical Officer, Ministry of Health, in which he said, speaking of the two basic resources, money and manpower:—

"Both these resources are limited and will continue to be so; whereas the demand for medical care is the very reverse and is virtually unlimited . . . We are faced, with the rest of the world, with a situation in which we can do more things in terms of medical and nursing care for more people than our resources can possibly sustain."

"In these circumstances a decision to develop a service in a particular way could result in the using up of so much of the available resources that some other necessary service could not be provided. This is an unacceptable position in the National Health Service in which it is axiomatic that a service must be provided *if it has been identified as necessary and has been differentiated from other types of service which may be useful or convenient but are not fully necessary*. These are the hard facts."

Having discussed the difficulty of deciding what is "essential" and what is "merely convenient" Dr. Yellowlees in summing up his paper went on to say "It must be clearly understood that all the services which are felt to be necessary cannot be provided unless it is accepted that non-essential services, services of convenience, and the non-essential aspects of essential services are curtailed or possibly abandoned altogether".

In a subsequent session of the conference "it was repeatedly stressed that desired staff levels are not going to be attained and that strenuous efforts must be made to make more efficient use of staff already in post. There will be only a very small increase in the total number of women in employment up to the 1980's, and in fact the number of unmarried women employed will fall". As an example, it was stated that to meet the potential demand for teachers alone would absorb the whole of the woman-power output of the schools over the next decade.

The use of ancillary staff, less highly trained, has been urged on local health authorities for some years, and such persons, nursing orderlies, have been employed in Kendal, Milnthorpe, Brough, Appleby and Tebay for some 15 years.

There is however a limit in a sparsely populated area to the "dilution" of staff which can be accepted, as such persons must work under the supervision of trained staff, and if the process be pushed to far, the trained staff could be spending an undue proportion of their time travelling about to supervise their assistants.

A survey carried out in 1966 in Westmorland revealed that no less than 22% of the time of the nurses was at that time spent in travelling, a further 16% on visits to G.P.'s surgeries care of equipment, calls at County Hall and other offices, courses and staff meetings, telephoning and clerical work, leaving 62% spent on the actual visiting of patients and attendance at Clinics.

It is difficult to see how the travelling time can be reduced; in fact, with attachments to general practices and the unavoidable pairing of districts, with one nurse doing Health Visiting and Midwifery for both districts and another doing the general nursing, travelling time and expenses must inevitably increase. This however is unavoidable now that the Department of Health & Social Security will no longer issue dispensations to allow unqualified Health Visitors to do this work.

Of the 16% of time spent on miscellaneous items, approximately three quarters, or 12% of the total time, is attributed to telephoning and clerical work. The keeping of records and statistics is by no means popular with the nurses, and over the past twenty years it has been a constant aim to reduce this to a minimum. There is however a grave risk involved in reducing case notes below a certain point, whilst the statistics collected are no more than the bare minimum required to complete the returns required by the Ministry and to provide the kind of information needed to permit intelligent management of the work being done — and incidentally to permit the compilation of reports such as this.

It should be noted that the costs shown in Tables I and II above specifically exclude administrative charges, which are separately shown in the Society of County Treasurers' publications. In this respect the Westmorland costs for the whole administration of its Health Services exceed the national average by only 0.7% and are in fact lower, by amounts varying from 20% to 75% than those of the Welsh Counties quoted in the same Tables.

Table IV below gives details of visits paid, cases attended, time on and off duty and sessional work over the past five years.

TABLE IV

No. of Visits and Cases

	1968	1967	1966	1965	1964
General Nursing—Visits	67,738	69,603	70,827	68,451	70,624
Cases	3,004	2,455	2,593	2,497	2,601
Midwifery—Visits	9,162	9,728	7,640	9,442	9,675
Cases—Deliveries	41	60	53	78	107
Hospital discharges	996	948	783	754	634
Health Visiting—Visits	27,622	34,250	32,138	33,347	33,142
Cases	6,848	7,326	6,439	7,364	7,010
School Children—Visits	1,206	1,111	1,015	1,092	1,142
Special Visits	239	161	157	228	286
TOTAL VISITS	105,967	114,853	111,777	112,560	114,869
Infant Welfare Sessions	474	490	453	457	478
Medical Inspection Sessions	294	303	260	255	276
School Cleanliness Sessions	359	416	395	354	415
Deaf Testing Sessions	69	105	108	100	156
Other Clinics	363	316	239	198	165
Mothercraft Classes—					
Sessions	244	337	318	290	357
Cases	385	318	349	287	288
Attendances	1,680	1,615	1,557	1,326	1,404

Ante-Natal Sessions at G.P. Surgeries	141	168	219	154	107
Health Education Talks	166	193	230	222	250
Hours on Duty	78,742	81,728½	78,143½	79,942¼	81,111½
Days off Duty	2,753	2,607	1,947	2,031	2,162
Half days off Duty	233½	287	329	391	382
Annual Leave (Days)	1,537	1,663	1,487	1,560	1,743½
Sick Leave (Days)	207	249	537½	437½	230
Special Leave, Courses (Days)	106	135½	138	138½	185

This table shows that the total number of visits paid and the hours worked by the nurses have fluctuated appreciably during the last five years. The fall in the total number of visits between 1964 and 1968 represents a reduction of 7.8%, the reduction in hours spent on duty is 2.3%, whilst the time off duty, on leave or on courses represents an increase of 3.4% over the same period.

Whilst the working week for hospital nurses has been reduced since 1964 from 44 hours to 42 hours, the Whitley Council agreement states, with regard to Local Authority Staff:—

"Para. 211 — In the case of nurses and midwives employed in the public health and domiciliary services . . . , no specific provision is made about hours of duty."

"Para. 212 — Subject always to the requirements of the service, domiciliary Nurses, and District Nurse Midwives should be off duty and free from call at least 24 consecutive hours a week and for one weekend of 36 hours in each period of four weeks in addition to daily off duty time."

A study of the monthly report sheets submitted by the nurses, from which Table IV is compiled shows that the full-time nurses work an average of 38 hours per week. Whilst this is 4 hours per week less than the time worked by hospital nurses, it must be borne in mind that domiciliary nurses are on call, and liable to be called out at any time of the day or night when they are not on leave or "day-off". Whilst this liability to be called out is real, it should not be overestimated — in 1968, nurses were called out between 10 p.m. and 6.0 a.m. on only 99 occasions, i.e. less than three times per nurse per year on average, but no information is available as to the times they were called out between, say 5.0 p.m. and 10.0 p.m. but it would certainly be greatly in excess of the 99 night calls.

On the other hand, the Superintendent Nursing Officer has tried to arrange as far as possible for the nurses to work a five-day week, and it is apparent that when a nurse is on duty on Saturdays and more particularly Sundays, she usually works very short hours on

those days, although she is, as stated above, liable to be called out in emergency.

Furthermore, there are considerable divergencies as between the hours worked and visits paid by individual nurses, but again, a study of the report sheets indicates that in almost every case, nurses reporting working hours below the average report numbers of visits equal to or even above the average, whilst nurses reporting hours in excess of the average frequently report visits no more, and in some cases appreciably less, than the average. It is therefore clear that neither "hours on duty" nor "visits paid" taken separately serve as a very reliable guide to the effort expended by individual nurses, although, taken in conjunction, they give the impression that, with very few exceptions, which require and will receive further investigation no practicable re-allocation of territory and/or work is likely to lead to any saving of staff, or even equalisation of work loads as between nurses.

The essence of this matter appears to be in the questions as to whether

(a) a 38 hour week with the associated "on call" time should be regarded as equivalent to the 42 hour week worked by Hospital staffs?

(b) Health Visitors, who are limited in the amount of useful work they can do on Saturday and Sunday by reason of the domestic arrangements of patients, could therefore continue to take these days off duty, but as they are not generally liable to call-out at night, their working hours inclusive of evening talks and clerical work, would in general be rather more than nurses on combined duties.

(c) Other nurses should so far as relief arrangements permit, take alternate Saturdays and Sundays off, and in the intervening period one day or 2 half days, it being accepted that in addition they will in fact be able to work only a short day on Sunday, and to a somewhat less extent also on Saturday.

In conclusion there are aspects of the Nursing Services which have not been touched on but an effort has been made to comment on the more obvious and important aspects of the service.

The statistical side of the report does not lead one to any definite conclusion but it would appear that in order to bring down the costs of the service to the level of English Counties as a whole there would need to be a reduction in the numbers of nurses which of course would mean a reduction in the quality of the service. Below a certain undefined level dilution of the staff would be likely to defeat its own ends in that more part-time staff must be employed to cope with off-duty, holidays, courses and illness. Comments on the statistical

side of the report have thus been kept to a minimum and members are encouraged to draw their own conclusions.

I am indebted to Miss Nicoll, Superintendent Nursing Officer, for the sections on nursing attachments to doctors and to Mr. Biddulph, the Chief Clerk, for the paragraphs on statistics.

APPENDIX "A" — NURSING STAFF

DN — District Nursing HV — Health Visiting
M — Midwifery SN — School Nursing

DN — District Nursing M — Midwifery HV — Health Visiting SN — School Nursing

District	*Name of Nurse*	*Qualifications*	*Duties*
Ambleside	Mrs. G. Marks	S.R.N., S.C.M., Q.N., H.V.	DN/M/HV/SN
Appleby	Miss C. A. Gardiner	—do.—	M/HV/SN
Arnside	Miss E. J. Davis	—do.—	DN/M/HV/SN
Askham	Mrs. E. Bayliffe	—do.—	—do.—
Bowness	Mrs. F. Gibson	S.R.N., S.C.M.	DN/M
Brough & Warcop	Miss V. Fell	S.R.N., S.C.M., Q.N.	DN/M
	Miss J. Kavanagh	S.R.N., Q.N., H.V.	HV/SN
Burneside & Skelsmergh	Miss B Miles	S.R.N., S.C.M., Q.N., H.V.	M/HV/SN
	Mrs. M. B. Cox	S.R.N.	DN
Burton	Mrs. E. Turner	S.R.N., S.C.M.	DN/M/HV/SN
Crosby Ravensworth	Miss B. Cartner	S.R.N., S.C.M., H.V.	—do.—
Crosthwaite	Mrs. P. I. Bownass	S.R.N., S.C.M., Q.N., H.V.	—do.—
Hutton	Miss E. Pearce	—do.—	—do.—
Kirkby Lonsdale	Mrs. A. Cox	S.R.N., S.C.M., H.V.	—do.—
Kirkby Stephen	Miss E. R. Wilson	S.R.N., S.C.M., Q.N.	DN/M
Kirkby Thore & Morland	Mrs. A. M. Scott	S.R.N., S.C.M.	DN/M
	Miss E. Henderson	S.R.N., S.C.M., Q.N., H.V.	M/HV/SN
Lakes	Mrs. E. M. Chapman	S.R.N., S.C.M.	DN/M/HV/SN
Levens	Miss F. I. Bracken	S.R.N., S.C.M., Q.N., H.V.	—do.—
Milnthorpe	Miss G. Gorman	S.R.N., S.C.M., Q.N., H.V.	—do.—
	Miss M. N. E. Moodie	S.R.N., S.C.M.	—do.—
Preston Patrick	Mrs. M. M. Wilson	S.R.N., S.C.M., Q.N., H.V.	—do.—
Shap	Mrs. D. A. Lee	—do.—	—do.—
Staveley	Mrs. G. B. Walker	S.R.N., S.C.M., H.V.	—do.—
Tebay	Miss D. Alderson	S.R.N., S.C.M.	DN/M/SN
Windermere	Miss M. I. Raw	S.R.N., S.C.M., H.V.	HV/SN
	Mrs. E. Pearson	S.R.N., S.C.M.	DN/M
Kendal	Miss B. M. Dale	S.R.N., S.C.M., H.V.	M/HV/SN
	Miss P. B. Thomas	—do.—	—do.—
	Miss M. A. Cookman	S.R.N., S.C.M., Q.N., H.V.	—do.—
	Mrs. L. Thompson	S.R.N., S.C.M., H.V.	—do.—
	Mrs. E. Fothergill	S.R.N., S.C.M.	DN
	Mrs. J. Johnston	S.R.N., Q.N.	DN
	Miss M. C. Stoker	S.R.N., S.C.M., Q.N.	DN
	Mrs. M. H. Woodhouse	—do.—	DN
	Mrs. I. Yare	S.E.N.	DN
Relief Staff	Mrs. L. M. Corless	S.R.N., S.C.M.	M/HV
	Mrs. D. Dennison	S.R.N.	DN
	Mrs. M. M. Wilkinson	S.R.N.	DN
	Mrs. M. Amies	S.R.N., Q.N.	DN
	Mrs. V. Dickinson	S.R.N.	DN
	Mrs. M. Dodgson	S.R.N., S.C.M.	DN/M
	Miss E. Mitchell	S.R.N., S.C.M., Q.N.	DN/M
	Mrs. F. Richardson	—do.—	DN/M
	Mrs. J. M. Stuart	R.N.M.D.	DN
	Mrs. M. A. Sykes	S.E.A.N., S.C.M.	DN/M
	Mrs. E. Watson	S.R.N.	DN

Nursing Orderlies (5) Assisting with general nursing.
Mrs. D. I. Burrow Mrs. M. A. W. Cradock Mrs. M. Nelson Mrs. E. Storey Mrs. S. M. Varey

APPENDIX "B" — LOAN EQUIPMENT

Available from County Hall

Air beds
Back rests
Bed cradles
Beds (2)
Bed blocks
Bed tables
Commodes
Crutches
Dunlopillo squares
Elbow crutches
Infra red lamp
Lifting frame
Divided mattresses
Test weighing scales
Tripod sticks
Walking sledges
Walking frames
Wheelchairs
Zimmer hoists
North bed pads
Enuresis pads
Maternity outfits

Available from Nurses

Air rings
Bed pans
Female urinals
Male urinals

APPENDIX "C" — HOUSING

Ambleside	County Council built house.
Appleby	County Council built house.
Arnside	House taken over from District Nursing Association. New house being built.
Askham	County Council built house.
Bowness	District Nursing Association house let to Police. New house programmed.
Brough	County Council built house.
Burneside	No house (nurse lives in own house).
Burton	County Council built house.
Crosby Ravensworth	County Council built house.
Crosthwaite ..	House rented Trustees of District Nursing Association (New house programmed).
Hutton	Nurse rents house from Kendal Corporation.
Kirkby Lonsdale ..	County Council built house.
Kirkby Stephen ..	County Council built house.
Kirkby Thore ..	County Council built house.
Lakes	House programmed.
Levens	County Council built house.
Milnthorpe	County Council built house.
Morland	County Council built house.
Preston Patrick ..	County Council built house.
Shap	Nurse lives in her own house.
Skelsmergh ..	County Council built house (Temporarily let).
Staveley	County Council built house (Temporarily let).
Tebay	County Council built house (Temporarily let).
Windermere ..	House bought from District Nursing Association (Temporarily let).
Kendal	2 County Council built houses. 1 Bought.

25 houses

APPENDIX "D"

ATTACHMENT OF DISTRICT NURSING SISTERS TO GENERAL PRACTICES

Drs. Turnbull & Land	Mrs. J. Johnston, Clova, Hincaster, Milnthorpe.
Drs. Birkett & Bradshaw	Mrs. J. Johnston, Clova, Hincaster, Milnthorpe.
Drs. Scott, Jackson & Kirkpatrick	Mrs. M. H. Woodhouse, 24, Empson Road, Kendal.
Drs. Cochrane, Oddy & Gill	Mrs. E. Fothergill, 96, Hallgarth Circle, Kendal.
Drs. Kemp. Stoddart & Hine	Miss M. C. Stoker, 19, Larch Grove, Kendal.

ATTACHMENT OF MIDWIFE-HEALTH VISITORS TO GENERAL PRACTICES

Drs. Scott, Turnbull, Jackson, Kirkpatrick & Land	Mrs. L. Thompson, 26 Spital Park, Kendal.
Drs. Cochrane, Oddy, Bradshaw, Birkett & Gill	Miss M. A. Cookman, 170, Windermere Road, Kendal.
Drs. Kemp, Stoddart & Hine	Miss B. M. Dale & Miss P. B. Thomas, 3, Burton Road, Kendal.

RELIEF NURSES IN KENDAL

Mrs. L. M. Corless,
2, Northgate, Kendal.

Mrs. D. Dennison,
Tudor House, Burton Road, Kendal.

Mrs. M. M. Wilkinson,
5, Lound Street, Kendal.

Mrs. I. Yare,
67, Burneside Road, Kendal.

VACCINATION AND IMMUNISATION

Since the Council submitted its original Proposals for providing vaccination against smallpox and immunisation against diphtheria, to take effect from the appointed day (4th July, 1948) for the National Health Service Act, 1946, a number of changes have been made possible by advances in immunology. The Secretary of State for the Department of Health and Social Security is advised on this subject by a Joint Committee on Vaccination and Immunisation, consisting of experts on the subject, and as a result of that Committee's recommendations, the following extensions to this branch of the service have been made:—

1949 B.C.G. vaccination of contacts with Tuberculosis

1950 Immunisation against whooping cough

1954 B.C.G. Vaccination against Tuberculosis of children between 13th and 14th birthdays

1956 Vaccination against Poliomyelitis

1959 Immunisation against Tetanus

1967 Vaccination against Anthrax of persons in trades involving risk

1968 Vaccination against Measles.

Active immunity against these diseases is induced either by the use of a living organism of the disease, attenuated to reduce its virulence, e.g. B.C.G. vaccine, oral poliomyelitis vaccine, the measles vaccine at present generally used in this country, and smallpox vaccine; by the use of vaccines using inactivated organisms, e.g. whooping cough vaccine; or by the use of prophylactics, e.g. tetanus and diphtheria, which depend for their action on toxoid which is bacterial toxin rendered harmless with formalin. A common factor of all these products is that they produce their protective effect by stimulating the production, in the person to whom they are administered, of antibodies.

There are a number of conflicting influences needing consideration in determining the optimum sequence and timing of injections, the aim being to secure the most effective immunisation with the minimum of undesirable reaction, and to do so to cover the period when the risk of infection is greatest.

There is however general agreement that immunisation should not commence before the child reaches 6 months of age, as in younger infants the antibody-forming system is not fully developed. The recommended intervals between doses are now longer than was customary in the past, and it is no longer felt inadvisable to give poliomyelitis vaccine at the same time as diphtheria/whooping cough/tetanus vaccine.

As the Department's advice as to recommended times for the various procedures is given in very general terms, e.g. "During the first year of life" it has been felt desirable to advise mothers in rather more specific terms, and the following scheme is recommended in this County.

(1) 6 months	Diphtheria, Tetanus, Whooping Cough (Triple) Poliomyelitis — Oral.
(2) 8 months	Second dose (Triple & Poliomyelitis).
(3) 14 months	Third dose (Triple & Poliomyelitis).
(4) 2 years	Measles.
(5) 2 years 1 month ..	Smallpox.
(6) 5 years	Diphtheria and Tetanus. Poliomyelitis — oral.
(7) Between 11 & 12 years	B.C.G. (Tuberculosis).
(8) At 15 years or ..	Poliomyelitis — oral. Tetanus. (Smallpox re-vaccination if necessary.)

Although in the early years of the immunisation campaigns by far the majority of the work fell on the medical staff of local authorities, general practitioners have in recent years taken an increasing part in this work, and the new arrangements between the practitioners and the Ministry for remuneration for the work, dating from 1st April, 1967, have accelerated this tendency. Indeed, so few mothers now apply to the Health Department for primary courses of immunisation that it is becoming increasingly uneconomic to arrange special sessions for this work, and an enquiry has been made of the Local Medical Committee as to whether the general practitioners may be willing to undertake the whole of this work.

Appendices A, B and C show, in the form submitted to the Department of Health and Social Security, details of the work done during

	Children born in 1967			Smallpox (Children under 2) (4)
	Whooping Cough (1)	Diphtheria (2)	Poliomyelitis (3)	
England and Wales	76	78	74	38
Westmorland ..	84	84	77	42

1968, whilst the Table on the preceding page, showing the percentages of children vaccinated against various diseases in Westmorland, together with comparable national figures, has been supplied by the Department.

The figures in columns (1) — (3) are calculated to show the percentage of children born in 1967 who have been vaccinated at any time.

Column 4 includes only children who were vaccinated during 1968 and were under 2 years old at the time, and is calculated as a percentage of children born during 1967.

Investigation of returns over a number of years indicates that by the time they attain the age of 5 years approximately 90% of the children in the County of Westmorland have received a primary course of protection against diphtheria, whooping cough, tetanus and poliomyelitis, and approximately 55% against smallpox.

APPENDIX A

SMALLPOX VACCINATION
Year Ended 31st December, 1968

Age at date of Vaccination	Number of Persons Vaccinated (or revaccinated during period)	
	Number vaccinated	Number revaccinated
0–3 months..	24	—
3–6 months..	19	—
6–9 months..	7	—
9–12 months..	18	—
1 year ..	402	—
2–4 years ..	144	8
5–15 years ..	28	42
TOTAL ..	642	50

APPENDIX B

TUBERCULIN TEST AND B.C.G. VACCINATION

Year Ended 31st December, 1968

Number of persons vaccinated through the Authority's approved arrangements under Section 28 of the National Health Service Act.

A. CONTACTS

(i) No. skin tested .. 43
(ii) No. found positive .. 13
(iii) No. found negative .. 30
(iv) No. vaccinated .. 40 (this includes infants vaccinated without previous testing).

B. SCHOOL CHILDREN AND STUDENTS

(i) No. skin tested .. 692
(ii) No. found positive .. 8
(iii) No. found negative .. 663
(iv) No. vaccinated .. 666

APPENDIX C

VACCINATION OF PERSONS UNDER AGE 16 COMPLETED DURING 1968

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

Type of vaccine or dose	Year of birth					Others under age 16	Total
	1968	1967	1966	1965	1961-64		
1. Quadruple DTPP..	—	—	—	—	—	—	—
2. Triple DTP ..	300	569	26	12	12	33	952
3. Diphtheria/Pertussis	—	—	—	—	—	—	—
4. Diphtheria/Tetanus	2	—	3	1	3	—	9
5. Diphtheria.. ..	—	—	—	—	—	—	—
6. Pertussis	—	—	—	—	—	—	—
7. Tetanus	1	—	—	—	3	26	30
8. Salk	—	—	—	—	—	—	—
9. Sabin	196	654	225	29	107	20	1231
10. Measles	12	233	245	211	564	13	1278
11. Lines 1+2+3+4+5 (Diphtheria) ..	302	569	29	13	15	33	961
12. Lines 1+2+3+6 (Whooping cough)	300	569	26	12	12	33	952
13. Lines 1+2+4+7 (Tetanus)	303	569	29	13	18	59	991
14. Lines 1+8+9 (Polio)	196	654	225	29	107	20	1231

Table 2—Reinforcing Doses—Number of persons under age 16

Type of vaccine or dose	Year of birth					Others under age 16	Total
	1968	1967	1966	1965	1961-64		
1. Quadruple DTPP..	—	—	—	—	—	—	—
2. Triple DTP ..	5	114	201	32	156	21	529
3. Diphtheria/Pertussis	—	—	—	—	—	—	—
4. Diphtheria/Tetanus	3	18	44	12	600	49	726
5. Diphtheria.. ..	—	1	—	—	—	—	1
6. Pertussis	—	—	—	—	—	—	—
7. Tetanus	—	—	5	5	26	113	149
8. Salk	—	—	—	—	—	—	—
9. Sabin	8	17	11	3	515	11	563
10. Measles	—	—	—	—	—	—	—
11. Lines 1+2+3+4+5 (Diphtheria) ..	8	133	245	44	756	70	1256
12. Lines 1+2+3+6 (Whooping cough)	5	114	201	32	156	21	529
13. Lines 1+2+4+7 (Tetanus)	8	132	250	49	782	183	1404
14. Lines 1+8+9 (Polio)	8	17	11	3	515	11	563

INFANT WELFARE CENTRES

The Local Health Authority provides 14 infant welfare centres, two of which are staffed by Health Visitors only, the remainder being attended by Local Health Authority Medical Officers. The clinics range in frequency from once weekly to once per month; Kendal is the only clinic which operates weekly, whilst two others operate fortnightly. The Local Health Authority provides no specialist's clinics; there are however ophthalmic, orthopaedic, paediatric and ear, nose and throat clinics run by the Regional Hospital Board to which mothers and children can have access. Owing to the scattered nature of the population many of the clinics tend to be small, but one feels that there is a definite need even for a small clinic. In Kendal, however, the numbers attending have risen to such an extent that additional sessions will probably be needed.

In addition to the arrangements outlined on the following pages for the distribution of Welfare Foods, the Local Health Authority has also made other dried milks and nutrients available at the Kendal Infant Welfare Centre, which acts as a mother centre to all the other clinics.

Details of Infant Welfare Centres in operation at the end of the year are given below:—

Area	Centre held at	Frequency of Sessions
Ambleside ..	British Legion Room ..	Monthly
Appleby ..	Old First Aid Post ..	Fortnightly
Bampton ..	Memorial Hall ..	Monthly
Bowness-on-W'mere	Rayrigg Room ..	,,
Burneside ..	Bryce Institute ..	,,
Endmoor ..	Working Men's Club ..	,,
Grasmere ..	Reading Room ..	,,
Kendal ..	Health Services Clinic ..	Weekly
Kirkby Lonsdale ..	Institute Hall ..	Monthly
Kirkby Stephen ..	Youth Centre ..	Fortnightly
Milnthorpe ..	Parish Church Hall ..	Monthly
Shap ..	Methodist Chapel Hall ..	,,
Staveley ..	Working Men's Institute	,,
Tebay ..	Methodist Chapel Hall ..	,,
Windermere ..	St. John Ambulance Rooms ..	,,

Once again thanks are due to the local branches of the British Red Cross Society, the St. John Organisation and all other voluntary workers, for their assistance in the running of the Centres.

Attendance at Centres

	1966.	1967.	1968.
Under 1 year	2,586	2,878	2,244
Over 1 year	6,576	6,655	6,274
Average per session	35.0	36.8	32.9

DISTRIBUTION OF WELFARE FOODS

The Council is responsible for the distribution to expectant and nursing mothers and children under 5 years, of Welfare Foods, previously a function of the local offices of the Ministry of Food.

A main centre for this work was established at the Kendal Clinic, and other subsidiary centres throughout the county; some at welfare centres, others at the homes of District Nurses, others run by the various voluntary associations, and others by local shopkeepers. To all who have taken a hand in this work, the thanks of the authority and of the mothers are due.

The annual distribution figures for Welfare Foods during the preceding 13 full years during which the Local Health Authority has been responsible for distribution are given in the following table:—

Year.	National Dried Milk. Tins.	Cod Liver Oil. Bottles.	Vitamin Tablets. Packets.	Orange Juice. Bottles.
1955 ...	34,430	8,858	3,089	38,822
1956 ...	33,108	7,676	3,251	40,079
1957 ...	25,768	7,198	3,502	41,824
1958 ...	20,894	4,301	2,924	24,875
1959 ...	20,202	4,218	3,420	26,212
1960 ...	18,117	4,271	3,404	24,017
1961 ...	14,990	2,894	2,706	15,564
1962 ...	15,423	1,263	1,761	10,513
1963 ...	14,595	1,108	1,679	12,204
1964 ...	13,135	1,092	1,634	12,966
1965 ...	12,585	1,129	1,630	13,330
1966 ...	9,156	1,017	1,692	13,447
1967 ...	8,350	913	1,564	13,958

The quantities distributed during 1968 were:—

Period.	National Dried Milk. Tins.	Cod Liver Oil. Bottles.	Vitamin Tablets. Packets.	Orange Juice. Bottles.
1st Quarter ...	2,254	218	410	3,342
2nd Quarter ...	2,164	166	291	3,760
3rd Quarter ...	1,682	169	255	3,670
4th Quarter ...	1,746	234	339	3,781
Total for Year ...	7,846	787	1,295	14,553

Increases in the price of National Dried Milk and Orange Juice and the imposition of charges for Vitamin Tablets and Cod Liver Oil would appear to be the reason for the noticeable fall in the quantities distributed from time to time.

Whilst a more varied and adequate diet is certainly available than was the case when these supplements were first issued during wartime, it has been generally accepted that they have contributed in no small measure to the health of the young children, and it remains to be seen whether the same high standard will be maintained without them.

In addition to the commodities referred to above, a fairly wide selection of proprietary infant foods and vitamin supplements is available at the Kendal Clinic for purchase at favourable rates. Foods to the value of £2,404 were disposed of during the 1968-9 financial year.

CHIROPODY

At the end of April, 1960, the approval of the Ministry was received to the Council's proposals to provide a Chiropody Service. The approved proposals are as follows:—

The Council will provide a chiropody service by utilising the services of qualified chiropodists or by aiding voluntary bodies willing to assist in the provision of the service.

Priority will be given to the elderly, physically handicapped and expectant mothers.

The services will initially be based on Kendal and will be extended as circumstances permit to the remainder of the County. The frequency of the service to be provided in any particular part of the County will depend on the demand for the service and the availability of qualified chiropodists.

Where possible use will be made of the Council's clinics, but use will also be made of other suitable premises, including chiropodists' own surgeries, and domiciliary visits will be paid where necessary.

Until July 1967, the work was carried out by a full-time chiropodist who undertook all surgery and domiciliary work in the Kendal, Lakes, and South Westmorland areas, whilst two part-time chiropodists dealt with the cases in the extreme north of the area. Due to the increasing demands on the service, a second full-time chiropodist was appointed on 1st August, 1967, and all the work under the Council's scheme has, since that date been undertaken by the two full-time officers. It is, however, apparent that the demands on the service are more than these two chiropodists can cope with, and authority has been given for the employment to a limited extent of part-time assistance.

The Ministry now requires the submission of statistics relating to chiropody treatment, and the following is a simplified version of the return for the year ended 31st December, 1968:—

Number of persons treated:—	
(i) Persons aged 65 and over ...	1,314
(ii) Expectant mothers	—
(iii) Others	9
	1,323
Number of treatments given:—	
(i) In clinics	3,465
(ii) In patients' homes	1,634
(iii) In old people's homes	797
(iv) In chiropodists' surgeries ...	—
	5,896

CERVICAL CYTOLOGY

The Health Committee first considered this matter early in 1965, at which stage the Ministry of Health were disposed to regard cytological screening as primarily a personal preventive technique for the family doctor, with local health authorities providing facilities only to the extent that such provision was necessary to complement the work of the general practitioners.

After consultation with the Regional Hospital Boards, Consultant Pathologists, and the Local Medical Committee it became apparent that because of limited facilities for examining these specimens at the pathological laboratories, it would be a better arrangement if the clinics were operated under the aegis of the Health Department, and an appropriate amendment of the Council's Proposals for carrying out the duties under the National Health Service Act was submitted to the Minister in July 1965.

Discussion of details with various interested persons and bodies, and the continuing shortage of qualified laboratory technicians delayed the introduction of the scheme until May 1966. When applications for the tests were first invited, the response, in relation to the limited capacity of the laboratories to examine the smears, was overwhelming, and from May to December 1966, 193 tests, all that the laboratory could accept, were carried out.

By the end of 1966 the laboratory was in a position to deal with up to 40 specimens per month and the waiting list was soon cleared, since when the response to repeated advertisement has been somewhat disappointing, a situation which has been commented on in many parts of the country. During 1968, 346 new patients were examined: 292 were normal, 24 required treatment for non-malignant conditions, 28 specimens were technically unsatisfactory, and 2 suspicious cases were reported.

All cases requiring further investigation or treatment are referred to the family doctor for treatment or reference to a consultant as he may consider necessary.

UNMARRIED MOTHERS AND THEIR CHILDREN

The Superintendent Nursing Officer is responsible for investigating and advising these cases, but it should be noted that by no means all unmarried expectant mothers come to her notice; some are dealt with entirely by the Diocesan Moral Welfare Workers, whilst in other cases the girl's family are able, and willing, to make all necessary arrangements for the confinement and subsequent care of the baby.

Births of Illegitimate Children notified	37
Confinements in:—	
Mother's own home	—
Helme Chase Maternity Home	25
Penrith Maternity Home	—
City Maternity Hospital, Carlisle	2
Other addresses	10
Disposal of Infants:—	
Mother keeping baby	24
Baby in care of aunt	1
Baby died	1
Left district	5
To foster parents	1
Adopted	2
Parents now married	3

Institutional accommodation for these cases is provided under arrangements made with the undermentioned voluntary homes:—

St. Monica's Maternity Home, Kendal

The Home possesses 21 maternity beds, and during the year 76 maternity cases were admitted, for 15 of whom the Westmorland County Council assumed financial responsibility.

In the case of this Home the apparently low number of admissions relative to the number of beds is largely explained by the fact that patients are admitted at least a month before confinement and retained for at least six weeks afterwards, so as to afford an opportunity for the making of arrangements for the care of the babies.

During the year the Sacred Heart Maternity Home, Brettargh Holt, Kendal, closed owing to falling demand for the services it provided, and it was with real regret that the Department severed its connection with the Sisters there, with whom relations had always been most cordial.

Cases are also sent to Mother and Baby Homes outside the County when these seem appropriate to the circumstances of particular cases, and in an increasing number of such cases the Diocesan Moral Welfare Workers are now recommending this.

CARE OF PREMATURE INFANTS

The following Table gives details of premature infants born to Westmorland mothers during 1968:—

Born in Hospital:	
Stillbirths	10
Live Births	47
Died within 24 hours of birth	4
Died between 1 and 7 days of birth	—
Survived 28 days	42
Born at Home or Nursing Home	
Stillbirths	—
Live Births nursed entirely at home or nursing home	—
Died within 24 hours of birth	—
Died between 1 and 7 days of birth	—
Survived 28 days	—
Live Births transferred to Hospital	3
Died within 24 hours of birth	—
Died between 1 and 7 days of birth	—
Survived 28 days	3

REGISTRATION OF NURSING HOMES
(Sections 187 to 194 of the Public Health Act, 1936)

There were three registered homes at the end of the year, providing beds for 21 maternity patients and 40 other patients. Two other homes surrendered their Certificates of Registration during the year. They have been inspected at regular intervals.

In August 1963, the Minister of Health made "The Conduct of Nursing Homes Regulations, 1963", which enable registration authorities to ensure that standards of accommodation, staffing, equipment and facilities generally are appropriate to the type of work done, and the kind of patients accommodated in the home. The authority is also enabled to prescribe the number of patients (both in total, and of any particular type) who may be kept in the home at any time.

These Regulations fill a long-felt need in the field of Nursing Homes Registration, as under the provisions of the Public Health Act, 1936, it was almost impossible to exert any form of control over a Nursing Home once it had been registered.

It is pleasing to be able to report that such changes as were felt to be necessary in the Nursing Homes registered by this Council were in general agreed with the proprietors without resorting to the formal procedure provided for in the Regulations.

The conditions of all the homes were generally satisfactory, and in some cases really excellent.

REGISTRATION OF DAY NURSERIES AND CHILD MINDERS

Under the Nurseries and Child Minders Regulation Act, 1948, the Local Health Authority was required to register, and empowered to supervise:—

(a) premises in their area, (referred to as Day Nurseries) other than premises wholly or mainly used as private dwellings, where children were received to be looked after for the day or a substantial part thereof, and

(b) persons, (referred to as Daily Minders) who for reward received into their own homes children under the age of five, to be looked after for the day or a substantial part thereof.

The Act did not apply to residential nurseries or to foster parents, nor was it an offence for a daily minder to receive into her home up to two children of whom she was not the relative, or more than two children from the same household.

The demand for registration of premises or persons was never heavy and apart from one daily minder, generally known in the locality as a "nursery school", though not recognised as such by the Department of Education and Science, who has been registered continuously since June, 1956, a further nursery was registered in 1965, a nursery (belonging to a local factory) and one daily minder, were registered in 1966, and one further nursery in 1967. One or two other persons applied for registration either of themselves or premises, but either did not proceed with their applications or relinquished their Certificates of Registration after very short periods.

About the latter part of 1967 however, considerable interest in day nurseries (usually described as "Play Groups" or Nursery Schools) became apparent and a further 5 nurseries and one child minder were registered during 1968.

Amendments to the Nurseries and Child Minders Regulation Act, 1948, enacted in the Health Services and Public Health Act, 1968, which became operative on 1st November, 1968, extended the scope of the original Act and strengthened local authorities' powers in the following directions:—

(a) a period of two hours in the day (or an aggregate of two hours), was substituted for "a substantial part of the day",

(b) the provision that an offence is committed by a daily minder only if she received more than two children from more than one household is deleted and an offence is now committed by any unregistered person who receives into her home for reward one or more children to whom she is not related,

(c) the maximum penalties for offences are increased to a fine of £50 for a first offence, and for a subsequent offence, to imprisonment for up to three months, a fine not exceeding £100, or both.

The authority is also enabled to refuse to register persons or premises because of the condition, situation, construction, or size of the premises, or the condition of the equipment thereof, or for reasons connected with other persons in the premises concerned. A statement is also required that no person to be employed, or who lives at the premises would be disqualified under the Children Act, 1958, from taking foster children without the consent of the local authority, or has had a child removed from her care under the Adoption Act, 1958.

When registering a person for the care of children in her own home the authority may determine the maximum number of children to be received, and make requirements concerning the number and qualifications of the persons who are to look after the children, the safety and maintenance of the premises and equipment, the feeding of the children and the keeping of records regarding them.

Power is also given to any person authorised by the authority to enter and inspect the home of any registered daily minder, the children received there and the arrangements made for them, including the records. Such a power previously existed only with regard to premises registered as a nursery, the only power of entry to a home being by virtue of a warrant obtained where admission had been refused and there was reason to believe that children were being received in contravention of the 1948 Act.

As a result of the increasing interest, to which reference was made earlier and of the publicity given to the new legislation, 7 nurseries and 6 daily minders have already been registered during 1969, and four other enquiries are pending at present.

When enquiries or applications for new registrations are received, in respect either of persons or premises, the County Medical Officer of Health investigates the matter in person, gives such advice as is necessary, and when, in his opinion, the circumstances so require, obtains the advice of the Fire Prevention Officer. The Council has authorised the Clerk of the Council to effect registration in any case in which a satisfactory report has been received from the County Medical Officer and in which the applicant has accepted any recommendation which he may have considered necessary.

The General Purposes Panel has been authorised to determine applications where unfavourable reports may be made, but this has not so far been necessary, as in the few cases where the County Medical Officer has not felt able, for any reason, to recommend registration, the applicant has either found alternative accommodation or has decided not to proceed with her application.

Follow-up inspections of registered premises or persons have in the past been made either by the Deputy County Medical Officer or an experienced Health Visitor, and it is intended that such visits should be made, without prior notice, at intervals of not more than 6 months, normally by a member of the Council's nursing staff.

DENTAL TREATMENT FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN

During 1968, 95 sessions were devoted to the treatment of mothers and young children. In addition, the equivalent of 10 sessions was devoted to discussions and talks with mothers attending baby clincs. This represents an increase in time devoted to these priority groups as compared with the previous year.

My thanks to the nursing staff, as always, for their continued help and co-operation in referring patients and for their constant dental health education of these priority groups by increasing their awareness, where necessary, of the advantages of regular dental attention.

M. D. McGARRY.

Part A. Attendances and Treatment

Number of Visits for Treatment during year

	Children 0-4 (incl.)	Expectant and Nursing Mothers
First Visit..	197	74
Subsequent Visits	82	123
Total Visits	279	187
Number of Additional Courses of Treatment other than the First Course commenced during year	39	7
Treatment provided during the year— Number of Fillings	247	292
Teeth Filled	234	256
Teeth Extracted	97	38
General Anaesthetics given	35	2
Emergency Visits by Patients ..	20	—
Patients X-rayed	2	13

	Children 0-4 (incl.)	Expectant and Nursing Mothers
Patients Treated by Scaling and/or Removal of Stains from the teeth (Prophylaxis)		36
Teeth Otherwise Conserved	69	
Teeth Root Filled		2
Inlays		2
Crowns		2
Number of Courses of Treatment completed during the Year	198	67

Part B. Prosthetics

Patients Supplied with F.U. or F.L. (First Time)	3
Patients Supplied with other Dentures	6
Number of Dentures Supplied ..	11

Part C. Anaesthetics

General Anaesthetics Administered by Dental Officers	37

Part D. Inspections

	Children 0-4 (incl.)	Expectant and Nursing Mothers
Number of Patients given First Inspections during year	A. 294	D. 80
Number of Patients in A and D above who required Treatment	B. 211	E. 77
Number of Patients in B and E above who were offered Treatment	C. 201	F. 77

Part E. Sessions

Number of Dental Officer Sessions (i.e. Equivalent Complete Half Days) devoted to Maternity and Child Welfare Patients:

For Treatment	G.	95
For Health Education	H.	10

M. D. McGARRY.

THE HOME HELP SERVICE

The Home Help Service is available to those in *need* of domestic help for such reasons as: old age, infirmity, confinement, physical disability, mental strain or disability, general illness, pre-operative and post-operative care, and for the care of young children during the absence of their mother.

Help is given on the recommendation of a doctor, midwife, health visitor, district nurse, medical social worker, mental health worker, welfare worker, etc. Any direct application from a prospective patient or unqualified person is carefully checked and help is only given if the Organiser is satisfied there is a real need. If the Organiser is doubtful she seeks the advice of the family doctor.

Prospective patients are visited before help is arranged. The question of charges is discussed and settled as far as possible. Payment for the service is made at the full cost rate of 7/- per hour or alternatively an assessment form is completed and the patient is charged on an income and expenditure basis. If the head of the family is in employment the assessment is based on his gross pay plus family allowances and any other income. If the patient is retired, income from all sources is taken into account, capital assets being dealt with in the manner laid down by the Ministry of Social Security Act. The following scale of allowances is used when determining the charge.

Basic Expenditure (Normal Requirements)

	£ s. d.
Husband and Wife	6 13 0
For person living alone who is a householder	4 1 0
For Dependants	
Over 21	3 9 0
Over 18 — under 21	2 15 0
Over 16 — under 18	2 7 0
Over 11 — under 16	1 15 0
Over 5 — under 11	1 8 0
Under 5	1 3 6
Rent and Rates	Actual
Hire Purchase Payments when in respect of necessary household furniture	Actual
Resident Home Help	1 13 6
Income	
Lodgers	1 5 6
Sons and Daughters (not dependants):	
Over 21	1 5 6
Under 21	14 0

The value of capital assets is assessed according to the prevailing market prices and the assumed income from the capital is calculated on the following basis:—

(a) The first £325 is disregarded.
(b) For every £25 from £325 to £825 a weekly income of 1/- is assumed.
(c) For every £25 above £825 a weekly income of 2/6d. is assumed.

e.g.: Capital of £600 produces an assumed weekly income of 12/-.
Capital of £800 produces an assumed weekly income of 20/-.
Capital of £1,000 produces an assumed weekly income of 40/-.
Capital of £2,000 produces an assumed weekly income of 140/-.

The higher assumed income on capital in excess of £825 is based on the assumption that part of the capital can be regarded as available for normal living expenses. In these calculations the value of an owner-occupied house is disregarded entirely.

Patients in receipt of the basic retirement pension or this plus an allowance from the Ministry of Social Security pay the minimum charge of 5/- per week.

Occasionally, there is a special case for which the assessment charge would be too heavy. Under these circumstances, the Medical Officer of Health has authority to make a special reduction in the charge.

The amount of help given is determined by the Organiser but this has to be based to a large extent on what is available, and it is not always the ideal amount. Although the amount of help given is kept to a minimum it has to be sufficient to ensure that the Home Help is able to do an efficient and satisfactory job. If the need for help is temporary, it is withdrawn gradually as the need decreases. It is recognised that many people, largely retirement pensioners, will need help for the remainder of their lives if they are to remain in their own homes. There are people receiving help now who have been on the books since 1951, 1954 and 1956. Maternity cases have help for one, two or three weeks, depending on home circumstances, or longer if the doctor recommends it. Long-term patients are visited periodically by the Organiser to see that the arrangements are working satisfactorily, but these visits are somewhat infrequent owing to lack of time.

The total number of people receiving help in 1968 was 426, made up as follows:—

Over 65	...	357
Chronic Sick	...	25
Maternity	...	15
Mentally Ill	...	4
Others	...	25

There are at present (July 1969) 57 Home Helps employed: that is 42 part-time helpers and 15 casual workers. These numbers are lower

than they should be. There is a severe shortage of staff in the Lakes and South Westmorland.

A part-time Home Help may undertake to work any number of hours each week up to forty; beyond this counts as overtime. The time worked is decided between the Organiser and the employee at the time of enrolment. This sort of work is physically and mentally exhausting and it has been found that the helper should decide for herself how much work she is able to cope with in addition to her home responsibilties. Casual workers are employed for a particular case, usually in an isolated area or for a case requiring special care and attention. This type of worker usually terminates her employment when the particular case finishes unless other suitable work has become available in the meantime. All Home Helps are paid at the rate at present of 5/2d. per hour and have their travelling expenses reimbursed. Part-time helpers receive holiday pay (amount depending on length of service) and also qualify for sick pay. Casual workers do not enjoy these benefits.

A Home Help is expected to carry out all household duties as required, such as cleaning, cooking, washing, mending, shopping and caring for young children when necessary. They are told they should not undertake heavy spring cleaning, but they are expected to do a thorough job of work. Part-time Home Helps receive a weekly instruction sheet from the Organiser. This tells the helper which households to visit, at what time of day and how long to stay. At the same time the patients receive notes telling them when to expect help. A helper working all day may visit as many as four houses each day, depending on the type of work on hand. If the Organiser has any special instruction on a particular case this is given to the helper either verbally or with her written instructions, but in most cases the actual work done has to be settled between the Home Help and her patient. She plans her work according to what she finds on arrival; some patients will co-operate, others give no assistance whatsoever. Only in very exceptional circumstances is a Home Help sent into a house whilst the patient is absent, but this may be done in order to prepare a house for a return from hospital if there are no relatives or friends to do the work.

If the service is asked to undertake the cleaning of a very dirty and neglected home it is usual for two Home Helps to do this work together, under the direct supervision of the Organiser. This sort of work is best done in the patient's absence and the Committee has agreed that helpers doing this work shall be paid an extra 10/- per day whilst the worst of the work is done to compensate for having to labour in such unpleasant conditions. Not many women will tackle such work so the task usually falls on the same few willing people. In the course of her working week the Home Help completes a time-sheet. This gives details of the patients she has helped and the

number of hours of help given. Each patient signs the time-sheet to indicate the work has been satisfactorily done. The time-sheets are sent to the County Hall at the end of each week and, after being checked are passed to the County Treasurer for payment. All Home Helps are paid weekly by cheque.

General supervision of the helpers by the Organiser is limited by the very nature of the work, but in addition to spot-checks visits are made to the patients when the Home Help is not present and to the helpers in their own homes after working hours so that work problems may be freely discussed with the Organiser and difficulties smoothed out. Complaints from patients have to be dealt with very carefully; sometimes they turn out to be completely unjustified and stem from nothing more than a clash of personalities. If the complaint is justified and the trouble continues after a fair warning the helper has to be dismissed. This does not happen often.

The recruitment of suitable workers is becoming increasingly difficult. Various methods are used — straightforward newspaper advertising does not always produce the best results. Sometimes a card displayed in the village shop or an enquiry from the District Nurse will bring the right person forward. The Organiser gives talks on the Service to such bodies as the Women's Institute and Mothers' Union, and in addition to awakening interest in our work this makes the public more aware of our difficulties. Most Home Helps are aged between forty and sixty. Such women have often brought up a family and are well experienced in the difficulties they are likely to encounter in their work. However, other age-groups produce good workers and our present staff varies in age from 21 to not far short of 70 years. In 1968, a Home Help retired who had given the County Council eighteen years' unbroken service. This is a very worthy record in view of the difficulties experienced in this type of work. Recently a Home Help collapsed and died shortly after finishing work one day, and the comments made by shocked patients and others in the neighbourhood have shown how much the Home Helps as a whole are esteemed in the community.

Generally speaking, the work is planned on a weekly basis. Towards the end of each week fresh time-tables are planned for the helpers according to the work on hand, and all instructions are despatched by Friday's post. As far as possible, a Home Help cares for the same patients regularly, but this is not always possible as the work changes to such a degree. Changes are naturally unpopular, except where there is a clash between patient and helper. Emergency requests for help are accommodated as quickly as possible, but there sometimes has to be a waiting-list for routine cases. This unhappy state of affairs is becoming more common as it becomes increasingly difficult to recruit staff.

In a rural county such as Westmorland, the actual location of the

work often provides a major headache. The rural bus services are poor and it is often impossible to plan the work on hand within the framework of the bus time-table. On the other hand, it is difficult to obtain local labour in small villages, especially if the work is of a temporary nature or if the person in need of help is not well liked locally. However, suitable local labour is enrolled when available and where regular work is expected in order to keep travelling expenses and time to a minimum. A Home Help is paid travelling time in excess of half an hour a day in addition to her bus fares. There are some areas where it is virtually impossible to recruit workers of a sufficiently high standard. These areas include all the Lakes, Burneside, Underbarrow and Crosthwaite, Burton, Arnside, Kirkby Lonsdale, and some of the small rural communities in North Westmorland.

It must be remembered that the work fluctuates in both quantity and location so that it is important the labour force be as mobile and adaptable as possible. There is a nucleus of Home Helps living in such centres as Kendal, Windermere, Kirkby Stephen and Milnthorpe. These helpers work in their own district but travel by public transport if help is needed in areas where local help is not available. For example, a Milnthorpe helper may work in Arnside three days a week, Milnthorpe one day, and spend the remaining day in Burton. A week or two later the pattern of her time-table may be quite different according to the present need.

In order to cope with areas not covered in the usual way, six Home Helps are paid a mileage allowance in order that they may use their own cars for work. The cars are only used where public transport is non-existent or unsuitable, and these Home Helps are not paid travelling time. The following districts are covered in this manner:—

Mrs. A., Kaber, Kirkby Stephen.

At present working in Kirkby Stephen, Winton and Crosby Garrett.

Will cover isolated areas up to the borders with County Durham and Yorkshire, Hartley, Musgrave, Soulby, etc. Relief work in Brough when necessary.

Mrs. L., Kirkby Stephen.

At present working in Ravenstonedale (isolated farm), Kirkby Stephen and Warcop.

Will cover country south of Kirkby Stephen to the Yorkshire border, west towards Tebay and Orton, and areas north west of Kirkby Stephen when not covered by Mrs. A. Also occasional relief work in Tebay.

Mrs. H., Endmoor.

At present working in Kirkby Lonsdale and transporting a second Home Help who works in the Kirkby Lonsdale area too.

Will cover country between Endmoor and Kirkby Lonsdale. Also Casterton and district.

Mrs. M., Holme.

At present working in Burton, Holme and Beetham, but claims only for journeys to Beetham.

Will cover isolated places in the Burton-Holme area.

Mrs. W., Kirkby Thore. Two miles from the village.

At present working in Kirkby Thore and Temple Sowerby.

Will cover outlying areas up to the Northern Fells.

Mrs. C., Troutbeck Park, Windermere.

At present helping two patients in Langdale. She has a small daughter who is left with a relative whilst she is at work, and it is hoped she may tackle more work in the Grasmere/Ambleside area when her child starts school. (At present another Home Help travels by bus from Windermere to Ambleside and Grasmere. The Grasmere journey takes 45 minutes in each direction from door to door when the roads are quiet. This does not include walking time between jobs in one district.)

It is realised that this is a very expensive method of providing help in some areas, but it does appear to be the only way of ensuring that help is given. If such transport were not available there would be many districts where requests for help would have to be refused owing to the scattered nature of the population and the infrequency or total absence of public transport.

It should be said in conclusion that Westmorland is more fortunate than many authorities in the type of worker it has been able to recruit. Many councils have found it necessary to introduce expensive training schemes in order to maintain a sufficiently high standard of work. It would appear, therefore, that although Westmorland has to spend more on transport, money is saved in other directions.

Tables I and II below, extracted from the Annual Statistical Returns to the Department of Health and Social Security, show the cases of the last five years.

Statistical and Financial

TABLE I

Home Help Service — No. of Cases

	Aged 65 years and over	Chronic Sick and tuber-culous	Mentally Dis-ordered	Maternity	Others	Total
1968	357	25	4	15	25	426
1967	330	32	4	22	27	415
1966	302	48	5	22	18	395
1965	291	38	3	37	33	402
1964	269	42	3	29	34	377
1959	234	2	—	53	51	340

TABLE II

Home Helps Employed

	No. employed Part Time	Whole-Time Equivalent
1968	56	23.2
1967	64	27.2
1966	57	25.0
1965	59	29.0
1964	63	27.1
1959	53	25.0

In Table I it should be noted that the figures for 1959 other than the total are not strictly comparable with those for more recent years, as the definitions have been changed — e.g. the figures in the column "Aged 65 years and over" for 1959 include the chronic sick above and below 65 years.

With this proviso, it will be seen that the old persons form by far the majority of patients helped, and that this figure and the total number of cases has risen steadily. Viewed in conjunction with Table II however, it is apparent that the total amount of help supplied, as measured by the Whole-time equivalent of the number of Home Helps employed, has fluctuated, but was during 1968 less than it had been 10 years earlier and appreciably less than it was in 1965.

Table III below is compiled from the Local Health Services Statistics published annually by the Society of County Treasurers, and reveals the fact, frequently commented upon in the past, that the expenditure on the Home Help Service in Westmorland expressed per 1,000 population, is usually less than half the average for the English Counties, whilst the cost per case is also noticeably below the national average. The inference to be drawn from the two sets of figures is that a smaller proportion of the population of Westmorland receives help than is the case in other counties and also that less help is given on average to those who do receive it.

TABLE III

Home Help Service

	Cost per 1,000 population		Cost per Case	
	Westmorland	English Counties	Westmorland	English Counties
	£ s.	£ s.	£ s.	£ s.
1967/8	167 6	343 8	39 18	47 12
1966/7	143 0	300 0	37 17	44 0
1965/6	145 0	272 17	35 12	41 10
1964/5	133 1	242 12	35 5	37 13
1963/4	109 6	225 18	28 17	35 17

The reason for this state of affairs is almost entirely the difficulty of obtaining additional suitable workers; as stated above, advertisement and personal approach have been tried, but neither the work nor the rate of pay are attractive to many women in an area where unemployment is at a very low level. What certainly is *not* the reason is unwillingness on the part of the Council to make available the necessary finance; frequently the Council has provided money in the Health Committee's Estimates to meet an anticipated increase in demand, which has not been spent. In fact, in the 1968/69 Financial Year, although the economic situation forced the Finance Committee to withhold sanction to a proposed increase of £1,000, the amount authorised, £14,150, was underspent by £1,500, despite the fact that a wage increase of 5% had been operative for 7 months of the year, i.e. an additional £1,900 could have been spent, representing 147 hours of help per week, or an increase of nearly 20%. Broadly stated the average help given per patient could have been increased from $3\frac{3}{4}$ to $4\frac{1}{2}$ hours per week, or an additional 40 patients could have been assisted.

A further reason, accounting for some of the difference, is the fact that again, owing to the economic position, the minimum charge of 5/- per week, at an estimated cost of £2,000, could not be withdrawn, as was hoped. This would, of course, have brought the net cost per 1,000 nearer to the national figures by almost £30.

It should perhaps be observed that, although administration costs are excluded from the cost statistics in Table III, administration of the Home Help Service is probably one of the most relatively costly branches of the Health Committee's functions. Not only is the supervision of the workers and allocation of their services a time-consuming job, but the checking of time-sheets, allocation of the time to individual patients for recharging purposes, recording of the charges due, rendering accounts, receiving payments, assessing and re-assessing charges due, involve an enormous amount of the time of the staff of the Health and Treasurer's Department, relative to the cost of the actual useful work done for the patients, despite every effort to reduce paper-work to absolute essentials.

MIDWIVES' ACT

Total number of Midwives practising at the end of the year		50
District Nurse Midwives		33
Midwives in Institutions:—		
(a) Helme Chase Maternity Home	10	
(b) St. Monica's Maternity Home, Kendal	7	
	—	17

Midwives' Notification Forms received during 1968 were as follows:—

Sending for Medical Aid	1
Stillbirth and death	10
Having laid out a dead body	—
Liability to be a source of infection	—

CARE OF BLIND PERSONS

Under the National Assistance Act, 1948, the County Council no longer has the power to give financial assistance to blind persons, but it is required to "make arrangements for promoting the welfare" not only of blind persons but also of the partially-sighted. Administrative responsibility for this work devolves upon the Council's Social Welfare Department, but the County Medical Officer is responsible for advising the Committee on "all matters relating to health or medical services arising in connection with the Council's functions under the Act . . . including, in particular, arrangements for the medical examination of applicants for registration as blind persons."

I am indebted to the County Welfare Officer for his kind permission to reproduce the following report which he presented to the Council's Welfare Committee.

REPORT UPON THE COUNCIL'S SERVICES FOR THE BLIND

As with most social welfare services of real value, the service to the blind began with voluntary help, probably as far back as the year 1260 when a charitable hospital for blind soldiers was set up in Paris, but it has long been recognised that the welfare of the blind is the concern of the community and should not be left wholly to voluntary organisations. The present development of the community service was initiated in 1914 when a resolution was unanimously moved in the House of Commons that the then "system of voluntary effort in aid of the blind did not adequately meet their necessities and that the State should make provision whereby capable blind people might be made industrially self-supporting and the incapable and infirm maintained in a proper and humane manner". Whilst it took time for the spirit of this resolution to be carried into effect, the wording could ably describe the purpose of the present service.

Over the years it has been recognised that the blind are not, or should not be, beings apart, and from being subject to separate legislation — e.g., the Blind Persons Act, 1920 — the blind are now included in the welfare services provided under National Assistance Act, 1948, which embraces not only the blind but also the deaf and persons otherwise handicapped. At the same time, the development of a specialised service over the years has not been lost to the blind, the help to them has been widened. The aim is to provide a service which will keep the blind as members of the community, as independent as possible and provide them with such means, financial and otherwise, as will contribute to this end. The scheme which the Council was required to make under the National Assistance Act, 1948, is such as to do this. A report upon the number of blind, the services being rendered to them and social factors affecting them follows:—

Definition of Blindness.—Comment is sometimes made upon the amount of sight apparently possessed by some persons registered as blind, and it is useful to know the statutory definition of "blindness" which is

> "so blind as to be unable to perform any work for which eyesight is essential."

This definition relates to any work and not merely the person's former occupation. Only visual conditions are taken into account and other infirmities are disregarded in reaching the decision.

Registration.—This is voluntary and the number registered depends upon the efficiency of the registration arrangements and the willing-

ness of the subject to be registered. Whilst figures for children are reasonably reliable, since certificates and registration are usually linked with education, figures of blindness among the elderly may not be so accurate.

Requests for examination reach the Department from Medical Practitioners, Ministry of Social Security offices, the Council's own welfare officers and other lay sources.

Examination and certification is by Consultant Opthalmologists of National Health Service Hospitals or private Consultants practising in the area, to whom the requests are referred by the County Medical Officer of Health.

Number of Blind and Age Groups.—The number on the Council's register at the 1st April, 1969, was 156, compared with 97 at the same period of 1948, the percentage of blind for the population is comparable to the national figure and the increased number does not necessarily suggest an increase in the incidence of blindness. In the past many elderly people with failing sight accepted this as the ordinary hazard of age and, with little knowledge of the services available to them, made no effort to register. With an increasing knowledge of treatment of blindness, the improvement in welfare services and allowances and a wider publicity of these services, more elderly people are willing to register and the increase shown is due in large measure to this rather than to an increase in the incidence of blindness, a factor which is shown by the following age groups:—

Blind

Age Groups	1–4	5–10	11–15	16–20	21–29	30–39	40–49	50–59	60–64	65–69	70–79	80–84	85–89	90 +	total
Males	1	1	1	—	2	3	2	6	7	6	6	7	5	4	51
Females	1	—	—	3	2	2	4	4	10	6	32	13	19	9	105
	2	1	1	3	4	5	6	10	17	12	38	20	24	13	156
1948 figures		—		1		4	6		16	11		59			97

Location.—The blind persons are located in the following areas:—

	Males.	Females.	Total.
Kendal Borough	22	41	63
South Westmorland Rural District Council	11	27	38
Windermere Urban District Council	4	17	21
Lakes Urban District Council ...	6	7	13
Appleby Borough	1	3	4
North Westmorland Rural District Council	7	10	17
	51	105	156

Marital Status.—Of the 149 persons 21 years of age and upwards:—

	Single.	Married.	Widowed.	Total.
Males ...	9	27	12	48
Females ...	32	18	51	101
	41	45	63	149

There are 3 married couples in which both husband and wife are registered blind, one of these couples with a child, aged 5 months (not blind).

Other Disabilities.—31 registered persons have other disabilities in addition to blindness:—

4 males and 15 females suffer with noticeable loss of hearing.
1 male is totally deaf, but has speech.
1 female is almost totally deaf, with defective speech.
2 males are diabetic.
2 males and 2 females in the lower age groups have a mental disability, one of the females (aged 18) also being a spastic.
2 females have a post-haemoplegic condition, one being without speech.
1 female has noticeable arthritis.
1 female wears a caliper because of a leg ailment.

Residential Condition.	Males.	Females.	Total.
1. Living Alone	2	27	29
2. With relatives	38	57	95
3. Private Lodgings	—	1	1
4. Private Old People's Home ...	1	1	2
5. Local Authority Homes ...	3	13	16
6. In Hospital—General and Geriatric	2	2	4
Mental	2	3	5
7. Schools	1	1	2
8. Training	—	1	1
9. Workshops	1	—	1
	50	106	156

Household Help.—Of the 2 men living alone, one man has home help from the local authority, and the other has private help from neighbours.

Of the 27 women living alone, 10 have home help from the local authority, 4 have private help, and 13 manage with the help of relatives or friends.

14 other blind persons have home-help assistance from the local authority and 16 privately arranged help.

The welfare officers for the blind are satisfied all cases are adequately covered although one woman with sight and hearing difficulties living alone presents special problems because of a refusal to accept other accommodation and temperamental difficulties which are difficult to contend with. Frequent visits are made and the help of neighbours is given in calling assistance when required. The assistance of the Deaf Welfare service is also invoked in this case.

Housing.—On the whole the blind are reasonably housed, either alone or with relatives, and are almost equally divided between houses which are rented and those which are owner occupied.

The welfare officers for the blind feel that 6 blind persons could have better conditions — 3 in houses which are small for the family as a whole, 1 which is inconvenient for a woman living alone who is not desirous of moving, 1 which is considered to have dampness, and 1 in which the ground floor of the house only is occupied.

These cases are being watched with the view of help when this can be arranged.

Education, Training and Employment

The object of the service is to see that children are properly educated, the employable are rehabilitated, trained and placed in employment, the unemployable and elderly properly cared for.

Children.—Of the 4 children under 15:—

1 has mental disability and in a hospital for the subnormal.

1, blind due to an accident, is in a Sunshine Home of the Royal National Institute for the Blind and will shortly be transferred to an educational school for the blind.

1, aged 4, is still resident with the mother and grandparents.

1 is attending a residential school for the blind, returning home for holiday periods.

Employable Group.—The age group 16-60 years represents those normally capable and available for training and employment, and particular attention is paid to this group. In addition to the Local Authority Services, the Ministry of Employment and Productivity are concerned with the training and employment of the blind and have appointed Placement Officers for the special purpose.

In the case of children about to leave school, these officers arrange interviews and obtain reports to assess the potential, consider the child's wishes and either place the child in employment or arrange a period of assessment at a special Centre and, if necessary, a further period of training for employment.

In the case of other employable adults, industrial and/or social re-habilitation is arranged, followed by training or placement in employment.

In seeking employment the endeavour is always to make a blind person as independent as possible, and according to ability to place them in

"Open Industry".—i.e. in normal employment alongside and in competition with sighted workers. Light engineering and, more recently, computer operating are two good outlets of this sort.

Where a blind person is not of an ability to compete in open industry, then efforts are made to place him in

"Sheltered Employment".—i.e. in an establishment such as a workshop for the blind where he can be employed and paid to his working capacity, with an augmentation of his earnings to a reasonable level. Such an establishment is the Cumberland and Westmorland Workshop for the Blind at Carlisle.

Some blind persons not capable or able to take work in open industry or sheltered workshop may still be capable of self-employment in their own home and, where a suitable occupation and a capable person is available employment may be arranged at home — examples of this are work as braille copyists, machine knitter and poultry keepers. As with "sheltered" workers earnings may be augmented.

The employment position of the 16/60 group in the area is:—

	Male.	Female.
Open Industry.		
School Teacher	1	—
Physiotherapist	1	—
Boot and Shoe Operative	2	—
Capstan Lathe Operator	1	—
Deburrer (Engineering Works)	1	—
Roadman	1	—
Sheltered Workshops.		
Brush Maker	1	—
Home Workers.		
Braille Copyist	—	1
Braille Proof Reader	1	—
Stocking Knitter	—	1
Poultry Keeper	1	—

Of the 16 persons in this group not in employment, 11 are women represented by 6 housewives not available for employment, 2 single women formerly in employment and no longer capable or available, and 3 single women with disabilities precluding employment.

The remaining 5 in the group are men, including:—

1 with progressive illness.
1 awaiting result of eye operation.
1 completing period of industrial rehabilitation.

1 who has completed industrial rehabilitation but does not wish to take employment away from the area. This man has a "Breakdown" superannuation allowance from his previous employer and has no financial difficulty. He occupies himself with craft work at home and at the organised class.

1 man, formerly a piano tuner, light engineering employee (during war years) and latterly a Braille Copyist, gave up his last employment because of periods of illness, and inability to continue recognised output.

Blind not capable or available for employment.—For those not available or capable for employment, the majority of whom are in the higher age groups, the need is for assurance and adjustment, security and a sense of still belonging. This is the work of the welfare officers for the blind, who visit, assess needs, social or otherwise and, either themselves or through other services, see that the need is satisfied. Every endeavour is made to see blind persons at least once in each month, with extra visits as necessary to those needing more supervision.

Instruction and Recreation.—Adequate group instruction and recreation presents difficulties because of the scattered nature of the County and a none too easy transport problem. However, a weekly meeting for craft instruction and recreation is held in Kendal, organised by the Welfare Officer for the Blind (Mrs. Stoves). An average of 10 attend the meeting from Kendal, Staveley, Burneside, Arnside, Appleby and Askham.

A social gathering is held in Kendal monthly, organised by the Welfare Officer for the Blind (Miss Pearson), and an average of 25 blind persons with their friends attend.

An annual holiday of one week — which for the past few years has been to Blackpool — is arranged and attended by a welfare officer for the blind, but, with individual holidays now being available and taken, the numbers attending the group holiday is decreasing and on the last occasion was only 16 blind persons plus guides. The group holiday is valuable to those who for one reason or another would not get a holiday otherwise, and the number attending is no indication of the value of the holiday.

Financial Circumstances.—Whilst many blind persons on the register, alone or with relatives, are financially secure due to employment or other means, 58 persons have recourse to supplementary benefits or pensions. Benefits for blind persons from the Ministry of Social Security include an addition because of blindness. The welfare officers for the blind are, however, satisfied that adequate financial provision is available in all cases and, should this occasionally not be so, take action to remedy the position, either through statutory or voluntary services.

Braille and other Reading Aids.—Reading and communication are matters of great importance to the blind and two methods are Braille — a system of dots which require delicacy of touch — and Moon, a system which requires less delicacy of touch and less concentration. Blind children at school and persons attending training and rehabilitation courses receive some tuition in these systems, and for others the welfare officers for the blind can and do offer instruction.

Thirteen men and 15 women on the Register are recorded as having a knowledge of Braille and 1 man and 1 woman as having a knowledge of Moon, it is problematic as to how many of these persons make regular and adequate use of the knowledge. Four other blind people are at present receiving instruction in Braille from the welfare officers for the blind.

Not all, even among the younger blind, become proficient in Braille or Moon reading and writing, some because of an inability to read by touch, some because of the effort of concentration and some merely from inclination, and there appears to be a larger desire for reading and recreation provided by the Talking Book Machine available from the Nuffield Talking Book Library for the Blind at a rental of £3 per annum per machine. The rent of these machines is met by the Local Authority, and, starting from none in 1957, 48 machines are now in use.

Aids for the Blind.—Aids to living are a very important matter to the blind and, both through the Local Authority and the Voluntary Organisations, these aids are provided, chiefly on the recommendation of the welfare officers:—

Aids include:

Radios.	Through the generosity of the British Wireless for the Blind Fund sufficient radios are available to supply all persons on the Register. Blind persons are exempt from the payment of radio licences.
Walking Sticks and Walking Canes.	It is of interest to know of the development of the long cane which is being sponsored by the Royal National Institute for the Blind. Special training is required in this special technique and the Local Authority has already sent one blind person on a special course of training.
	Braille clocks and watches.
	Kitchen and household aids — Measuring aids, specially marked cookers.
	Sewing machine.
	Braille copying machines and typewriters.

Careful note is taken of new aids and the information is brought to the notice of the blind, but there would seem to be much scope yet for the use of gadgetry and aids to living which would make life easier for the blind.

Partially Sighted

In 1948, on the suggestion of the Central Authority, an additional Register of persons, not registerable as blind but who are substantially and permanently handicapped by congenitally defective vision, was set up and the welfare services provided for the blind are applicable to persons on this Register.

At the 1st April, 1969, there were 20 persons on the Register in the following age groups:—

	0-15	16-20	21-49	50-64	65+
Males ...	1	1	1	1	5
Females ...	—	1	1	3	7

The child under 15 is attending a residential school.

Of the 16-20 age group, consideration was given to the placement of the boy in sheltered employment conditions, but his father, the surviving parent with whom he lives, supported his wish not to leave home and he is now employed in the warehouse of a local supermarket and appears to be doing reasonably well at present, but this case needs supervision as problems of home conditions and employment may arise in the foreseeable future.

The girl in this group has mental disability and lives at home with her parents. She attends the Centre for the mentally handicapped and the Craft Class for the Blind.

In the 21-49 years group, the man is in sheltered employment at the Cumberland and Westmorland Workshops for the Blind, and the woman has a mental disability which makes her not capable and available for employment.

The services of the welfare officers for the blind are available to all these persons, and it is ensured that social service benefits are known to them.

Staff

The staff consists of two Welfare Officers for the Blind, both holding the Home Teachers' qualification. The case load is more or less equally divided which, with the Register of Partially Sighted Persons, is approximately 88 persons each; compared with a recognised case load of 100 persons in a rural area. Some consideration is given to the travelling distances in the county, but the staff is adequate to deal with the work involved.

The role of the welfare officer has changed over the past few years

and the part of "home-teaching" as such is now much smaller than in the past. More social welfare work is necessary and this is the field in which the officers are now giving the greatest service.

Voluntary Organisations

No report upon services for the blind in the area would be complete without mention of the work of the voluntary organisation. Prior to 1957, both the statutory and the voluntary service for the blind in Westmorland was undertaken on an agency basis by the (now) Barrow and South Cumberland Society for the Blind. In that year, the County Council undertook a direct service for the blind and Barrow withdrew the voluntary service. The Westmorland Voluntary Society for the Blind was then formed for the purpose of supplementing the statutory services to the blind and partially sighted and to promote their well-being. Much excellent work has been done by the Society who, in addition to contributing to the Royal National Institute for the Blind to assist national services, has provided monetary grants, assistance towards holidays, special equipment of all kinds — e.g., clocks, watches, aids to living, grants towards recreational facilities and general support not available from other sources.

Relations between the Voluntary Society and the Local Authority are excellent and helpful. Secretarial assistance is given by the Welfare Department staff to the Society and the help of the Society to the blind is also help to the Council's service.

General

The number of blind and partially sighted in the area and the staff of Welfare Officers for the Blind is such that a personal service can be given and, whilst the role of the welfare officers as instructors in methods of communication and craft instruction has reduced, due to the higher age groups of the blind, they have become more general and skilled social workers with particular knowledge of the problems of the blind, giving a service which is adequate and acceptable to them, overcoming difficulties such as those created by a scattered population and the need for an almost wholly domiciliary service.

There does appear to be a need for a Centre of their own, which would be available to the blind for purposes of recreation and possible instruction in aids to living and other aids to a normal life, in the areas of population, and it is hoped that when the County Council's programme for the Multi-purpose clinic at Appleby and a Multi-purpose centre at Kendal is effected, this need can be met.

T. ASPINALL,
County Welfare Officer.

MENTAL HEALTH

The following is a copy of a report on the Mental Health Service of the County submitted to the Health Committee.

In this, the first general review of the Mental Health Service provided in the County, it may be appropriate to refer to the Proposals made by the Council in February 1960, and approved by the Minister in May 1960, for the provision of these services, having regard to the changes brought about by the Mental Health Act, 1959.

The services which the Council then proposed to provide fall broadly under 5 heads.

(i) *Training Centres.*—The Council here undertook to provide a Centre in Kendal "for about 30 patients" indicating that should the numbers able and willing to use such accommodation require it, additional Centres should be provided in Kendal or elsewhere, and that it would, if necessary, make arrangements with other local authorities or voluntary bodies to accommodate patients unable to attend the Council's own Centre.

In place of the part-time Centre previously held in hired premises, the Council did, in fact, provide a new purpose-built Centre to accommodate 50 persons, which was eventually occupied at Easter, 1966. This Centre, originally intended to accommodate 30 Juniors and 20 Seniors, at present has on its Register 18 Juniors (including Nursery Group) and 24 Seniors. The Capital Cost of the Sandgate Centre, including equipment, was £37,904.

Whilst the Centre was in course of construction the Health Committee decided that a Special Care Unit, to deal with children more severely handicapped than those normally attending a Training Centre, was needed. Every effort was made to expedite the project, but although Loan Sanction was secured, and a starting date of 1st March, 1967, with a contract period of five months agreed, it was not until January 1968 that the premises were fit for occupation, and final work has not yet (May 1968) been completed. This Unit is designed to accommodate 12 children in two rooms — one for the non-ambulant and one for the hyperactive types, and has at present 6 patients in attendance.

The staffing of the Centre at present is as follows:—

Supervisor	1
Assistant Supervisor — Qualified ...	1
Assistant Supervisor — Unqualified ...	4
General Assistants	2
Caretaker	1

The estimated running costs for the year 1968/9 are £19,311 of which the major items are:—

Staff	...	...	...	£7,301
Meals	...	...	...	£1,000
Transport	...	...	...	£4,200
Debt Charges		...	...	£3,800
Establishment Expenses			...	£1,285

The cost per attendance during 1966/7, as given in the "Local Health Service Statistics" published by the Society of County Treasurers, was 45/- compared with the average of 31/3d. for English Counties and 38/11d. for Welsh Counties. This Westmorland figure can be expected to shew an increase in 1968/9, when the costs of the new premises will make their full impact for the first time.

The very considerable proportion of the cost attributable to transport of itself, and by the attention it draws to the long journeys made by a considerable number of patients, may indicate the need to consider carefully whether, either on financial or health grounds, a limit has to be placed on the distance which it is felt proper to convey patients of various ages to the Centre.

To relieve the pressure on the Senior accommodation in the Centre and to extend the facilities available for the adults, the Committee had included in its building programme the proposal to provide an Adult Work Centre in 1969/70, but the Minister has indicated that Loan Sanction for this project is unlikely to be forthcoming, at least until after 1970/71.

(ii) *Residential Accommodation.*—The Council at present provides no such accommodation, but its proposals indicated that it would, "if sufficient need is found to exist", provide such accommodation "Primarily for patients suffering from subnormality or severe subnormality", so situated as to enable the residents to attend the Training Centre or to work, either in ordinary or sheltered employment.

It was further proposed, that in appropriate cases, the Council should, instead of providing hostel accommodation provide for the boarding-out of patients, and that it should, either directly or otherwise, provide residential accommodation for persons recovering from mental illness.

The Health Committee decided to include a Hostel for 24 persons in its Building Programme for 1970/71 at an Estimated Cost of £31,850. In view of the Minister's notification of the inclusion of the project in the list for which he hopes to recommend loan sanction in that year, it will now be necessary for the Committee to decide the functions of the hostel, and to secure the approval of the Finance Committee, and the Council to the proposal and the necessary Capital Estimate. The latest edition of "Local Authority Building Notes", issued by the Ministry, would appear to indicate that a Capital Cost

of something of the order of £41,000, plus fees, and furnishings may be involved, but until the scope of the Hostel is determined by the Committee there has not seemed any point in asking the County Architect for a revised Estimate.

A detailed report on the present need for a Hostel is under consideration by the Mental Health Panel.

(iii) *Home Training.*—The Council proposed to provide "home-group teaching by suitably qualified staff for patients who will benefit by such teaching", indicating that such services may be provided by home teachers employed in other services of the Council. The Council's Welfare Committee propose to employ a Craft Instructor if the services of a suitable person can be obtained, and in that event the Health Committee may consider investigating the possibility of sharing the services of such Instructor, depending on the work load which the Welfare Department may find among its own patients.

(iv) *Home Visiting.*—Since the 1st February, 1967, the Council has employed two full-time Mental Welfare Officers on whom rests the main responsibility for the visiting of both mentally subnormal and mentally ill persons — in the case of both categories, maintaining close contact with general practitioners and any psychiatrist who may be treating a particular case. Their duties also involve the arranging of admission to hospital where this is necessary — either on a voluntary basis, or using one of the several compulsory procedures provided in the Mental Health Act, 1959, and in fact they provide the main connecting link between the various branches of the service. The duties of these officers are indeed manifold, and in addition to their statutory duties as defined in the Act they are called upon to act as guide, philosopher and friend to patients and relatives alike in matters concerning not only their illness in the narrow sense, but also its effects on their financial, matrimonial, family and almost every other affair. The demands made on their patience and ingenuity defy adequate description, and the statistical tables given at the end of this Report give but little idea of the problems with which they are daily called upon to wrestle.

(v) *Guardianship.*—Provision is made in the Mental Health Act, 1959, for placing mentally disordered persons under the guardianship either of the Local Health Authority or of any suitable person willing to act as guardian. The general effect of such action is to confer on the guardian, to the exclusion of any other person, all the powers normally exercisable by the father of a child under the age of fourteen years.

This provision now has very limited practical value, in fact it must be in the region of fifteen years since the last Westmorland case under Guardianship was discharged by the old Board of Control.

As far as can at present be foreseen the most probable practical use of this provision would be in order to secure the residence in a hostel of a patient for whom this were considered the proper course, but in whose case either the patient or his relatives were unwilling to agree to his doing so. In such a case it would appear possible to place the person under the guardianship either of the authority itself, or of the warden of the hostel, the guardian then being in a position to determine the patient's place of residence. Two medical certificates in support of the application would be required, in the same way as if he were being compulsorily admitted to hospital.

Staff

The staff concerned with the Mental Health Services consists of:—

Dr. I. S. Bailey, Deputy County Medical Officer.
2 Mental Welfare Officers.
Staff of Training Centre.

Ascertainment

A function undertaken under Education Act, 1944, Dr. Bailey's functions in this respect are almost entirely confined to the Ascertainment of children, who are reported by parents, school teachers, Education Adviser, Family Doctors, etc., as being below average intelligence or unable by reason of mental defect to take advantage of school teaching. Then it becomes the statutory duty of the Department under the Education Act to examine such a child with a view to deciding, on the basis of intelligence tests, teachers' and parents' reports on the most suitable education, for any particular child. In practice, wherever possible, every child in Westmorland is given a trial at school. During the past year:—

Total number of children examined	...	42
Number found ineducable ...	...	5
Number educationally subnormal	...	37

The object of ascertainment is to determine whether or not a child is able to profit by education in an ordinary school. Other forms of Ascertainment are in connection with the other various categories of handicapped children which do not concern this Committee.

Mental Welfare Officers

There are two Mental Welfare Officers giving a ratio of 1 to 34,000 population which is about the average for the country:—

Mr. Holloway, Certificate of Social Science, University of Southampton.
Mr. Matthews, S.R.N., M.R.N.

The functions of the Mental Welfare Officers may be summarised:—

1. To convey persons of unsound mind to hospital when necessary.
2. To have a knowledge of all Mental Subnormals within the community.
3. To have a knowledge of certain Mentally ill within the community.
4. To liaise with Employment Officer in finding work for patients.
5. To oversee welfare of patients, especially those at work.
6. To provide various links between Hospital, Family Doctor, Training Centre, and Local Authority Clinics.
7. Home visiting.

Originally the main if not sole duty was that of Category I, and Mental Welfare Officers were known as Duly Authorised Officers. This function, due to changed and improved medical treatment is almost extinct, and the work could be summed up as Medico Social.

It is hoped that the provision of a work centre may provide for a better progression. Subnormals are admitted as children, progress to Juniors and later Seniors, and lastly work centre. The provision of a work centre and hostel should make the provision of services for the Mentally Disordered as complete as is compatible with present-day ideas. Although the Services for Mentally Disordered are in a state of constant development at the moment, no-one can say that we have reached the end of development.

General Comments

Dealing with the trends that can be foreseen in this Service, first of all, the responsibility for the Mental Welfare Service may be possibly changed from the Health to the Education Committee. In a statement, Mr. Cashban, the Lecturer in the Education of Handicapped Children, Manchester University, says, "In spite of some delays, it now seems certain the Government will announce, before the end of the current Parliamentary Session, that the responsibility for the education of severely subnormal children is to be transferred from the Ministry of Health to the Department of Education and Science." This is a rather revoluntionary change, and we do not know just quite what is going to happen. Unless the complete Service is taken over by the Education Committee, it will mean that while the Centre is run by the Education Department, the Mental Welfare Officers will have to be managed by the Health Department, and it will mean that matters are rather complicated and that half the Service is in one Department, and the other half in another. We must just wait and see what is going to happen.

With regard to trends in treatment and conditions of mental deficiency, Medical knowledge is increasing in this sphere, although slowly. Mental deficiency due to faulty metabolism, in other words to the production of phenylketonuria, is now partially understood, and the diagnosis and treatment of this condition are improving. Unfortunately, this accounts for only a very small number of mental defectives, but nevertheless it is a start. Similarly, other causes due to meningitis, encephalitis and so on are better understood, and treatment, it is hoped, will prevent mental deficiency arising from these causes. You know that perhaps the earliest condition to be recognised was cretinism which was prevalent particularly in Switzerland, and other limestone areas, where mental deficiency was due to lack of thyroid, the internal gland secretion, and considerable improvement in the condition of many cretins was due to the administration of this drug. Another type of mental deficiency has been found, due to blood of mother and child before the child is born being incompatible, with the result that after birth the child's blood undergoes changes, with the result that mental deficiency often results. The cure of course here is to perform an exchange transfusion of blood, and this is fairly generally done. At the moment I am only aware of one case in Westmorland where this has arisen, but there will undoubtedly be others from time to time. Laboratory diagnosis of mongols and sex linked diseases has made strides recently.

In Westmorland, the future of Training Centres, I think, must centre in Kendal. The numbers of mental defectives, in other words, mental disordered, are few and far between in the north of the County, and to establish another Training Centre elsewhere would hardly be warranted on the numbers that are available. It might be possible to consider sharing with Cumberland, if they do develop another Training Centre in Penrith, so that journeys which are inevitable when the Centre is in Kendal could be avoided or lessened. The use of Special Care Units is now fairly general, the idea here being to relieve parents of the burden of looking after two categories of children which have formed an intolerable burden to the unfortunate parents. One category is the very severely subnormal child who can neither appreciate the difference between day and night, never speaks, has to be fed and all daily wants carefully attended to. Cases of this sort often prove an intolerable burden on the parents and it often happens that father and mother cannot go out to enjoy themselves, to the pictures or for any other recreational purpose, and often are unable to take holidays together. The provision of Special Care Units for this type of child, although they are few in Westmorland, is proving a great blessing. The other type of special care child is the hyperactive child who is always in a state of perpetual activity, who does not understand obedience, probably never speaks, and here again continual oversight of the child's daily needs is necessary. We provide

for both these categories in the present Training Centre, and while all the places have not yet been filled at the moment, a considerable relief is being given to the parents of the 6 children who are in this category at the moment. It is likely that one additional trained member of staff will be required here. The future of workshops will undoubtedly be bound up with what happens as a result of Parliamentary decision on the authority to be responsible for caring for the Training Centre. If Training Centres go to the Education Department, then the question of workshops will probably come up afresh when this takes place.

In Westmorland, hitherto, there has been a fairly low criterion of ineducability. In other words, a child in perhaps another county might be assigned to a Training Centre, where in Westmorland he would be given a chance at Special School for the Educationally Subnormal. It is possible that a number of pupils who have been allowed to go to Educationally Subnormal Schools might be better in a Training Centre. If this were so there would undoubtedly be a higher category of pupils attending a Training Centre and, consequently, the ability to perform more complicated and difficult work. At the present in the Training Centre, the level of intelligence is fairly low, and, consequently, the type of work that these pupils can be put on to is rather of a simple repetitive kind, and this of course will be reflected on the amount and type of work which could be undertaken in Workshops. It would seem to me that the future of Workshops for the mentally subnormal is not altogether clear. For this reason, that should unemployment rise any further, it would mean that the use of normal individuals for doing work being done by mental subnormals is likely to cause trouble, and it may be that those subnormals who have been trained in Workshops have no further work to do, permanently or temporarily. The matter of inducement payment for work done in the Centres is a new venture and is coming to the fore. So far the subnormals in the Training Centre in Kendal, that is to say in the Senior section, are concerned, a small subcontract has been obtained for the packing of combs and this has been done with enthusiasm and with profit. It is likely that this avenue of work will be explored wherever possible, but the situation of employment is not altogether happy at the moment and it is possible that no further work of this sort is open in the meantime. In general, in Westmorland, we are fairly fortunate with regard to the employment of subnormals. The Mental Welfare Officers have been fairly successful in placing many of the subnormals, who are capable of doing work, on farms, industry and particularly domestics in schools, institutions, hospitals and above all, hotels. Unlike some Boroughs where employment is more difficult, this has been a fairly fortunate part of the service hitherto. The training of Instructors for Centres is also coming much to the fore. Hitherto very few Instructors for Training Centres

have undergone courses or obtained certificates or diplomas. With the exception of the Supervisor, Mrs. Stanley, for our Centre in Sandylands, and one other, none of the other teachers have had instruction or hold diplomas in this subject, and this is becoming quite a national matter. There is obviously need for courses to be given so that a better quality of instructions can be given to the pupils. This may fall within the scope of the Local Government Training Board Scheme.

AMBULANCE SERVICE

The following is an edited copy of a Joint Report by the County Medical Officer and Chief Ambulance Officer presented to the Health Committee.

This Report covers not only the Annual Report to the Health Committee on the Ambulance Service, required under the new constitution of the Committee, but also the report on the visit made to the County by the Minister's Ambulance Adviser, arising out of the death in the ambulance of a patient on 6th February, 1968, when allegations of delay and the inability of the ambulance crew to administer oxygen were made.

Under the N.H.S. Act, 1946, it is the duty of the County Council as Local Health Authority to provide "ambulances and other means of transport, 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".

The N.H.S. (Amendment) Act, 1949, makes provision for the recovery, in certain circumstances, of the cost of returning to their home area, of patients on their discharge from hospital in the area of another authority, whilst the N.H.S. (Amendment) Act, 1957, provides for the hiring of ambulances by local authorities for the conveyance of persons not eligible for such transport under the Principal Act.

In formulating their proposals for carrying out these functions, the Council, in 1947, decided that the stretcher carrying vehicles should operate under the control of the Chief Fire Officer who was also appointed Chief Ambulance Officer, and who should be responsible to the Committee for the day to day operation of the service. It was further decided that the Hospital Car Service, hitherto operated under the agency of the British Red Cross Society should continue to be used for the conveyance of sitting cases, and that long-distance journeys should, where appropriate, be made by rail — the Hospital Car and Railway Transport arrangements falling under the direct control of the County Medical Officer of Health, to whom the Chief

Ambulance Officer was to be generally responsible. Whether this divided control of the service would have been adopted had the rapid and continuing expansion of the service been foreseen is perhaps open to doubt. The extent of this unforeseen increase in demand for sitting case transport, in particular, is perhaps best illustrated by the fact that the Estimates for the period 1st July, 1948 to 31st March, 1949, included the figure of £75 for this service; by 1967/8 the actual expenditure had risen to £16,867!

Table I shews, in summary form, the comparative figures for 1949, the first full year of the service, and 1967.

TABLE I

		No. of Journeys	*No. of Patients*	*Accident & Emergency Calls*	*Mileage*
Ambulances	1949	1,788	1,842	185	75,406
	1967	3,372	4,555	576	107,290
Sitting Case Cars	1949	2,128	2,579	25	94,512
	1967	13,600	35,801	140	445,306

(Table II giving details of the work done by the Ambulances in 1967 is not reproduced).

The Ambulance Service is provided in Kendal by full-time employees, under the direct control of the Chief Ambulance Officer, and there are outlying stations at Ambleside, Appleby and Kirkby Stephen where the service is operated by part-time personnel as follows:—

Kendal. 9 whole-time driver/attendants — 4 ambulances + 1 Reserve.

Kendal Station is manned from 0800 hours to 1700 hours. After 1700 hours one driver is "on-call" at home until 0800 hours the following morning. If an emergency call is received the "on-call" driver and one other whole-time driver are alerted by telephone. They then proceed to the Station and respond to the call. When a non-urgent removal is ordered the "on-call" driver reports to the Station and then proceeds to the home of a St. John Ambulance Brigade member who acts as attendant.

Ambleside. Part-time for emergency calls only, manning by Mr. C. Otway, Ambleside. 1 ambulance.

Appleby. Part-time 24-hour service, handles all calls, manning by Spooner's Garage, Appleby. 1 ambulance.

Kirkby Stephen.	Part-time 24-hour service, handles all calls, manning by Hook Bros., Kirkby Stephen.	1 ambulance.

Premises

Kendal.	New Station, September 1967.
Ambleside.	The ambulance is garaged at Bell's Garage, Ambleside. The vehicle is garaged in very crowded conditions at present, but a new building is under construction and the position should then be much improved, although still not ideal as the yard is often blocked by parked cars.
Appleby.	The ambulance is garaged at Spooner's Garage, and again conditions are not ideal due to the number of vehicles in and around the garage.
Kirkby Stephen.	The ambulance is garaged at Hook Bros. in good conditions.
Brough.	Approval for the building of an Ambulance Station at Brough to replace the Appleby and Kirkby Stephen Stations has been obtained from the Ministry. The proposal is for a joint site with the Highways Department and a Compulsory Purchase Order is required for some property on the site, this is being dealt with at the moment.

Communications

All ambulance calls for the South Westmorland area are received and dealt with by the Kendal Fire Control.

In North Westmorland, calls are routed directly to either Kirkby Stephen or Appleby, dependent on the telephone areas. Calls from the parishes covered by Cumberland County Council are routed to Penrith.

At a very early stage the British Red Cross Society found the arranging of the increasing volume of Sitting Case Car work beyond them, and for many years this service has been controlled directly from the Health Department. Although the greater part of the work is still carried out by volunteer drivers, it has, almost from the "appointed day", been necessary to supplement their services by the use of taxis and private hire cars; at present 45 voluntary drivers and 33 taxis and hire-car proprietors have made themselves available for the service.

Arising out of criticisms of the Ambulance Service made to the Minister, the Minister's Ambulance Adviser visited the county on 7th and 8th May, 1968, and his report, received on 2nd August, 1968, makes comments and suggestions on various aspects of the Service under the following headings:—

Control Room Procedure (paragraphs 2-4).

The suggestion that calls which do not result in the dispatch of an ambulance should be recorded was put into operation immediately after the Adviser's visit, and every effort is made to obtain accurate information as to the degree of urgency in each case.

Sudden Illness at Home (paragraphs 5 and 6).

In these cases where the recommended procedure on the receipt of a call from a relative is to advise him to call a doctor, arrangements have been made to have an ambulance available for immediate dispatch should the doctor eventually request one. At night this means that the stand-by driver is called to the station.

Training of Control Staff (paragraphs 7 and 8).

Regular training of control room staff is recommended. This matter is adequately covered in respect of the regular day-time control room assistant, but is practicable to only a limited extent with the night-time staff, who are firemen allocated to this duty in turn. Control room instructions have been drawn up to deal with all foreseeable circumstances, but in view of the infrequency with which any one man is likely to be on this duty, little more can be done at present.

Ambulance Equipment (paragraphs 9 and 10).

The Adviser expresses himself as satisfied with the arrangements made for checking of the equipment of the vehicles, subject to regular briefing and spot-checks and inspections. (It will be remembered that the inability of the driver to find the key to the oxygen cylinder was one of the main complaints made to the Ministry.)

Appleby Ambulance (paragraphs 11 and 12).

On a separate complaint to the Minister about the Appleby Ambulance (882 SPH) the Adviser considers the vehicle sound and well maintained, and points out that from the aspect of comfort of patients there is little to choose between different types of vehicles available during recent years. He points out the importance in this respect of driving standards.

Kendal Staff Duty Rota (paragraphs 13 and 14).

A review of the rota, to reduce the numbers available at week-ends, where there are no out-patient clinics is suggested, and is in hand. The suggestion of "more technical supervision" of the staff could be met only by relieving the foreman driver of more of his driving duties,

or by the appointment of a full-time Ambulance Officer. The appointment of an Ambulance Station Officer was one of the points raised by the Union, in the recent dispute, in the following terms: "In Kendal there should be an Ambulance Station Officer who would remain on the Station; such an individual would have an overall picture of the work of the ambulances, could allocate the work efficiently because of this, and might also have charge of the Hospital Car Service. This would be preferable to the existing control by a foreman driver who is often away from the station on calls."

Supplementary Service (paragraphs 16-18).

The use of the Hospital Car Service in appropriate cases is acknowledged to be efficient and economical provided care is taken that cases requiring ambulances do "not have to manage as best they can" in private cars, that watch is kept to avoid excess demands made by doctors and hospitals, and that their use is co-ordinated with the service as a whole. These points have been continually in mind and changes from ambulance to car or vice-versa are made whenever this appears necessary.

Ambulance Attendants (paragraph 19).

Instructions have already been issued to meet the suggestion that the ambulance attendant must always travel with the patient in the rear compartment.

Operational Control (paragraphs 20 and 21).

The divided control arrangements (i.e. ambulances from Fire Station, cars from Health Department), it is suggested, must lead to overlapping and complications. Complications, in view of the fact that all concerned are familiar with the set-up, are infrequent and never serious, and whilst some degree of overlapping does undoubtedly occur, it appears on consideration that the elimination of this is unavoidable as long as voluntary cars and taxis are used for sitting-cases.

All calls for Sitting Case Cars are received and dealt with in the Health Department except for urgent calls at week-ends and Bank Holidays which are dealt with by the Fire and Ambulance Service Control Room.

All ambulance calls for the South Westmorland area are received and dealt with by the Kendal Control Room, and at the moment the Appleby and Kirkby Stephen personnel receive and deal with all calls in North Westmorland other than the area covered by Cumberland.

Kendal Control is manned from 0900-1800 hours Monday to Friday by a disabled man, who through experience has achieved a high standard of proficiency. At nights and week-ends the Control is manned by on duty firemen who work on a rota which brings them on control

AMBULANCE SERVICE

1st January—31st December, 1968

CALLS		Patients Carried								
Station	No.	Infectious	Accidents	Maternity	Others	Total Patients	Patient Carrying Journeys	Abortive and Service Journeys	Total Journeys	Mileage
Kendal ..	*5+1	12	435	197	2764	3408	2794	90	2884	73578
Ambleside ..	1	1	95	6	82	184	160	6	166	5776
Appleby ..	1	1	58	33	162	254	219	8	227	14618
K.Stephen ..	1	—	38	22	107	167	145	6	151	11897
	9	14	626	258	3115	4013	3318	110	3428	105869
1967 ..	7	5	576	271	3703	4555	3248	124	3372	107290
1966 ..	7	12	612	298	3495	4417	3140	112	3252	104070

Average miles per journey:—

	1968	1967	1966
Kendal	25.51	27.35	26.81
Ambleside	34.8	35.87	38.54
Appleby	64.4	62.44	66.19
Kirkby Stephen	78.79	74.00	77.01

1968	1967	1966
30.88	31.82	32.00

On behalf of the other Authorities 49 journeys were carried out with a mileage of 1,751.

*One awaiting disposal

duties about once a fortnight. There are obvious deficiencies in manning a control in this way and the possibility of errors is difficult to eliminate.

Radio is fitted to the Kendal ambulances only, but arrangements are in hand for Appleby to be equipped.

The manning of the Control Room by specialist personnel for 24 hours each day, rather than using operational firemen, with all calls routed into Kendal, is attractive but this would require 5 full-time men at a cost of £5,075 per annum, less saving on Fire Brigade personnel of £1,000 and Health Department staff of £1,000, i.e. £2,975 net. All vehicles should be equipped with radio.

Agency Services (paragraphs 22 and 23).

The arrangements at Appleby, Ambleside and Kirkby Stephen are described as "a last ditch, pre-1948, method of meeting ambulance responsibilities", and some criticism of the congested access to the garage at Ambleside is made. On the other hand the Adviser, in particular at Kirkby Stephen, "was impressed with the enthusiasm and knowledge of some of the personnel concerned".

The proposed new Station at Brough will of course deal with the situation as far as Appleby and Kirkby Stephen are concerned. The Ambleside arrangements deals purely with emergency calls to which it can respond more quickly than the Kendal Station, and as stated above, the position will be improved when the new garage is completed.

Development

Night-Cover (paragraph 24).

The Report suggests that at least one ambulance in Kendal should be manned for 24 hours a day, that out of normal day hours a second crew should be on stand-by, and that the stand-by crew should be called in if the first ambulance is despatched on anything other than local duty.

Existing arrangements.

The whole-time staff man the Station from 0800 hours to 1700 hours after which one man is "on-call" at home and responds to all calls. Personnel are provided with telephones and if an emergency occurs the man "on-call" is contacted and immediately proceeds to the Station, in this circumstance a second off-duty ambulance man is brought in to act as attendant. The personnel who are on-call receive a fee of 1/- per hour (with enhanced rates at week-ends and Bank Holidays) and normally one other man agrees to be available at home for which he receives no fee. The Control Room is informed each evening which of the personnel are available. If the call appears to be non-emergency a member of the St. John Ambulance Brigade acts as attendant. In this case the "on-call" driver picks up the attendant

from home, and there is no means of pre-warning the St. John personnel. The Council pays the St. John Ambulance Brigade £100 per annum for this service and the Brigade sends a list of volunteers each week, which indicates who will be available on any particular night.

The use of St. John personnel inevitably leads to some delay, and it also leaves either the Control Room operator or the duty driver with the decision as to what should be classed as an emergency. The use of these volunteers dates back to pre-1948 days, but by 1968 standards it is doubtful whether such a system can be considered efficient.

Incidence of calls after 1700 hours.

October and November 1967.	Total number of calls	60
	Calls received after 2359 hours	12
December and January 1967/8.	Total number of calls.	77
	Calls received after 2359 hours	16
February 1968.	Total number of calls	38
	Calls received after 2359 hours	9

Cover for 16 hours.

If the Station were manned for sixteen hours each day all but approximately 20% of the night-calls would receive immediate response, but it should be remembered that calls after midnight are invariably true emergencies.

Eleven men would be required to maintain a cover of six men from 0800 hours to 1600 hours and two men from 1600 hours to 2359 hours. The period from 2359 hours to 0800 hours could then be covered by placing the two evening duty men "on-call" until 0800 hours.

To implement a duty system covering 16 hours per day, the establishment would have to be increased by two whole-time men, but some savings would be made by a reduction in the overtime worked at present. (Net increase in cost £1,440.)

Cover for 24 hours.

To provide an operational cover of six men from 0800 hours-1600 hours, two men from 1600 hours-2359 hours, and two men from 2359 hours-0800 hours, a minimum of fourteen drivers would be required. This, plus reducing the day-time cover by 2 men on Saturday and Sunday would barely make sufficient allowances for sickness, annual leave and Bank Holiday leave. (Net increase in cost £4,490.)

Observations

1. The use of Volunteers after 1800 hours is not the most efficient method of manning ambulances.

2. Recent complaints and events indicate that some extension of the hours of immediate availability of ambulances would be desirable.
3. A large section of the M6 motorway will be covered by Kendal machines, and, owing to the distances involved, an immediate turn-out over a 24-hour period will be an important factor.
4. The Committee will, in the light of the Minister's Adviser's report, need to decide whether to provide:—
   (a) as at present, 8-hour full cover;
   (b) 16-hour cover at an increased cost of approximately £1,440 per annum;
   (c) 24-hour cover at an increased cost of approximately £4,490 per annum.

In deciding on either (b) or (c) it must be borne in mind that the additional cover will benefit the south of the county only, although the proposals for the Brough Station will provide a somewhat lower standard of availability for the remainder.

A further point which cannot be disregarded is the effect on the present full-time personnel of a reduction in their overtime and rest-day working which will reduce their earnings. This could result in the loss of some of the present personnel, and may narrow the field for recruitment of the additional men which would be needed.

New Station at Brough (paragraph 25).

The Adviser suggests that one ambulance should be manned for 16 hours per day, another for 8 hours, with one crew on stand-by outside normal day hours. The report to the Committee when they approved this project was based on manning two vehicles for 8 hours, and a stand-by crew for the remainder, and with an annual average of 350 journeys it is difficult to see the justification on financial grounds for anything more.

Despite the clear advantage of unifying control systems, the following points must not be lost sight of.

If an ambulance is to carry a stretcher case and several sitting cases to out-patient departments it will obviously be detained there for longer periods, thus depleting the vehicles available for accident and emergency calls. Repeated, prearranged, journeys, with the same patients are already co-ordinated so that the fullest use is made of the ambulance. Sitting-case car journeys, using volunteers and taxis, must as far as possible be arranged late on the day before the journey is required (again co-ordinated so as to make the fullest use of each car, having regard to the location and destination of the patients). If such car journeys, having been arranged, were repeatedly cancelled because it was subsequently found that an ambulance needed to travel in the same direction, it would inevitably result in a reluctance on

the part of many of the car drivers to continue to hold themselves available for this work.

Nevertheless, an investigation is taking place with regard to long-term cases to ensure that any co-ordination of stretcher and sitting case transport which can be done, without creating bigger problems than it solves, is done.

A further approach to the hospitals in the south of the county requesting them to have regard to economy in the use of ambulances and sitting cars, in the planning of clinics, admissions and discharges, and for the earliest possible notification of transport requests may be worth-while, though earlier requests have done little, due no doubt to the fact that each ward and department of the hospital works independently.

Special difficulties (paragraphs 27-31).

The difficulties and problems referred to have been very obvious, both to the staff concerned in running both branches of the service, and also to the Committee, during the past twenty years, and the fact that the opening of that part of the M6 passing through the county will pose new, though not necessarily greater, problems which will need consideration has also been noted at both levels. It is, however, a matter of some doubt whether the Adviser appreciated that, in fact, so far as Westmorland County Council is concerned at least, the service has been planned having regard to neighbouring authorities' needs, e.g., the Westmorland Service deals with three parishes to the west of Lake Windermere on behalf of Lancashire County Council which has no station conveniently situated to do so, whilst Cumberland County Council from its Penrith Station serves fourteen parishes in North Westmorland and also the Patterdale Ward. No doubt further consideration of the problem will be necessary with Cumberland and Lancashire County Councils before the M6 is open to determine sectors of operational responsibility on the motorway, having regard to the access points and location and strength of ambulance stations in each authority's area.

Vehicle Replacement Policy

This matter is not dealt with in the report of the Minister's Adviser, but is, nevertheless, one to which it is felt desirable to direct the attention of the Committee.

All areas of Westmorland are such that ambulances have to cover long distances and therefore have a high mileage annually. In the the past the replacement policy has varied somewhat and often replacement has been on an alternate year basis. This has made for high maintenance expenses and resulted in three of the vehicles in 1966/7 having covered well over 100,000 miles. The standard vehicle used

at present is the B.M.C. L.D.5, for which works reconditioned engines are no longer available.

It may be necessary to change from the standard L.D. vehicle in the future, but this depends upon changes made by B.M.C. Replacement policy should be at least on the basis of one machine per year and, in the case of Kendal, consideration should be given to replacement on something like a five-year life or when 80,000-100,000 miles have been covered.

Consideration should also be given to the possibility of eventually providing a vehicle whose primary function would be the attendance of motorway accidents. The vehicle would have to carry two stretchers, but should be capable of maintaining high speeds over long distances without sustaining undue engine wear.

N. W. G. LANGLEY,
Chief Ambulance Officer.

JOHN A. GUY,
County Medical Officer.

TUBERCULOSIS

The Tuberculosis work in the County is now divided between the Manchester and Newcastle upon Tyne Regional Hospital Boards, the former being responsible for Kendal Borough, Windermere Urban District, Lakes Urban District and South Westmorland Rural District, whilst the latter is responsible for Appleby Borough and North Westmorland Rural District.

The co-ordination of the prevention and treatment aspects of the tuberculosis problem is secured through the arrangements made by the Local Health Authority under which the Consultant Chest Physicians employed by the Manchester and Newcastle upon Tyne Regional Hospital Boards act as the Council's Tuberculosis Officers for the parts of the County falling under their jurisdiction for diagnostic and treatment purposes. The Chest Physicians give general directions to the work of the Tuberculosis Visitors.

The County Council has also agreed to accept financial responsibility for cases where admission to a rehabilitation colony or village settlement is recommended by the Tuberculosis Officers, but it is many years since this was found necessary.

Since 1949 B.C.G. vaccination has been available under arrangements with, and on the advice of, the Chest Physicians to contacts who appeared particularly susceptible to the disease, and during 1968 43 contacts were tested, of whom 13 were found positive. Forty contacts were vaccinated. This latter figure includes a number of newborn infants vaccinated without any preliminary skin test.

Since the Spring of 1955 B.C.G. Vaccination has been available to schoolchildren between their thirteenth and fourteenth birthdays in accordance with the suggestions of Ministry of Health Circular 22/53, and from May 1959 this was extended to all young persons in attendance at schools or other educational establishments.

The following Table gives details of the work done under the scheme during 1968:—

Number Skin Tested.	Found Positive.	Vaccinated.
692	8	666

A significant feature of this work is the almost uninterrupted fall in the number of children showing a positive reaction to the test (indicating that they have previously been exposed to infection) since the commencement of the scheme, as shown in the following Table:—

Year.		Percentage of children found positive.
1955	...	34
1956	...	25.6
1957	...	27.6
1958	...	20.8
1959	...	14.3
1960	...	15.6
1961	...	10.7
1962	...	7.8
1963	...	7.9
1964	...	4.6
1965	...	4.1
1966	...	3.4
1967	...	3.6
1968	...	1.2

TUBERCULOSIS

In the following Table are the figures for the notifications of, and death from Tuberculosis in 1968:—

Age Periods	New Cases				Deaths			
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory	
	M.	F.	M.	F.	M.	F.	M.	F.
Under 1	—	—	—	—	—	—	—	—
1	—	—	—	—	—	—	—	—
5	—	—	—	—	—	—	—	—
15	—	2	—	—	—	—	—	—
25	—	—	—	—	—	—	—	—
35	—	—	—	—	—	—	—	—
45	3	—	—	—	—	—	—	—
55	—	—	—	—	—	—	—	—
65	1	—	—	—	—	—	—	—
75	1	—	—	1	—	—	—	—
1968	5	2	—	1	—	—	—	—
1967	1	2	—	—	1	2	—	—

TUBERCULOSIS AND OTHER CHEST DISEASES
NORTH WESTMORLAND

There has been a very gratifying decrease in both the number of new cases of pulmonary tuberculosis discovered during 1968 and in the number of new cases of bronchial carcinoma. The former have dropped from 38 in 1967 to 19 in 1968, and the latter from 76 in 1967 to 57 in 1968. These are the total figures covering the City of Carlisle, the Eastern Division of the County of Cumberland, and North Westmorland.

Tuberculosis

Table 1 shows the total number of new cases of pulmonary tuberculosis for England and Wales, and for the three areas of East Cumberland, the City of Carlisle, and North Westmorland, for 1968 and the previous five years:—

TABLE 1

Year	England and Wales	East Cumberland	Carlisle City	North Westmorland
1963	16,355	18	19	—
1964	15,026	25	14	3
1965	13,552	14	20	—
1966	12,461	11	20	4
1967	11,029	23	13	2
1968	10,707	6	12	1

The number of chest beds available during 1968 with the number of patients discharged during the years 1967 and 1968 are shown in Table 2:—

TABLE 2

Hospital	Beds available	No. discharged in 1968	No. discharged in 1967
Ward 18, Cumberland Infirmary	13	239	263
Blencathra Hospital	11	29	43
Longtown Hospital..	26	134	135

The number of notified cases of tuberculosis on the Chest Centre register as at the 31st December, 1968, totalled 371; the number of cases of tuberculosis, whether notified or not, under treatment, supervision or observation, totalled 1200. Of the 19 new cases of pulmonary tuberculosis discovered during 1968, 14 were found to have a positive broncho-pulmonary secretion.

The regimen of therapy remains much as it did before, but resistance to first- and second-line drugs has been a problem in two cases during the year. No cases of pulmonary tuberculosis have been submitted for surgery.

Contact examinations have continued as in previous years, and all contacts under the age of 21 have been Mantoux tested — 747 having been done.

Table 3 gives the number of B.C.G. vaccinations carried out during the year:—

TABLE 3

	Male	Female	Total
Carlisle City	49	46	95
East Cumberland ..	70	88	158
North Westmorland ..	7	6	13
Hospital Staffs ..	2	44	46
	128	184	312

Last year I mentioned some difficulties of Mantoux testing. When B.C.G. vaccination was first introduced in 1950 Mantoux testing was essentially part of the campaign. First, only negative reactors amongst contacts were given B.C.G. vaccination. It is still the practice to do Mantoux tests on all contacts and only negative reactors are given this vaccination. We used to follow up the B.C.G. vaccination with a further Mantoux test about six weeks later, and the vast majority of cases so vaccinated then gave a positive reaction. We also carried out Mantoux testing in all our contacts who had been vaccinated at five-yearly intervals, and in the past we have re-vaccinated with B.C.G. vaccine those contacts who had become Mantoux negative again. From our experience, and the fact that none of these contacts having a negative reaction following B.C.G. vaccination have developed pulmonary tuberculosis, we have felt that the degree of protection by B.C.G. vaccination did not depend entirely on the degree of sensitivity shown by the Mantoux test. We therefore feel that there is now no need for re-vaccination in negative reactors

following orthodox B.C.G. vaccination. It certainly appears that even when in a B.C.G. vaccinated contact the follow-up Mantoux test is still negative, there is still some degree of immunity.

It is quite a different problem when the initial Mantoux test is found to be positive, particularly in children entering school for the first time. In such cases there are ample grounds for investigating the whole of the child's family, and in certain cases perhaps for instituting prophylactic chemotherapy. At present children are Mantoux tested in school at the age of 13, and the negative reactors are given B.C.G. vaccination; positive reactors at that age should also continue to be referred for X-ray examination.

Bronchial Carcinoma

Table 4 shows the number of new cases of bronchial carcinoma found at the Chest Centre during 1968. One should again note the small number of cases accepted for surgery.

TABLE 4

	Males	Females	Total
East Cumberland			
New cases	20	6	26
Admitted for surgery..	—	—	—
Carlisle City			
New cases	20	9	29
Admitted for surgery..	2	—	2
North Westmorland			
New cases	1	1	2
Admitted for surgery..	—	—	—

The five-year survival rate after surgery remains low and is not greater than 4%. Indeed, although great advances have been made in the past 20 years in many aspects of medicine and surgery, there has been little advance in the prognosis and treatment of cancer of the lung.

In many areas now it is the most common visceral cancer in men, and there has undoubtedly been, over the last 20 years, an actual increase in the incidence of the disease. The small number of cases found at the Chest Centre here during 1968 is, I think, purely fortuitous, and the figures for the first quarter of 1969 suggest that there has been no actual drop in its incidence. Cancer of the lung

now accounts for one in 17 of all male deaths and the mortality throughout England and Wales has risen by an average of 8% per annum.

Over the past ten years we have seen approximately 700 new cases of lung cancer, and the overall pick-up rate of the disease through the mass radiography unit in this area has been 18%. Approximately half of the total number diagnosed have not been submitted for bronchoscopy as the lesion when first seen was so advanced, or the patient's condition so poor that the diagnosis was purely academic. Our overall five-year survival rate, as far as the Chest Centre cases go, is approximately 3%. I must point out, of course, that all cases of cancer of the lung in this area do not come through the Chest Centre; many other departments in the Hospital Service see cases just as we do.

In a disease for which there is not yet any adequate surgical or medical treatment, the approch must be preventive. It is a serious reflexion on the state of medicine today that advances in therapy (and I need only take heart transplants as an example) are applauded by the press and public even when a particular therapy results in no more than keeping a relatively small number of people alive.

Although the association of cancer of the lung with heavy cigarette smoking has been known for years now and has often been mentioned in these reports, there has unfortunately been comparatively few public health measures to counteract this. If, however, we get an advance in preventive medicine, the public and press take little notice and both continue to invest in as many, if not more, cigarettes than before.

We should naturally like to have a diagnosis of the disease at as early stage as possible, but I must emphasise that even early diagnosis does not generally improve the survival rate after surgery. I do not feel that mortality from cancer of the lung would be reduced greatly by early diagnosis, and I feel that we must wait for the day when adequate chemotherapy of some kind will be available before the prognosis can be improved.

OTHER CHEST CONDITIONS

Chronic bronchitis

Many cases of chronic bronchitis continue to be seen at the Chest Centre with, or without, emphysema. Here again, probably the best advice one can give to such patients is to give up smoking cigarettes, and it is surprising how much benefit can accrue to the patient as a result of doing just this. Treatment is largely a question of accurate antibiotic therapy, depending on the sensitivity of the organisms in the patient's sputum and well managed physiotherapy.

Asthma

Many cases of asthma are seen at the Chest Centre. Asthma remains quite a serious condition and is certainly very common in this East Cumberland area. All groups of severity are found, and although uncommon, death can actually occur. Assessment and care of these patients is undoubtedly difficult and full use is made of the services of the physiotherapist in their treatment. Continued care of these patients is essential, as even when treatment results in apparent complete cure the condition is very liable to recur. Admission of the patients to the wards is often necessary, especially in cases of status asthmaticus, when one usually finds that the patient has failed to carry out instructions. As I indicated, treatment can be very difficult and investigation of such cases can be most time-consuming as there is often an underlying anxiety syndrome with a domestic background. In some cases one has even to secure the help of a psychiatrist.

Farmer's Lung

We continue to see many new cases of "Farmer's Lung"; this now comes under the Industrial Injuries Act. Most cases clear up satisfactorily, but should the condition occur in a young farmer or farm-worker then it would be wise for him to change his occupation.

Bronchiectasis

The number of new cases of bronchiectasis seen during the year is a new low figure of 19. Table 5 gives the total number of cases of bronchiectasis on the Register as at 31st December, 1968. No cases of bronchiectasis have been submitted for surgery during the year.

TABLE 5

	Male	Female	Children	Total
East Cumberland..	62	56	—	118
Carlisle City ..	64	57	—	121
North Westmorland	10	4	—	14

Mass Radiography Service

Table 6 gives the statistical summary of the work done by the static mass radiography unit at Warwick Road, Carlisle, for the years 1966, 1967 and 1968.

TABLE 6

Statistical summary of the work done at the Static Mass Radiography Unit

	1968	1967	1966
Miniature films	6,259	5,726	5,635
Referred for clinical examination ..	360	316	393
Active tuberculosis	3	7	9
Inactive tuberculosis	25	9	13
Bronchiectasis	7	19	20
Neoplasm	15	17	29
Pneumoconiosis	1	—	—
Sarcoidosis	2	3	—
Cardiac conditions	36	29	30
Doctors' cases	2,966	2,719	2,669
Contacts per the chest centre ..	251	59	78
General public	2,368	2,335	2,109
Works personnel	667	613	779

This will be my last report as Consultant Chest Physician to this area. I cannot let this pass without expressing my sincere thanks, not only to the Medical Officers of Health in this East Cumberland area, but to all doctors and colleagues who have made my work so very rewarding.

W. HUGH MORTON, M.B., D.P.H., M.R.C.P.(Ed.),
Consultant Chest Physician.

SOUTH WESTMORLAND

Tuberculosis

At the end of 1968 the number of patients on the Clinic Register had not altered at 224 compared with 1967. Nine new respiratory cases and two non-respiratory were discovered during the year. None were picked up by Mass Radiography but three were diagnosed at an early stage by examination of contacts by Health Visitors. No drug resistent organisms were found, and of the seven infectious patients all but one were rapidly freed from infectivity. The remaining patient, a chronic defaulter from treatment and hospitals, has left the area but still accepting treatment.

Hospitals

Beaumont Hospital, Lancaster, remains the centre for treatment of patients admitted from the Chest Clinics in the area. There is no waiting list, as an adequate number of beds is available.

Clinics	1965.	1966.	1967.	1968.
New Cases	306	379	291	293
B.C.G. Vaccinations	40	59	45	39
Total Attendances	1,190	1,073	931	909
Visits by Tuberculosis Health Visitor ...	731	810	452	445

The number of total attendances has fallen over the years and this reflects the shorter period of follow-up required by patients treated by adequate drug therapy rather than a reduction in the number of new patients. The relative number of patients with tuberculosis, bronchitis, bronchial neoplasm and asthma remain much as before.

A Lung Function Department was established at Beaumont Hospital during the year and has proved valuable in the diagnosis of patients complaining of breathlessness. It also enables further assessment of patients with suspected Farmers' Lung Syndrome or Asbestosis, these tests being required by Industrial Injuries Panels.

I am indebted to the Medical Officers of Health for their co-operation during the year and to all members of the Chest Clinic team, both nursing and secretarial.

R. DOUGLAS YOUNG, M.D., M.R.C.P.E.,
Consultant Chest Physician.

TABLE I

ANTE-NATAL, MOTHERCRAFT and RELAXATION CLASSES

Number of women who attended during the year ..	Institutional booked ..	347
	Domiciliary booked ..	38
	Total	385
Total attendances during the year		1620

TABLE II

DOMESTIC HELP

Number of cases where Help was provided during 1968:—

(1) Aged 65 years or over	357
(2) Chronic Sick and tuberculous	25
(3) Mentally disordered	4
(4) Maternity	15
(5) Others	25
	426

TABLE III

HOME NURSING

	Persons aged under 5 yrs. at first visit	Persons aged 5-65 yrs. at first visit	Persons aged over 65 yrs. at first visit	Totals
No. of persons nursed during year ..	139	832	2,033	3,004
No. of visits paid during year ..	784	12,164	54,790	67,738

CHILD WELFARE CENTRES

TABLE IV

No. provided	No. of children who attended and who were born in:—			No. of sessions held by:				Total number of sessions	Total attendances of children who were born in:—		
	1968	1967	1963-66	Medical Officers	Health Visitors	G.Ps. on sessional basis	Hospital Medical Staff		1968	1967	1963-66
14	415	424	327	79	87	93	—	259	2,244	2,931	3,343

TABLE V

HEALTH VISITING

	Children born in:—			Total children	Persons aged :—		Mentally disordered persons	Persons (excl. maternity cases) discharged from hospitals	Tuberculous households	Households visited on account of other infectious diseases
	1968	1967	1963-66		5-65 yrs.	65 yrs. or over				
No. of cases visited ..	1,176	1,369	2,450	4,995	344	791	28	149	149	392
No. of visits	9,303	6,612	7,944	23,859	1,098	1,198	206	209	575	477

TABLE VI

DELIVERIES ATTENDED BY DOMICILIARY MIDWIVES

Number of domiciliary confinements attended by midwives under N.H.S. arrangements			Number of cases delivered in hospitals and other institutions but discharged and attended by domiciliary midwives before 10th day
Doctor not booked	Doctor booked	Total	
6	35	41	996

TABLE VII

AMBULANCE SERVICES

(1)	No. of Vehicles at 31-12-68 (2)	Total No. of patients (3)	Total No. of Journeys (4)	No. of emergency patients included in col. (3) (5)	Total mileage during period (6)
Ambulances ..	9	4,013	3,428	626	105,869
Cars	See below*	36,680	14,641	94	477,770

NOTE.—*The Sitting-case Car Service was provided by voluntary drivers and by taxis.

MENTAL HEALTH ACT, 1959
PATIENTS IN COMMUNITY CARE

	MENTALLY ILL				PSYCHOPATHIC				SUB-NORMAL				SEVERELY SUB-NORMAL				ELDERLY MENTALLY INFIRM		GRAND TOTAL
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over				
	M. (1)	F. (2)	M. (3)	F. (4)	M. (5)	F. (6)	M. (7)	F. (8)	M. (9)	F. (10)	M. (11)	F. (12)	M. (13)	F. (14)	M. (15)	F. (16)	M. (17)	F. (18)	
1. Number of Patients under L.H.A. care at 31-12-68 .. .. .. Total Number	11	8	16	18	–	–	–	–	2	4	42	43	14	12	15	13	–	1	199
2. Attending day training centre ..	–	–	1	–	–	–	–	–	2	2	7	7	11	10	6	4	–	–	50
3. Awaiting entry thereto	–	–	–	–	–	–	–	–	–	1	1	–	1	–	–	–	–	–	3
Resident in residential training centre	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Awaiting residence therein	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
4. Receiving home training	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
5. Awaiting home training	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
6. Resident in L.A. home/hostel ..	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
7. Awaiting residence in L.A. home/ hostel	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
8. Resident in other home or hostel ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
9. Boarded out in private household ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
10. Attending Day Hospital	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Receiving home visits and not included under 2-10	11	8	15	17	–	–	–	–	–	1	28	29	2	2	9	8	–	1	131

AWAITING ENTRY TO HOSPITAL, ADMITTED FOR TEMPORARY CARE OR TO GUARDIANSHIP

	MENTALLY ILL				PSYCHOPATHIC				SUB-NORMAL				SEVERELY SUB-NORMAL				ELDERLY MENTALLY INFIRM		GRAND TOTAL
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over				
	M. (1)	F. (2)	M. (3)	F. (4)	M. (5)	F. (6)	M. (7)	F. (8)	M. (9)	F. (10)	M. (11)	F. (12)	M. (13)	F. (14)	M. (15)	F. (16)	M. (17)	F. (18)	
1. Number of Patients in L.H.A. area on waiting list for admission to hospital at 31-12-68:																			
(a) In urgent need of hospital care ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	1
(b) Not in urgent need of hospital care	–	–	–	–	–	–	–	–	–	–	4	4	2	2	2	4	–	–	18
2. Number of patients admitted temporarily for residential care:																			
(a) To N.H.S. hospitals	–	–	–	–	–	–	–	–	–	–	–	2	1	2	1	3	–	–	9
(b) To L.A. Residential Accom. ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
(c) Elsewhere	–	–	1	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2
3. (a) Number admitted to Guardianship during year	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
(b) Total under Guardianship at 31-12-68	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

NUMBER OF PATIENTS REFERRED TO LOCAL HEALTH AUTHORITY DURING YEAR ENDED 31st DECEMBER, 1968

REFERRED BY	MENTALLY ILL				PSYCHOPATHIC				SUB-NORMAL				SEVERELY SUB-NORMAL				TOTAL
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M. (1)	F. (2)	M. (3)	F. (4)	M. (5)	F. (6)	M. (7)	F. (8)	M. (9)	F. (10)	M. (11)	F. (12)	M. (13)	F. (14)	M. (15)	F. (16)	
(a) General practitioners	9	8	6	7	–	–	–	–	–	–	–	–	–	–	–	–	30
(b) Hospitals, on discharge from in-patient treatment	–	–	7	6	–	–	–	–	–	–	1	–	–	–	–	–	14
(c) Hospitals, after or during out-patient or day treatment ..	3	1	3	6	–	–	–	–	–	–	–	–	–	–	–	–	13
(d) Local education authorities ..	2	1	–	1	–	–	–	–	–	–	1	–	–	3	–	–	8
(e) Police and courts	–	1	3	4	–	–	–	–	–	–	2	1	–	–	–	–	11
(f) Other sources	4	–	15	23	–	–	1	–	–	–	–	3	–	–	–	–	46
(g) Total	18	11	34	47	–	–	1	–	–	–	4	4	–	3	–	–	122

NOTIFIABLE DISEASES (OTHER THAN TUBERCULOSIS) DURING THE YEAR 1968

Ages	Smallpox	Scarlet Fever	Paratyphoid Fever	Acute Pneumonia	Acute Poliomyelitis non-Paralytic	Acute Poliomyelitis Paralytic	Acute Polio-Encephalitis	Dysentery	Puerperal Pyrexia	Opthalmia Neonatorum	Measles	Whooping Cough	Meningococcal Infection	Food Poisoning	Acute Infective Encephalitis	Typhoid Fever	Acute Meningitis	Infective Jaundice
Under 1 year ..	—	—	—	—	—	—	—	—	—	—	24	2	—	1	—	—	—	—
1-2 Years ..	—	—	—	1	—	—	—	—	—	—	222	10	—	—	—	—	1	—
3-4 Years ..	—	—	—	1	—	—	—	1	—	—	289	6	—	—	—	—	—	—
5-9 Years ..	—	3	—	—	—	—	—	—	—	—	381	11	—	1	—	—	—	4
10-14 Years	—	—	—	—	—	—	—	2	—	—	47	1	—	—	—	—	—	—
15-24 Years	—	—	—	—	—	—	—	1	—	—	6	—	—	1	—	—	—	2
25 years and over ..	—	—	—	8	—	—	—	1	1	—	7	—	—	5	—	1	—	8
Age unknown ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total Cases notified	—	3	—	10	—	—	—	5	1	—	976	30	—	8	—	1	1	14

NOTIFIABLE DISEASES, 1968

	Smallpox	Scarlet Fever	Paratyphoid Fever	Pulmonary Tuberculosis	Other Forms of Tuberculosis	Acute Pneumonia	Acute Poliomyelitis non-Paralytic	Acute Poliomyelitis Paralytic	Acute Polio-Encephalitis	Dysentery	Puerperal Pyrexia	Opthalmia Neonatorum	Measles	Whooping Cough	Meningococcal Infection	Food Poisoning	Acute Infective Encephalitis	Typhoid Fever	Acute Meningitis	Infective Jaundice
Appleby ..	—	—	—	—	—	—	—	—	—	2	—	—	1	—	—	8	—	—	—	2
Kendal ..	—	1	—	3	1	—	—	—	—	1	1	—	418	13	—	—	—	1	—	8
Lakes ..	—	—	—	—	—	—	—	—	—	—	—	—	33	4	—	—	—	—	—	1
Windermere	—	—	—	—	—	—	—	—	—	—	—	—	51	4	—	—	—	—	—	1
N. Westmorland	—	—	—	—	—	—	—	—	—	2	—	—	42	—	—	—	—	—	—	2
S. Westmorland	—	2	—	4	—	10	—	—	—	—	—	—	431	9	—	—	—	—	1	—
Totals 1968	—	3	—	7	1	10	—	—	—	5	1	—	976	30	—	8	—	1	1	14
Totals 1967	—	7	1	3	—	5	—	—	—	13	—	—	499	35	—	—	—	1	—	—

STAFF OF THE SCHOOL HEALTH SERVICE

Principal School Medical Officer—JOHN A. GUY, M.D., D.P.H.

Deputy Principal School Medical Officer—
I. S. BAILEY, M.A., M.R.C.S., L.R.C.P., D.P.H.

Principal School Dental Officer—M. D. MCGARRY, L.D.S.

School Dental Officers—
D. J. HARRISON, B.D.S. (Resigned 31.7.68).
J. B. MILLAR, B.D.S., L.D.S.
B. C. TOMLINSON, L.D.S., R.C.S.
A. DUNN, B.D.S. (Commenced 1.8.68).

Audiometrician—Part-time: Mrs. V. I. BIELBY.

SPECIAL CLINICS AND CONSULTANTS

Diseases of the Eye—
O. M. DUTHIE, M.D., F.R.C.S.

Diseases of the Chest—
Dr. W. HUGH MORTON, Consultant Chest Physician, Chest Centre, Carlisle.
Dr. R. DOUGLAS YOUNG, Consultant Chest Physician, Lancaster and Kendal.

Consulting Psychiatrists—
Dr. R. C. CUNNINGHAM, Medical Superintendent, Royal Albert Hospital, Lancaster.
Dr. J. CURRAH, M.B., B.S., D.P.M., Consultant Child Psychiatrist, Lancaster Moor Hospital, Lancaster.

THE EDUCATION AREA

County of Westmorland:—

Area	504,917 acres
Population (estimated mid-1968) ...	70,340
Estimated Product of 1d. Rate, 1968-69 ...	£9,764
Number of Schools—Primary	80
Secondary	11
Nursery	1
Special ...	2
Number of pupils (January 1968)—	
Primary	6,421
Secondary	4,224
Nursery	58
Special	87
	10,790

MILK IN SCHOOLS SCHEME

The Local Education Authority now enters into annual contracts with dairymen for the supply of milk to schools. The responsibility of the Principal School Medical Officer for approving the source of supply remains unaffected. Despite efforts to obtain the safest milk available, too many schools are still supplied with Untreated Milk, and the position cannot be regarded as entirely satisfactory until all supplies are heat-treated and delivered in one-third pint bottles.

County Schools

Designation of milk supplied.	No. of schools.
Untreated	24
Pasteurised	70
	94
Number of schools taking milk in other than ⅓-pint containers	12

Independent Schools

Untreated	2
Pasteurised	10
Number of schools taking milk in other than ⅓-pint containers	1

By arrangement with the Council's Sampling Officer, milk supplied to schools is submitted to bacteriological and pathological examination periodically, and out of 27 samples taken 2 failed to satisfy the prescribed tests.

From the end of the Summer Term, 1968, supplies of milk to all schools, maintained or independent, having senior pupils on their registers, were terminated as part of the Government's economy measures, and the Local Education Authority, owing to the need to curtail its expenditure, no longer felt it possible to continue to supply milk under this scheme to any Independent School after the end of the 1968-69 financial year.

Infestation (Uncleanliness)

During the past year 16,615 examinations were carried out by the District Nurses, and the number of children found to be infested with lice or nits was 84 compared with 71 during the previous year. These figures show an unwelcome increase over the record low figure reported in 1965, but compare favourably with 708 children found unclean in 1945.

The following Table shows the incidence of infestation during the past ten years.

Year.	No. of examinations for uncleanliness.	No. of children found unclean.	Per cent of children found unclean.
1959	20,872	57	0.8%
1960	18,693	107	1.5%
1961	19,124	94	1.8%
1962	19,287	82	1.3%
1963	18,736	110	1.7%
1964	18,502	71	1.0%
1965	16,956	35	0.5%
1966	15,691	72	1.0%
1967	19,029	71	1.0%
1968	16,615	84	1.1%

The numbers of individual pupils found unclean are expressed in the right-hand column of the foregoing Table as a percentage of the number of pupils on the registers during the respective years.

Ear, Nose and Throat Conditions

The enlargement of tonsils and adenoids now comprise only a small proportion of the list of defects found at school medical inspection to require treatment, and it is interesting to note that although only 18 pupils were referred to hospital on account of this defect as a result of school medical inspection, evidence is available to show that no less than 84 children received operative treatment for adenoids and chronic tonsillitis during the year. This no doubt reflects largely the fact that patients are now usually referred to hospital by the School

Medical Officer only after repeated observation and also that by far the majority of the children are referred for this operation by their family doctors.

The Department of Education and Science is interested in the wide variations in the proportion of children in different parts of the country who have undergone tonsillectomy and is now asking medical officers to record for each child seen at periodic inspection whether he or she has undergone the operation at any previous time.

The figures observed in this County in 1968 are as follows:—

	No. examined.	No. who had had tonsillectomy.	Percentage.
Entrants ...	1,064	13	1.2
Intermediates ...	915	94	10.2
Leavers ...	652	118	18.1
Others ...	337	53	15.7

Children with special defects or abnormalities are referred to the hospitals in Kendal, Lancaster and Carlisle, to be seen by the consulting surgeons. This procedure has been helpful in dealing with such cases as chronic otorrhœa, increasing deafness and infected sinuses, and particularly children found to be deaf as a result of routine audiometric surveys in the schools. The following list illustrates the type of case referred:—

Condition.	No. of children referred.
Defective hearing	26
Enlarged tonsils and adenoids with other symptoms	18
Other ear, nose and throat defects and infections	7

Speech Therapy

Number of children who have attended for Speech Therapy	83
,, attendances made	663

Up to the time of writing we have still been unable to obtain a permanent full-time Speech Therapist to replace Miss Cade who resigned in August 1963, although, since April 1966, we have had the part-time services of Mrs. Spencer, and, since 1st November, 1968, the whole-time services of Miss Wilkinson, who will not however be available after the summer of 1969.

Audiometric Surveys

In 1960 the Committee decided to institute routine audiometric surveys of children in attendance at maintained schools in the County. Now that this work is carried out by a part-time member of the staff who has no other duties it is possible to arrange the programme at times more convenient to the schools, and arrangements were made for the Audiometrician to receive instruction at Mr. Freeman's Ear,

Nose and Throat Clinic, and also to attend a course of instruction in this work at Manchester University.

The normal procedure is for all children in attendance at a school to be subjected to a Sweep Test, using the Amplivox Pure Tone Audiometer. Any children failing to respond satisfactorily to this test are investigated more fully by being given a more thorough test either at the school, or if, as frequently happens, conditions there are unsatisfactory on account of noise, etc., at a clinic. Many failures at Sweep Test may be due to catarrhal conditions, and when these exist the test is repeated when the condition has resolved.

Children whose response to further testing is still unsatisfactory are then seen by a member of the Medical Staff of the Department who decides in each case whether reference to an Ear, Nose and Throat Consultant is necessary.

Figures showing the work undertaken in this connection are given below:—

Schools visited	31
Number of children Sweep tested	2,143
Requiring further investigation	183

Child Guidance Clinic

Since 29th July, 1968, the Authority has had the services for one day per week of Dr. Joan Currah, Consultant Child Psychiatrist of the new Child Psychiatric Unit set up by the Manchester Regional Hospital Board at Lancaster Moor Hospital. Dr. Currah holds regular clinics in Kendal.

The services of Dr. R. C. Cunningham continue to be available for advice in cases of mental abnormality and educational matters relative thereto.

Number of cases during 1968	29
,, attendances	87

School Clinics

The Department has requested that this Report should give the location and details of the session held at the School Clinics, and the relevant information is given below:—

Location.	Types of Clinics.	Frequency of Sessions.
Health Services Clinic, Kendal ...	Dental treatment ...	Daily
	Ophthalmic examination ...	Weekly
	Speech Therapy ...	As required
	Vaccination ...	As required
	Child Guidance ...	Weekly

U.D.C. Offices, Ambleside	...	Dental	...	As required
Appleby Clinic	...	Dental	...	As required
		Vaccination	...	As required

Orthopaedic Scheme

All cases within reasonable reach of Kendal are referred to the Orthopaedic Out-Patient Department at the Westmorland County Hospital, and Mr. Kitchin, the Orthopaedic Specialist, has undertaken to arrange for remedial exercises, etc., and follow-up treatment of these cases.

Number of children known to be attending Hospital Out-Patient Departments during the year was 103.

Handicapped Pupils

Under the Education Act, 1944, it is the duty of the Local Education Authority to ascertain what children require special educational treatment. These children are usually reported by the school-teachers or the Educational Adviser to the School Medical Officer who examines them and reports to the Local Education Authority. The number of cases examined during the year was 65, of whom 25 were recommended for admission to Special Schools for educationally subnormal pupils, 1 for partially hearing pupils, 1 for partially sighted pupils, and 1 for delicate children.

In addition, 8 children were found to be ineducable and recommented for action under Section 57(4), Education Act, 1944. Twelve children were referred for further examination after a trial period; 16 children were recommended for special help in ordinary schools, and 1 child was referred to Child Guidance Clinic. A copy of the report on each case is submitted to the Educational Adviser so that any special attention possible in the ordinary school may be given to those children needing it.

The position with regard to the placing of pupils in special boarding-schools is now much improved, and the opening of Ingwell and Higham Special Schools by the Cumberland Local Education Authority, and of Eden Grove Special School as a private venture, has enabled places to be found for most of the pupils whose parents are willing for them to attend, whilst the opening of Roundhills School, Kendal, a day Special School for Educationally Subnormal Pupils has gone far to remove the main cause of objection on the part of parents, i.e. unwillingness to allow children to leave home.

I am indebted to the Director of Education for the figures in the Tables on pages 116 to 118.

Treatment of Defective Vision

All schoolchildren found to be suffering from refractive errors are referred for examination under the General Ophthalmic Service administered by the Executive Council under the National Health Service Act, and spectacles, where necessary, are supplied under the provisions of that Act. By arrangement with the Local Executive Council, sessions are held as required at the Kendal Clinic, but parents are given the opportunity to make their own arrangements with opticians if they prefer it.

Mr. O. M. Duthie, F.R.C.S., formerly Consultant Ophthalmologist at the Manchester Royal Eye Hospital, now undertakes the work at the Kendal Clinic.

Children whose eye condition necessitates treatment other than the provision of spectacles are referred to the Ophthalmic Consultants at the Westmorland County Hospital or at the Cumberland Infirmary.

Total number referred for testing of vision ... 488

B.C.G. VACCINATION OF SCHOOLCHILDREN

A full report on the B.C.G. Vaccination arrangements is given in the Report of the County Medical Officer of Health, but it may be mentioned here that during 1968 the following work relating to school-children was undertaken:—

Number Skin Tested.	Number Positive.	Number Vaccinated.	Percentage Positive.
692	8	663	1.16

The percentage of children found positive shows a welcome reduction from the previous lowest figure of 3.4%, recorded in 1966.

POLIOMYELITIS VACCINATION

This work is carried out under the control of the Local Health Authority and is reported fully in the Report of the County Medical Officer of Health, but I would here like to acknowledge once again the ready co-operation of the teachers and their forbearance in the frequent interruption of the school routine which repeated visits to the schools in connection with this work entails.

REPORT OF THE PRINCIPAL SCHOOL DENTAL OFFICER FOR THE YEAR 1968

I have the honour to present the Annual Report for the School Dental Service for the County of Westmorland for 1968. The statistical tables will be found on pages 114 and 115.

Staff

Dental Officers: Mr. D. J. Harrison resigned from his post with effect from 31st July. Mr. A. Dunn was appointed to replace him and took up duty on 1st August.

Dental Surgery Assistants: Mrs. J. Donovan resigned from her post on 31st July and was replaced by Mrs. D. Cooper. Mrs. Cooper subsequently resigned with effect from 31st December, as she was leaving the County, and was replaced by Miss J. Carruthers.

Dental Inspection and Treatment

The dental inspection and treatment figures show no significant change from 1967. The proportion of children requiring treatment remains disturbingly high, despite the regular treatment provided over the years, backed by intensive dental health education. The fact that the number requiring treatment remains so high in these circumstances, highlights the absence within the County of the other obvious preventative measure, the fluoridation of public water supplies.

M. D. McGARRY,
Principal School Dental Officer.

STATISTICAL TABLES

PART I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS

A.—PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By year of birth)	No. of Pupils Inspected	Physical condition of Pupils Inspected		Pupils found to require treatment		
		Satisfactory No.	Unsatisfactory No.	For defective vision (excluding squint)	For any of the other conditions recorded in Pt. II	Total individual pupils
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1964 and later	145	145	—	2	4	5
1963	726	726	—	4	27	29
1962	193	193	—	2	8	10
1961	70	70	—	6	3	9
1960	47	47	—	1	1	2
1959	72	72	—	2	2	4
1958	795	795	—	40	12	51
1957	120	120	—	10	2	11
1956	81	81	—	2	1	2
1955	39	39	—	—	—	—
1954	28	28	—	—	1	1
1953 and earlier	652	652	—	13	8	20
Total	2968	2968	—	82	69	144

Col. 3 as percentage of Col. 2 — 100%. Col. 4 as percentage of Col. 2 — Nil

B.—OTHER INSPECTIONS

Number of Special Inspections	61
Number of Re-Inspections	3,748
Total ..	3,809

C.—INFESTATION WITH VERMIN

(i)	Total number of examinations in the schools by the school nurses or other authorised persons	16,615
(ii)	Total number of individual pupils found to be infested ..	84
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 [2], Education Act, 1944)	7
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 [3], Education Act, 1944) ..	Nil.

PART II.—DEFECTS FOUND BY PERIODIC AND SPECIAL MEDICAL INSPECTIONS DURING THE YEAR

Defect code (1)	Defect or Disease (2)		Periodic Inspections				Special Inspections
			Entrants	Leavers	Others	Total	
4	Skin	T	2	1	2	5	—
		O	44	8	28	80	2
5	Eyes (a) Vision	T	14	12	56	82	8
		O	62	24	165	251	15
	(b) Squint	T	11	—	3	14	—
		O	28	1	10	39	2
	(c) Other..	T	—	—	—	—	—
		O	7	2	10	19	1
6	Ears (a) Hearing	T	—	—	2	2	1
		O	41	3	33	77	6
	(b) Otitis Media ..	T	—	—	—	—	—
		O	53	2	26	81	—
	(c) Other..	T	—	—	—	—	—
		O	—	—	1	1	—
7	Nose and Throat	T	10	1	7	18	1
		O	235	8	105	348	9
8	Speech	T	4	—	1	5	1
		O	7	—	5	22	1
9	Lymphatic Glands	T	—	—	—	—	—
		O	188	3	66	257	2
10	Heart	T	3	—	1	4	—
		O	10	—	5	15	—
11	Lungs	T	—	1	2	3	—
		O	39	2	33	74	—
12	Developmental (a) Hernia ..	T	—	—	1	1	—
		O	11	—	2	13	—
	(b) Other ..	T	1	—	1	2	—
		O	47	1	25	73	—
13	Orthopaedic (a) Posture ..	T	1	—	—	1	—
		O	1	9	15	25	—
	(b) Feet ..	T	3	1	3	7	—
		O	123	14	73	210	3
	(c) Other ..	T	2	—	1	3	—
		O	45	5	30	80	1

T = found to require treatment.
O = found to require observation.

PART II—DEFECTS FOUND BY PERIODIC AND SPECIAL MEDICAL INSPECTIONS DURING THE YEAR—*continued*

Defect code (1)	Defect or Disease (2)		Periodic Inspections				Special Inspections
			Entrants	Leavers	Others	Total	
14	Nervous System (a) Epilepsy ..	T	—	—	1	1	—
		O	1	—	2	3	—
	(b) Other ..	T	—	—	1	1	—
		O	5	—	13	18	1
15	Psychological (a) Development ..	T	—	—	—	—	—
		O	10	—	6	16	3
	(b) Stability ..	T	—	—	—	—	—
		O	4	—	5	9	—
16	Abdomen	T	1	1	—	2	1
		O	4	3	9	16	1
17	Other	T	1	3	1	5	—
		O	24	16	51	91	6

T = found to require treatment.
O = found to require observation.

PART III

A.—EYE DISEASES, DEFECTIVE VISION AND SQUINT

Number of cases known to have been dealt with:	
External and other, excluding errors of refraction and squint ..	—
Errors of refraction, including squint	488
Total ..	488
Number of pupils for whom spectacles were prescribed ..	218

B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

Number of cases known to have been treated:	
Received operative treatment:—	
(a) for diseases of the ear	29
(b) for adenoids and chronic tonsillitis	84
(c) for other nose and throat conditions	11
Received other forms of treatment	41
Total ..	165

Total number of pupils known to have been provided with hearing aids:—	
(a) in 1968	10
(b) in previous years	11

C.—ORTHOPAEDIC AND POSTURAL DEFECTS

Number of pupils known to have been treated:—	
(a) Treated at clinics or out-patient departments ..	103
(b) Treated at school for postural defects	—
Total ..	103

D.—DISEASES OF THE SKIN (excluding Uncleanliness, for which see Table C of Part I)

	Number of cases known to have been treated
Ringworm—(a) Scalp	—
(b) Body	—
Scabies	—
Impetigo	—
Other skin diseases	4
Total	4

E.—CHILD GUIDANCE TREATMENT

Pupils treated at Child Guidance Clinics	29

F.—SPEECH THERAPY

Pupils treated by Speech Therapists	83

G.—OTHER TREATMENT GIVEN

Number of cases known to have been dealt with:

(a) Pupils with minor ailments	—
(b) Pupils who have received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination	706
(d) Other: Miscellaneous Medical and Surgical conditions	147
Total	853

NOTE—It should be observed throughout Part III above that the figures given for treatment other than that carried out under the Authorities' arrangements can be regarded only as incomplete. Information received from hospitals varies considerably, whilst little or no information is available regarding treatment carried out in Private Nursing Homes or by general practioners.

1. Attendances & Treatment	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First Visit	2,017	1,469	491	3,977
Subsequent visits	1,372	1,496	683	3,551
Total visits..	3,389	2,965	1,174	7,528
Additional courses of treatment commenced ..	276	202	149	627
Fillings in permanent teeth	1,519	3,122	1,566	6,207
Fillings in deciduous teeth	1,824	103	—	1,927
Permanent teeth filled ..	1,294	2,715	1,394	5,403
Deciduous teeth filled ..	1,747	99	—	1,846
Permanent teeth extracted	92	401	162	655
Deciduous teeth extracted	1,375	418	—	1,793
General anaesthetics ..	202	47	9	258
Emergencies	229	123	31	383

Number of Pupils X-rayed	127
Prophylaxis	287
Teeth otherwise conserved	849
Number of teeth root filled	20
Inlays	4
Crowns	16
Courses of treatment completed	3,573

2. Orthodontics

Cases remaining from previous year	49
New cases commenced during year	39
Cases completed during year	42
Cases discontinued during year	6
Number of removable appliances fitted	47
Number of fixed appliances fitted	2
Pupils referred to Hospital Consultant	26

3. Prosthetics

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time) ..	—	1	3	4
Pupils supplied with other dentures (first time) ..	6	11	14	31
Number of dentures supplied	8	12	18	38

4. Anaesthetics

General Anaesthetics administered by Dental Officers ..	199

5. Inspections

(a) First inspection at school. Number of Pupils ..	7,752
(b) First inspection at clinic. Number of Pupils ..	422
Number of (a) + (b) found to require treatment ..	4,763
Number of (a) + (b) offered treatment	4,432
(c) Pupils re-inspected at school clinic	559
Number of (c) found to require treatment ..	325

6. Sessions

Sessions devoted to treatment	1,335
Sessions devoted to inspection	94
Sessions devoted to Dental Health Education	42

RETURN OF HANDICAPPED PUPILS

In the Calendar Year:—	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally sub-normal		(9) Epileptic (10) Speech Defects		Total 1-10
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. Handicapped Pupils **newly assessed** as requiring education at Special Schools or Boarding in homes	—	1	—	3	1	—	1	30	—	—	36
B. (i) Handicapped Pupils (included at A) **Newly placed** in Special Schools or Homes	—	—	—	2	1	—	1	10	—	—	14
(ii) Of the children assessed prior to January, 1968 numbers who were newly placed in special schools (other than Hospital Special Schools) or boarding homes	—	—	—	1	1	—	—	1	—	—	3
Total B (i) and B (ii)	—	—	—	3	2	—	1	11	—	—	17
Number of children who were subject to new decisions recorded under Section 57 of the Education Act, 1944											8
Number of children for whom reviews were carried out under the provisions of Section 57A of the Education Act, 1944											1
Number of decisions cancelled under Section 57A(2) of the Education Act, 1944											1
C. On 23rd January, 1969, Number of Handicapped Pupils requiring places in Special Schools:											
(i) Total—											
(a) Day	—	—	—	—	—	—	—	20	—	—	20
(b) Boarding	—	1	—	1	—	—	—	3	—	—	5

RETURN OF HANDICAPPED PUPILS (*continued*)

	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally sub-normal		(9) Epileptic (10) Speech Defects		Total 1-10
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(ii) Number in (i) above who have not reached the age of five years—											
(a) Awaiting day places ..	—	—	—	—	—	—	—	—	—	—	—
(b) Awaiting boarding places..	—	—	—	—	—	—	—	—	—	—	—
(iii) Number in (i) above who have reached the age of five years but whose parents had refused consent to their admission to Special School—											
(a) Awaiting day places ..	—	—	—	—	—	—	—	—	—	—	—
(b) Awaiting boarding places..	—	—	—	—	—	—	—	2	—	—	2
On 23rd January, 1969:—											
D. (i) Number of Handicapped Pupils from the area—											
(1) attending maintained Special Schools as Day Pupils..	—	—	—	—	1	—	—	68	—	—	69
as Boarding Pupils ..	—	—	—	1	1	—	—	10	1	—	13
(2) were on the registers of non-maintained Special Schools	2	—	—	6	3	—	—	3	—	—	14

RETURN OF HANDICAPPED PUPILS (*continued*)

	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally sub-normal		(9) Epileptic (10) Speech Defects		Total 1-10
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(ii) Were on the registers of Independent Schools (under arrangements made by the authority)	—	—	—	—	—	—	2	5	—	—	7
E. Number of Handicapped Pupils being educated under arrangements made under Section 56 of the Education Act, 1944:—											
(i) In hospitals	—	—	—	—	—	2	—	—	—	—	2
(ii) In other groups	—	—	—	—	—	—	—	—	—	—	—
(iii) At home	—	—	—	—	—	—	—	—	—	—	—

TYPE OF EXAMINATION AND/OR TREATMENT

provided, at the School Clinics, either directly by the Authority or under arrangements made with the Regional Hospital Board for examination and/or treatment to be carried out at the Clinic.

Examination and/or treatment	Number of School Clinics (i.e., premises) where such treatment is provided— directly by the Authority	under arrangements made with Regional Hospital Boards or Boards of Governors of Teaching Hospitals
(1)	(2)	(3)
A. Minor ailment and other non-specialist examination or treatment	—	—
B. Ophthalmic*	1	—
C. Ear, Nose and Throat ..	—	—
D. Pædiatric‡	—	—
E. Speech Therapy ..	1	—
F. Sunray (U.V.L.) ..	—	—
G. Vaccination and Immunisation	2	—
H. Audiology	—	—

* Arrangements made with the Supplementary Ophthalmic Service are returned in Column (2).

‡ Clinics for children referred to a specialist in children's diseases.

CHILD GUIDANCE CENTRES

Number of Child Guidance Centres provided by the Authority 1

Staff of Centres	(a) Number	(b) Aggregate in terms of the equivalent number of whole-time officers
Psychiatrists	1	0.2
Educational Psychologists ..	1	0.01
Psychiatric Social Workers ..	Nil	Nil
Others (specify) Mental Welfare Officer ..	1	0.4

The Psychiatrist is made available by the Manchester Regional Hospital Board.