

**General Hospital Nursing In Sheffield During The Early Years Of The
NHS, 1948-1974**

Judith Hilary Redman

PhD

Department of History

September 2005

Judith Redman

**General hospital nursing in Sheffield during the early years of the NHS,
1948-1974**

Summary

This study examines the history of general hospital nursing in Sheffield between approximately 1948 and 1974 - the first 26 years of the operation of the National Health Service (NHS) in England. The availability of nurses in quantity and in quality, their knowledge and skills, working practices and organisation, are themes that endured during this quarter-century. This was a period when administrative and therapeutic innovation was juxtaposed with – and constrained by – resource limitations. In particular, the inability to match nursing availability to patient needs caused operational and strategic problems in developing and delivering hospital-based health care. These problems were exacerbated when innovations in nursing and medical care required new approaches to the organisation of hospital beds and equipment, which also had to be implemented in nineteenth century buildings with inadequate basic facilities. Making extensive use of archived records of Sheffield's hospitals, the present study explores how the coalescence of these factors influenced nurses and their work, and how this contributed to continuity and change in nursing in the city's general hospitals.

TABLE OF CONTENTS

SUMMARY	2
TABLE OF CONTENTS	3
TABLE OF FIGURES	5
ABBREVIATIONS	6
ACKNOWLEDGEMENTS	7
INTRODUCTION	8
Research Questions and Outline of Thesis	16
Sources and Methods	20
1. SHEFFIELD'S HOSPITALS AND THE NHS, 1930-1974	30
1.1 The Origins of the NHS	30
1.2 Pre-NHS Hospital Services in Sheffield	40
1.3 Establishing the NHS – 1948 to 1962	48
1.4 Building on the Foundations – 1962 to 1974	71
2. NURSING IN THE NHS, 1948 TO 1974	81
2.1 Nursing Availability, 1948-1974	81
2.2 Nursing Knowledge and Skills, 1948-1974	100
2.3 Nursing Practice, 1948-1974	107
2.4 Nursing Organisation, 1948-1974	111
3. 'THE SAME OLD DIFFICULTY' - RECRUITING AND RETAINING NURSES TO WORK IN SHEFFIELD'S GENERAL HOSPITALS, 1948-1974	117
3.1 The Nursing Workforce in Sheffield, 1948-1974	118
3.2 The Availability of Nurses in Sheffield, 1948-1974	121
3.3 Demand for Nursing Care, 1948-1974	136
3.4 Managing The Availability Of Nursing Time In Sheffield, 1948-1974	139

4. 'THESE VERY UNCERTAIN DAYS' - NURSE TRAINING IN SHEFFIELD, 1948 TO 1974.....	172
4.1 Nurse Training in Sheffield – the Sheffield School of Nursing	173
4.2 Nurse Training in Sheffield – The Nurse Training School at the General ...	180
4.3 The Gradual Amalgamation of Nurse Training in Sheffield, 1963-1974.....	185
4.4 Recruiting and Retaining Student and Pupil Nurses.....	187
4.5 Pre-Registration Nurse Training	197
4.6 Post-registration Nurse Training.....	200
4.7 Training of Nursing Auxiliaries.....	207
5. 'YOU CANNOT MECHANISE NURSING' - NURSING WORK IN SHEFFIELD'S GENERAL HOSPITALS, 1948-1974.	211
5.1 The Content of Nursing Work	213
5.2 The Context of Nursing Work	218
5.3 Nursing Work and Non-nursing Work – Redefining the Boundaries	231
5.4 Changing Relationships with Medical Colleagues	237
5.5 Changing Relationships with Patients.....	242
5.6 Nurses' Changing Relationships With Visitors To The Hospital	248
6. 'WE ARE DEALING WITH PEOPLE AND NOT THINGS' – MANAGING NURSING IN SHEFFIELD'S GENERAL HOSPITALS, 1948-1974.	253
6.1 Nurses in the NHS Hierarchy	254
6.2 The Matrons	270
6.3 Preparation for the role of Matron	275
6.4 Matrons and Non-Nurses	278
CONCLUSIONS	290
BIBLIOGRAPHY	307
Primary Sources	307
Secondary Sources	314

TABLE OF FIGURES

3.1	<i>Nursing Staff in Post, The General – General Nursing Wards, 1951, 1962 and 1970</i>	120
3.2	<i>Nursing staff in post, The Infirmary, 1951, 1962 and 1970</i>	120
3.3	<i>Percentage of Registered Nurses, Enrolled Nurses and Nursing Assistants employed on a part-time basis at City General/Northern General Hospital, 1951, 1962, 1971</i>	148
3.4	<i>Percentage of Registered Nurses, Enrolled Nurses and Nursing Auxiliaries employed on a part-time basis at the Infirmary, 1951, 1962, 1971</i>	148
4.1	<i>Table of prior occupations declared by students of the Royal Hospital Sheffield, 1948, 1953, 1958, 1963 and 1966</i>	189
4.2	<i>Numbers of students completing and not completing nurse training at Royal Hospital Sheffield, 1948-1966</i>	193
4.3	<i>Reasons for non-completion of training: students from Royal Hospital Sheffield Unit, 1948, 1958, and 1966</i>	194

Abbreviations

BG	Board of Governors
BMA	British Medical Association
CHSC	Central Health Services Council
CNO	Chief Nursing Officer
Fir Vale	Fir Vale Infirmary
The General	City General Hospital [to 31 March 1967]/ Northern General Hospital [from 1 April 1967]
GNC	General Nursing Council for England and Wales
HMC	Hospital Management Committee
The Infirmary	Royal Infirmary, Sheffield
NAC	Nursing Advisory Committee
NHS	National Health Service
NPHT	Nuffield Provincial Hospitals Trust
PIB	National Board for Prices and Incomes
PNO	Principal Nursing Officer
RCN	Royal College of Nursing
RHB	Regional Hospital Board
The Royal	Royal Hospital, Sheffield
SEAN	State Enrolled Assistant Nurse
SEN	State Enrolled Nurse
SNAC	Standing Nursing Advisory Committee
SNO	Senior Nursing Officer
SRN	State Registered Nurse
SSEN	Senior State Enrolled Nurse
USH	United Sheffield Hospitals

Abbreviations used in the footnotes:

PRO	Public Record Office
SA	Sheffield Archives
TNA	The National Archives

Acknowledgements

Thanks are due to all those people who have helped me in preparing this thesis. Most of them I have met only through the records of the hospitals and health authorities held in the archives that I have consulted. However, in addition to those who may never know the crucial role that they have played in my work are those who are well aware. I am especially grateful to my supervisors, Dr Flurin Condrau and Dr John Woodward, whose patience and practical advice have been essential to completion of the project - and to Dr Clare Griffiths, who was on stand-by to assist if required. My family – Haytham, Munya, Alistair, Jane and Peter – and many friends, colleagues and nursing students have encouraged me to keep on working even when I have felt tempted to give up. Angela, Jan and Jane proofread my work – thank goodness! Staffs of the Sheffield Archives, Sheffield Local Studies Library and the University of Sheffield's Special Collections and Archives have been unfailing in their guidance towards sources of information. It is customary to absolve all of the above of any responsibility for errors or omissions in what follows, and this I gladly do.

INTRODUCTION

Despite scrutiny of the National Health Service (NHS) by historians and policy analysts since its early days, the contribution of nurses to the service and its impact on them and their work are still relatively neglected issues in the historiography. General political histories of the development of the NHS consider primarily the contribution of politicians, administrators and the medical profession to the coalescence of policy and politics that resulted in the NHS Act of 1946 and its implementation, focusing on the national and strategic. This is necessary but not sufficient, however detailed and analytical, to a full understanding of the impact of the NHS as the central instrument of post-1945 health policy in the United Kingdom (UK). That requires scrutiny of the specific contribution of many actors, jointly and severally, within and without the service, to its development, and of the broader political, economic and social contexts nationally and internationally in which this has taken place. Complementary to and interwoven with this is the impact that the NHS has had on those who use, work in and pay for the service, which has local as well as national dimensions.

The main argument of this thesis is that the contribution of nurses to the development of the NHS during its first quarter century is deserving of greater attention than it has hitherto been accorded in most general and policy histories of the service. Nursing, as the most sizeable single occupational group involved in the direct delivery of healthcare, was crucial to the capacity of the NHS to provide the universal, comprehensive health care that the Central Office of Information's advance publicity for the new service advertised.¹ Furthermore, notwithstanding the limitations imposed by examining the experiences of nurses working specifically in the general hospitals of only one provincial city, a case study – here, of Sheffield – offers an ideal opportunity

¹Central Office of Information [COI], *Your Very Good Health!* [film] (London, 1948).

for an in depth examination of the contribution of nurses and their work to the interplay between local and national circumstances in the implementation of the English NHS, as the central plank of post-Second World War health policy.

This study contributes to the existing body of knowledge through an examination of the work of general hospital nurses working in two hospital groups in Sheffield, England, during the third quarter of the twentieth century. The first of these comprised the City General and Nether Edge Hospitals, which, with the former Public Assistance Institution, Fir Vale Infirmary, became Sheffield Number One Hospital Management Committee (HMC) at the inception of the NHS on 5 July 1948. The second consisted of the four former voluntary hospitals, the general hospitals of the Royal and the Royal Infirmary, and the specialist hospitals, the Jessop Hospital for Women and the Children's Hospital, with their annexes, and the Edgar Allen Physical Treatment Centre; these were known collectively as the United Sheffield Hospitals (USH).²

Although an extensive literature centred on the NHS has been published since 1948, general histories and policy analyses of the service have mostly neglected the part played by nurses as an occupation in the development of the NHS. As the largest individual staff group, central to the capacity of hospital and community sectors alike to provide a service to patients and their families, the role of nurses and of nursing in the NHS appears to be eminently worthy of investigation. Yet the focus of attention has been more on the centre than on the periphery, more on the top than the bottom of the hierarchical structure.

Histories of the development and early years of the NHS by Eckstein, published in 1958, and by the Jewkes and by Lindsay, in 1962, help to explain the early impact of

² Hereafter, in the interests of brevity, the City General Hospital/Northern General Hospital are referred to as The General, Fir Vale Infirmary as Fir Vale, the Royal Hospital as The Royal, and the Royal Infirmary as The Infirmary. Sheffield Number One/North Sheffield University Hospital Management Committee is abbreviated to The HMC, and the United Sheffield Hospitals to USH.

the NHS.³ Inevitably, these and others that deal with the founding of the service cover a limited time-period, however comprehensive their treatment of the early history of the NHS.⁴ Webster's histories of the NHS - his two-volume official history and briefer political history - expand upon previous work, both by extending the historical period addressed and by broadening the analysis to consider regional as well as national events.⁵ The preface to the first volume of the official history, though, acknowledges that Webster's focus is the history of policy, not of health care and medicine. This is a characteristic shared by Klein's policy analysis of the NHS from its origins to its fifth decade.⁶

Titmuss's analysis of the social impact of the Second World War encompasses an examination of the Emergency Medical Service and its contribution to the development of the NHS. Although painstaking in detail, its publication so close to the events it describes means that it provides only limited information.⁷ Fox's comparative history of health policy in Britain and the United States during approximately the first half of the twentieth century provides a detailed and analytical account of the regional structure of the NHS.⁸ The fiftieth anniversary of the NHS in 1998 was the occasion not only for the publication of Webster's political history of the service but also for new histories of the service and those who had contributed to it. These include Rivett's analysis of developments in medicine and health care, as well as in the political and administrative aspects of the NHS, in every decade of the

³H Eckstein, *The English Health Service* (Cambridge Massachusetts, 1958); J Jewkes and S Jewkes, *The Genesis of the British National Health Service* (Oxford, 1962); A Lindsey, *Socialized Medicine in England and Wales. The National Health Service 1948-1961* (Oxford, 1962).

⁴F Honigsbaum, *Health, Happiness and Security: The Creation of the National Health Service* (London, 1989).

⁵C Webster, *The National Health Service Since the War, Volume I* (London, 1988); C Webster, *The National Health Service Since the War, Volume II* (London, 1996); C Webster, *The National Health Service: a Political History* (Oxford, 1998).

⁶R Klein, *The Politics of the NHS* (1983, 1987, 1995).

⁷R M Titmuss, *Problems of Social Policy* (London, 1950).

⁸D M Fox, *Health Policies, Health Politics: The British and American Experience 1911-1965* (Princeton, 1986), Chapters 6 and 8.

service's existence. Rivett's account thus helped to address the need for a history of the NHS that included analysis of the contribution made to the service by developments in therapeutics and the health care occupations.⁹ Powell's evaluation of its achievements since 1948 contributed another useful dimension to the half-century anniversary's reflective histories by offering a variety of ways in which an assessment of the impact of the NHS might be made, measured against its original aims and the achievements made by other health care systems over the same period.¹⁰

Another dimension to the historiography on the NHS developed from the mid-1990s, reflecting broader concerns about the impact of post-war health and social policies. Work in this genre considered the NHS as one of a number of policy instruments or factors in the history of health and, or health and social welfare. Jones's history of health in Britain during the twentieth century drew on the development of scholarship in diverse fields, including feminist history. This enabled her to bridge the gap between general histories of post-war Britain and histories of the NHS, setting the latter in a broader context of changing patterns of health and contributory social and economic factors, as opposed to the narrow focus on the politics of health care delivery seen in many other accounts.¹¹ Others who have contributed to the historiography of the NHS by exploring its relationship to broader developments in health and welfare include Berridge, Hardy, Jones, Porter and Timmins.¹²

Looking beyond the boundaries of the NHS is one part of developing an understanding of its impact. Another is to examine relationships between the service and those who have worked within it. Published in 1967, Willcocks's study of pressure group politics

⁹ G Rivett, *From Cradle to Grave. Fifty Years of the NHS* (London, 1998); and, for example: G Macpherson ed., *Our NHS: A celebration of 50 years* (London, 1998).

¹⁰ M A Powell, *Evaluating the National Health Service* (Buckingham, 1997).

¹¹ H Jones, *Health and Society in Twentieth Century Britain* (London, 1994), pp. 16-17.

¹² V Berridge, *Health and Society in Britain Since 1939* (Cambridge, 1999); A Hardy, *Health and Medicine in Britain Since 1860* (Basingstoke, 2001); D Porter, *Health, Civilization and the State – a History of Public Health from Ancient to Modern Times* (London, 1999); N Timmins, *The Five Giants – a Biography of the Welfare State* (London, 1996).

examined the emergence of the NHS from the perspective of occupational groups and politicians during the years leading up to the Appointed Day, so adding to extant understanding of the processes by which disparate plans and policies contributed to the NHS as established in the 1946 NHS Act.¹³ Pater's analysis of the creation of the NHS, based on personal experience as well as documentary evidence, is rich in detail about the central arena of health care politics especially during the decade immediately preceding the Appointed Day, but deals with events in the regions only insofar as they interacted with those at the centre.¹⁴ In addition, in concluding with the commencement of the service, Willcocks's and Pater's studies leave unexplored what followed.

Ham's study of policy making in the NHS examines the working of the health service from the perspective of one region, Leeds, during the early years of the NHS.¹⁵ Honigsbaum's analysis of the medical profession in Britain enlightens discussion of the particular contribution of Doctors and their representative organisations to the establishment of the NHS, its administrative structure and its internal politics.¹⁶

General historical accounts of British nursing, including for example Seymer's *General History of Nursing*, Abel-Smith's *History of the Nursing Profession*, Dingwall, Rafferty and Webster's *Introduction to the Social History of Nursing* and Baly's *Nursing and Social Change* represent an enduring interest in the occupation's origins and significance.¹⁷ However, a burgeoning range of academic studies – including research by some of the authors noted here – has developed since the early

¹³ A J Willcocks, *The Creation of the National Health Service - A Study of Pressure Groups and a Major Social Policy* (London, 1967).

¹⁴ J E Pater, *The Making of the National Health Service* (London, 1981).

¹⁵ C Ham, *Policy-Making in the National Health Service* (London, 1981).

¹⁶ F Honigsbaum, *The Division in British Medicine* (New York, 1979).

¹⁷ L R Seymer, *A general history of nursing* (4th edn., London, 1957); B Abel-Smith, *A History of the Nursing Profession* (London, 1960; 1975); R Dingwall, A M Rafferty, C Webster, *An Introduction to the Social History of Nursing* (London, 1988); M Baly, *Nursing and Social Change* (3rd edn., London, 1995).

1980s. Davies's edited volume on *Rewriting Nursing History*, while not the first of this new wave of writing on nursing history, encouraged new scholarship in the field which has, characteristically, probed aspects of nursing that have either been neglected or have previously gone relatively unchallenged.¹⁸ Examples include Rafferty's study of the interplay between professional politics and policy in nurse education, Starns' analysis of the influence of the military on civilian nursing in Britain, and Baly's critique of Nightingale's influence on British nursing.¹⁹

As Starns notes, the NHS has exerted as strong an influence as Nightingale on the historiography of British nursing.²⁰ Dingwall, Rafferty and Webster, introducing the social history of nursing over a far longer historical period than the lifetime of the NHS, considered the 'nationalisation' of nursing in the health service in its historical perspective, highlighting national events that had shaped the development of British nursing.²¹ White's history of the NHS and the occupational politics of nursing remains an important source for this period, though addressing the subject primarily from a national perspective and with particular emphasis on the RCN's role, while Hart's focus is on the relationship between nurses and trades unions.²² Scott considers the role that nurses played at the Ministry of Health between 1919 and 1968, thus encompassing much of the first phase of the NHS' existence.²³ Conversely, Starns evaluates the influence of military on civilian nursing between 1939 and 1969, noting that this has often been to the detriment of the latter.²⁴ Davies, Rafferty, Collingwood and Bradshaw have variously examined specific aspects of the professional preparation

¹⁸ C Davies, ed., *Rewriting nursing history* (London, 1988).

¹⁹ A M Rafferty, *The Politics of Nursing Knowledge* (London, 1996); P Starns, *The March of the Matrons* (Peterborough, 2000); M Baly, *Florence Nightingale and the Nursing Legacy* (London, 1986).

²⁰ Starns, *March of the Matrons*, p. 10.

²¹ Dingwall, Rafferty and Webster, *Social History*, Chapter 6.

²² R White, 'The Effects of the National Health Service on the Nursing Profession, 1948-1961' (Manchester, 1982); C Hart, *Behind the Mask: Nurses, their unions and nursing policy* (London, 1994).

²³ E J Scott, 'The Influence of the Staff of the Ministry of Health on Policies for Nursing, 1919-1968' (London, 1994).

²⁴ Starns, *March of the Matrons*.

of nurses, including the nature of 'knowledge' and its incorporation in nursing curricula, and its inculcation through the 'apprenticeship' system.²⁵ Writing by Maggs, Kirby, Lorentzon, and Wildman on the history of nursing examines the occupation in a local context, whether in particular hospitals, cities or regions of England, providing an important corrective to national histories by permitting a more in-depth examination of the origins of individual nurses and the nature of their working lives. Their work deals primarily with historical periods earlier than that addressed in this study, though.²⁶

Overall, the existing literature appears at first to offer a reasonably comprehensive macro-historical narrative of the founding and early existence of the NHS – who was involved, what happened, why it happened, when it happened, and how. Available accounts include insights into the internal politics of the Ministry of Health, the NHS and the medical profession. They also provide a wealth of detailed analysis concerning specific aspects of nursing during the twentieth century. Without this framework of historical facts and assessment, it would be difficult even to begin to make sense of the experiences of nurses away from the centre of power and professional influence.

However, the obverse of the strengths of these mainly centrist accounts is that they are nonetheless partial in their coverage of important aspects of the history of the NHS and

²⁵ C M Davies, 'Professional Power and Sociological Analysis: Lessons from a Comparative Historical Study of Nursing in Britain and the USA' (Warwick, 1981); A M Rafferty, *The Politics of Nursing Knowledge* (London, 1996); M P Collingwood, 'The goals of nurse education 1948-1992: a study to identify the goals of nurse education relating to the preparation of the registered general nurse in Scotland and to determine the extent and form of any change' (Edinburgh, 1997), A Bradshaw, *The Nurse Apprentice 1860-1977* (Aldershot, 2001).

²⁶ C J Maggs, *The origins of general nursing* (London, 1983); S Kirby, 'Marketing the municipal model: the London County Council Nursing Service Recruitment Strategies 1930-1945', *International History of Nursing Journal* 4:1 (1998), pp. 17-23; M Lorentzon, 'Nurse education at the London Homeopathic Hospital 1903-1947: preparation for professional specialists or marginalised Cinderellas?' *International History of Nursing Journal* 5:2 (2000), pp. 20-27; S Wildman, 'The development of nursing at the General Hospital, Birmingham', *International History of Nursing Journal* 4:3 (1999), pp. 20-28; S Wildman, 'The development of nurse training in the Birmingham Teaching Hospitals, 1869-1957', *International History of Nursing Journal* 7:3 (2003), pp. 56-65.

may be wholly negligent in some respects. Events are analysed at a macro, national level, or only follow one aspect of either the NHS (administration; foundation) or nursing (education; unions; the role of nurses in one field or at one level of the NHS; divisions in nursing; the influence of the military). The tendency of existing accounts of the formation and development of the NHS, to privilege male and elite - often, but not always the same - versions of events exhibit unconscious gender and class biases.²⁷ Moreover, the literature reveals a relative neglect of the role of nurses and nursing in the implementation and operation of the NHS. Yet nurses formed the largest single staff group in the new service, without whom its capacity to provide and develop health care services was limited. This at least raises questions about the relationship between the availability of nurses and their capacity to contribute to the development of existing and new hospital and community health services into which the historiography of the NHS provides little insight at present.

Another limitation of the existing literature is the relative lack of attention given to local as opposed to national perspectives. Central financial and legal controls over the delivery of health services in the community may be assumed erroneously to be sufficient to guarantee that a policy is implemented as intended by its originators, but ‘...other factors also come into play at the micro-level which can affect the implementation of policy.’²⁸ Further consideration of the actual - as opposed to the intended - consequences and impact of policy is warranted, therefore. Finally then, while probably the most symbolically significant change brought about by the new service was its extension of hospital services to all, the historiography would be enhanced by the availability of accounts of the impact of this nationalisation on the people who worked in and the communities that were served by those hospitals.

²⁷ S Lukes, *Power – A Radical View* (Basingstoke, 1974), *passim*, but especially pp. 34-35.

²⁸ G Walt, *Health Policy – An Introduction to Process and Power* (London, New Jersey, Johannesburg, 1994), p. 165.

The existing literature is, thus, extensive but not sufficient. Despite an enduring interest in the NHS on the part of historians, there remain gaps in the account. In particular, there is a need for historical research that brings nurses and the contribution of nursing to the everyday operation of the NHS to the fore in mainstream histories of the service. There is a need also to extend the scope of the historiography of the NHS to include local histories that allow consideration of the contribution of 'street level bureaucrats' to the development of health services in the post-Second World War welfare state.²⁹ Existing accounts of the early years of the NHS, rendered by historians and policy analysts alike, indicate that these years were distinguished by localism. This adds a further dimension to the argument that the historiography of the NHS should include histories of the institutions of which it was composed and the activities of those who worked therein.

Research Questions and Outline of Thesis

Pickstone has suggested that local studies might succeed for one or more of three reasons. First, they may allow a re-examination of 'claims in existing secondary literature'. Second, they may allow holistic examination of aspects of medicine usually treated separately in national or international studies. Finally, they may allow the history of health care to be seen as part of the life of the community as a whole, rather than as a separate entity.³⁰ The value of a local study is thus that it affords the opportunity for both depth and breadth of analysis. This provided the conceptual framework for the research reported here. Its focus on one city, Sheffield, over a relatively brief period, from 1948 until 1974 and thus from inception to first reorganisation of the NHS, permitted detailed analysis of issues pertaining specifically

²⁹ 'Street level bureaucracy' refers to the bottom-up influences on policymaking. M Lipsky, 'Towards a theory of street-level bureaucracy' in *Theoretical Perspectives on Urban Policy*, ed. M Lipsky and W D Hawley (New Jersey, 1976).

³⁰ J V Pickstone, 'Medicine in Industrial Britain: the Uses of Local Studies', *Social History of Medicine* 2 (1989), pp. 197-203.

to general hospital nursing alongside consideration of relationships between nursing and the immediate environment and the broader community within which it was practiced. Moreover, the historical period was selected because it offered the opportunity to reflect on the relationship between the existence of the NHS and daily nursing organisation and practice within the hospitals. This enabled examination of continuity and change in nursing within the context of a key policy change.

Four major research questions guided interrogation of the data. The first of these asked 'what were the issues that concerned nurses in Sheffield during the period between 1948 and 1974?' Initial analysis of Sheffield's hospital and health authority records revealed four recurrent concerns of nurses in the city - the availability of nurses in quantity and in quality, their knowledge and skills, working practices and organisation. Three further questions were then addressed to each of these themes. These were: 'in what respects did this aspect of nursing change between 1948 and 1974?', 'what factors influenced continuity and change in nursing in Sheffield during this period?' and 'what was the relationship between local and national factors in influencing nursing in Sheffield?'

Chapter One examines the extent of continuity and change in health care before and after the establishment of the NHS in 1948 and the changing relationship between hospital and community in Sheffield to 1974. The influences of conflicts and controversies in the foundation of the NHS to enduring patterns and problems of organisation and resourcing are analysed.

Chapter Two focuses on the interplay of influences between the NHS and nursing. The aim is to add to the framework for interpreting the development of hospital-based nursing services in Sheffield within the NHS. Between 1948 and 1974, the key concerns of the Ministry of Health and nursing professional and statutory organisations

at national level were the recruitment and retention of the nursing workforce, nurse training and education, nursing work, and the status of nurses and nursing.³¹ Reports commissioned by central government and others had drawn attention to concerns over the interrelated problems of nurse recruitment and retention that predated the establishment of the NHS.³² The capacity of the NHS to provide a universal and comprehensive range of health services required the availability of not only a numerically adequate nursing workforce, but also one that was increasingly diversified and technically skilled. The problem of recruitment and retention of sufficient nurses presented a continuing challenge to politicians as well as to hospital administrators, as it had done before 1948 and continued to do after 1974.³³ The main chapters of the thesis address each of these in turn.

Comparing local and national situations, Chapter Three explores factors that influenced nurse staffing levels and approaches to the determination of nursing establishments in Sheffield's hospitals from the inception of the NHS in 1948 until reorganisation in 1974. The ways in which Sheffield's hospital authorities addressed the juxtaposition of fluctuations in the availability of new recruits with both increasing requirements for nurses and widening alternative employment opportunities for young women – in particular - are analysed.

Recruiting staff was only one part of the challenge, however. The aim of Chapter Four is to explore the development of nurse training and education in Sheffield's general

³¹ Scott, 'Policies for Nursing, 1919-1968', p. 9.

³² The Lancet, *The Lancet Commission on Nursing*, Chairman: The Earl of Crawford and Balcarres (London, 1932); Ministry of Health/Board of Education, *Interim Report of the Interdepartmental Committee on Nursing Services*, Chairman: Rt. Hon. the Earl of Athlone (London, 1939); Ministry of Health/Department of Health for Scotland/Ministry of Labour and National Service, *Report of the Working Party on the Recruitment and Training of Nurses*, Chairman: Sir Robert Wood (London, 1947); Ministry of Health/Department of Health for Scotland/Ministry of Labour and National Service, *Report of the Working Party on the Recruitment and Training of Nurses - Minority Report* Author: J Cohen (London, 1948).

³³ *Lancet Commission; Interdepartmental Committee; Working Party - Majority Report; Cohen, Working Party - Minority Report; G M Mercer, The Employment of Nurses* (London, 1979), pp. 7-10.

nursing schools, in the context of changes in the nature of health services provided by the NHS. This aspect of the history of nursing is closely related to general recruitment and retention issues, since the majority of members of the nursing workforce were recruited as student or pupil nurses. Thus, the ability to maintain approval as a training school for nurses was of central importance. Much of the material for this chapter is concerned with the training of nurses for initial registration with the statutory professional body, the General Nursing Council for England and Wales. The development of new technologies of care, including both therapeutic interventions and administrative and organisational innovation, tended to accelerate specialisation in hospital-based care.³⁴ Medical specialisation and therapeutic developments brought with them an increasing demand for more qualified and specialised nursing staff in specific departments of the general hospital, whether established departments such as operating theatres, or new ones, including intensive care units. Concomitantly, the demand for basic nursing care exceeded the capacity of qualified and learner nurses and a growing number of auxiliary nursing staff were employed in Sheffield's general hospitals. Therefore, the provision both of 'post-graduate' courses for nurses and of basic training for auxiliaries and assistants is also considered.³⁵

The focus of Chapter Five is the practice of nursing in Sheffield during the early period of the NHS.³⁶ The influences of the physical and social contexts within which nursing care was delivered in the hospital are considered. The interdependence of hospital medical and nursing work in relation to the development of medical and

³⁴ Rivett, *Cradle to Grave*, pp. 136-138, *inter alia*.

³⁵ 'Postgraduate' was the adjective conventionally used to describe training programmes undertaken by nurses following registration with one of the General Nursing Councils, whether they had graduated from a University or Polytechnic (CNAAs) degree programme or – more commonly – had trained in a hospital-based school of nursing.

³⁶ Rivett, *Cradle to Grave*, has a section in each chapter on nursing; Bradshaw, *The Nurse Apprentice*, *passim*; Hart, *Behind the mask*, Chapter 6.

surgical specialisation between 1948 and 1974, and attempts to define the boundaries between 'nursing' and 'non-nursing' work, are addressed.

Chapter Six considers changes and continuity in the management of nursing work and relations between staff groups in the light of those factors analysed in the preceding chapters. Analysis of this aspect of the organisation of the hospital also involves examination of inter-professional relationships.³⁷ The chapter examines the extent to which nurses were able to influence specific aspects of the functioning of the hospitals.

Throughout, the relationship between the hospitals and their staff and the lay people who entered them in several capacities as members of the committees that helped to run the hospitals, as volunteers providing various services not encompassed by the tenets of the NHS Act of 1946, who were admitted for treatment or who visited them is also deliberated. The narrative will return finally to the question of the relationship between national NHS policy and local responses to local priorities in the provision of general hospital nursing services. In so doing, the study contributes both to the history of general nursing since 1948, and also to illuminating aspects of the local character of the NHS.

Sources and Methods

This dissertation is the product of a case study of general hospital nursing in two hospital groups in one city, Sheffield, between 1948 and 1974. Of the hospital groups concerned, one comprised institutions that had been part of the voluntary sector before 1948, the other comprised hospitals that the municipal Health Committee had owned

³⁷ Ministry of Health, *National Health Service: The Development of Consultant Services* (London, 1950); Ministry of Health - Central Health Services Council, *Report of the Committee on the Internal Administration of Hospitals*, Chair: Alderman A F Bradbeer (London, 1954); Ministry of Health/Scottish Home and Health Department, *Report of the Committee on Senior Nursing Staff Structure*, Chairman: Brian Salmon (London, 1966).

and administered. The periodisation of this study was determined by two changes in the organisation of hospital services in England; namely, the inception of NHS-based delivery of hospital services on 5 July 1948, and the reorganisation of the administration of these services from 1 April 1974. This permitted consideration of the several ways in which the implementation of the NHS, and particularly the nationalisation of hospital services as a significant national policy, interwove with extant and independent local circumstances to produce change and continuity in the work of nurses in the city's general hospitals.³⁸

Sheffield's selection as the focus for the study was serendipitous; it was the biggest city, with large general hospitals in both voluntary and municipal sectors and the only medical school, in its region in July 1948. Furthermore, a collection of local hospital and regional hospital board administrative records existed in the city's archives, complemented by a collection of local newspapers, journals and ephemera in the city's Local Studies Library that provided both general information about the socio-economic and political circumstances of the city and direct information about its health care services. Thus, primary sources for historical research were available, and this case study had the potential to highlight issues for further study in relation to nursing in hospital groups in other towns in either this or other NHS regions. There was also the possibility of comparing the post-1948 development of services in the former municipal and voluntary sector hospitals of the city. Simultaneously, Sheffield was intrinsically interesting as a city that was both internationally known for its cutlery and steel industries and yet, according to a history published to mark the 150th anniversary of its becoming a borough, and centenary of the conferment of city status, lacking the quality of '...architecture, civic tradition or communal sense..' associated with other

³⁸ J E Zelizer, 'Clio's lost tribe: public policy history since 1978', *Journal of Policy History* 12:3 (2000), p. 369.

provincial English cities, some far smaller than Sheffield itself.³⁹ Yet early on in the study, relatively cursory reviews of the sources available indicated a network of people whose political, personal and working lives brought them into voluntary service in the hospital, municipal and local charitable fields. As noted, this first trawl also permitted identification of themes for further investigation. In this respect, the present study reflects at local level what Scott in her history of the influence of officials at the Ministry of Health on policies for nursing found, when she described and analysed five broad areas of continuing concern to nursing in the official records: nursing regulation; recruitment; remuneration; education and training; and management. In this study, four themes are identified: availability (recruitment); knowledge and skills (education and training); working practices; and organisation (management).⁴⁰ There are thus some overlaps between the concerns at national and local levels, albeit that Scott's study considered the lifespan of the Ministry of Health from its creation in 1919 to 1968 when it became subsumed in the new Department of Health and Social Security, and some differences.

Cherry's analysis of voluntary hospital finance during the late 19th and early 20th centuries had included reference to interesting, some unique, aspects of the funding of Sheffield's voluntary general hospitals and their working relationships with the city's municipal hospitals. Johnson's dissertation on the founding and early expansion and contraction of the number and range of hospitals in the city between the late eighteenth and mid-nineteenth centuries, Sturdy's critique of the development of medical practice in Sheffield between 1890 and 1922, and the *Hospital Survey of the East Midlands*, indicated that the city's hospitals were deserving of further study.⁴¹ Sheffield's

³⁹ C Binfield, 'Introduction' in *The History of the City of Sheffield, 1843-1993: Volume II, Society*, ed. C Binfield, R Childs, R Harper, D Hey, D Martin, G Tweedale (Sheffield, 1993), p. 3.

⁴⁰ Scott, 'Policies for Nursing, 1919-1968'.

⁴¹ S Cherry, 'Accountability, entitlement and control issues and voluntary hospital funding c1860-1939' *Social History of Medicine* 9 (1996), pp. 215-233; S Cherry 'Before the National Health Service:

industrial development as a centre of cutlery manufacture and steel-working influenced both specific aspects of the community's health needs and the development of individual philanthropic donations and organised contributions to the city's pre-NHS hospitals.⁴² Further, the reports of the city's Medical Officers of Health during the 1930s and 1940s, records of the Royal Infirmary's League of Trained Nurses and comments of the Hospital Surveyors drew attention to local issues in general hospital work, particularly nursing, that must influence and be influenced by the implementation of the NHS locally. These included nurse recruitment and retention problems, developments in nurse training and in the work and physical environment of the hospitals, all of which would affect the capacity of the city's hospitals to fulfil the promise of comprehensive, universal access to secondary care.

The use of the case study approach can provide rich data, as it '...has the potential to reveal multiple dimensions of any given "case"...', whether in a historical study, such as this, or used in conjunction with any other research design.⁴³ The use of case study in this research permitted close examination of the local impact of the NHS on and by nursing. Furthermore, case study is a methodology that has been described as particularly suitable for the solo researcher working within limitations of time.⁴⁴ Conversely, the weaknesses of case studies include their vulnerability to bias, particularly when being undertaken by a single researcher with a focus on one or a very limited number of 'cases'. The very strength of the case study as an approach, its

Financing the voluntary hospitals, 1900-1939' *Economic History Review* 50:2 (1997), pp. 305-326; M P Johnson, 'Medical Care in a Provincial Town – the Hospitals and Dispensaries of Sheffield c1790-1860' (Sheffield, 1977); S Sturdy, 'The political economy of scientific medicine: Science, education and the transformation of medical practice in Sheffield, 1890-1922', *Medical History* 36 (1992); Ministry of Health, *Hospital Survey of the Sheffield and East Midlands Area* (London, 1945).

⁴²C Shaw, 'Aspects of Public Health' in *History of the City of Sheffield: Volume II, Society*, pp. 100-117; Cherry, 'Accountability'; Cherry, 'Before the NHS'; Ministry of Health, *Hospital Survey: Sheffield..*

⁴³C Jones and C Lyons, 'Case study: Design? Method? Or comprehensive strategy?', *Nurse Researcher* 11:3 (2004), pp. 72-73.

⁴⁴M A Innes, S M Greenfield, M Hunton, 'Using case studies for prescribing research – an example from homeopathic prescribing', *Journal of Clinical Pharmacy and Therapeutics* 25 (2000), p. 400.

generation of complex and detailed information about a clearly defined situation, limits to the extent to which its findings can be generalised.⁴⁵

However, to state that the case study approach was taken is not sufficient. The case study may be used to test a hypothesis; it may be also be used in order to seek answers to one or more research questions. In other words, it is the application of an approach to enquiry.⁴⁶ My training and subsequent work as a general hospital nurse in Sheffield, my familiarity with some – though not all - local hospitals, and study of the NHS at undergraduate (social history) and at taught postgraduate (NHS policy and politics) levels since 1978 contributed to my possession of prior knowledge of each of the elements in which I was interested. While this conferred some advantages, as the present study was to be undertaken on a part-time basis in parallel with full-time employment, this also represented more than twenty years of accumulated personal bias, both positive and negative. These provided the potential for fallibility in the questions I asked of my sources and the way I interpreted the historical facts that I found in them.⁴⁷ Thus, I made a conscious decision to approach the documentary evidence in an informed but critical way, and to ask firstly and simply ‘what were the issues that concerned nurses in Sheffield during the period between 1948 and 1974?’ Admitted, this attempt to be self-conscious in my approach to the topic may be specious.⁴⁸ I may believe that my intention is to contribute a meticulous interpretation of historical facts from the primary sources, which if achieved might allow for the addition of new insights into general hospital nursing in the NHS as an aspect of the broader social history of Sheffield, of nursing and of the NHS itself. The case study

⁴⁵ Jones and Lyons, ‘Case study’, pp. 74-75; Innes, Greenfield, Hunton, ‘Using case studies’, p. 401.

⁴⁶ A Marwick, *The New Nature of History – Knowledge, Evidence*, (Basingstoke, 2001), pp. 4-20, 241-263.

⁴⁷ C Hallett, ‘Historical texts: factors affecting their interpretation’, *Nurse Researcher* 5:2 (1997/98); Marwick, *New Nature of History*, pp. 44-49.

⁴⁸ J Topolski, ‘Historical narrative: towards a coherent structure’, *History and Theory* 26:4 (1987), pp. 77-80; K Jenkins, *Re-thinking History* (London, 1991), pp. 11-13; A M Rafferty, ‘Writing, researching and reflexivity in nursing history’, *Nurse Researcher* 5:2 (1997/98), pp. 7-8

approach, despite its limitations, appears the most appropriate means to the attainment of this end. However, this seems to be a fool's errand, notwithstanding Hobsbawm's view that historians should aim to seek and verify historical facts and destroy myths by '...insist[ing] on the supremacy of evidence...'.⁴⁹ The possibility, even the desirability, of seeking after 'truth' – to some a contested concept, to others elusive not by virtue of its inherently relative quality but for more practical reasons that finding the evidence can be difficult if the contemporary records of events have been lost, destroyed or are 'closed' – appears so ridiculously difficult that it would be better not to start. Conversely, the historiography of the NHS, nursing and nursing within the NHS being incomplete, an empirical approach to the present study offers to furnish additional material for others who wish to develop the historiography of general hospital nursing and, or the NHS at local level from a more overtly theory-driven perspective – feminist, perhaps - to examine. Being empirical in approach, this study of Sheffield has something in common with the work of Baly, Webster, Thane and others, who researched primary source material in order to seek answers to 'what', 'why' and 'how' questions, respectively in relation to the influence of the early Nightingale training schools, the official history of the NHS, and the history of 'old age' in England.⁵⁰

Reading of contemporary records, press reports and ephemera, applying principles of inductive reasoning, identified four aspects of nursing as of enduring importance during – and beyond – the period studied. Initial reading and detailed notes made of written, primary sources yielded this information, which subsequently informed the systematic, iterative analysis of these themes as distinctive though interrelated facets of

⁴⁹ Jenkins, *Re-thinking History*, p.15; E Hobsbawm. 'The Historian between quests' in *The Social Responsibility of the Historian – Diogenes 153* ed. F Bédarida (Providence/Oxford, 1994), pp. 51-63; Marwick, *New Nature of History*, p. 49.

⁵⁰ M Baly, *Florence Nightingale and the nursing legacy* (London, 1997, 2nd edition); Webster, *Health Service – Volumes I and II*; P Thane, *Old Age In English History: Past Experiences, Present Issues* (Oxford, 2000).

general hospital nursing, influencing and influenced by the development of the post-Second World War English NHS, during the first quarter century of its existence in Sheffield.

This study draws on extensive archival research, mainly conducted in Sheffield using locally held hospital and health service records. The personal papers of Albert Ballard, first Chairman of the USH Board of Governors, were also consulted. Local and national newspapers and ephemera - including publicity leaflets and pamphlets about nurse training courses, and hospital open days - provided a perspective not available from the official records of NHS administration.⁵¹

When I began work on this study, I anticipated that the primary sources that I consulted would include not only written records but also oral testimony. Personal stories from people who had worked in and perhaps been patients in Sheffield's general hospitals would complement the information gleaned from the written record.⁵²

Marwick allows that oral history can contribute to the information that we have about the past – while being decidedly unenthusiastic about this approach. Others – of whose opinions Marwick is often at best sceptical - are themselves less sceptical about oral history, while recognising the limitations of the approach. While oral history offers advantages in enabling insights to past events and situations that are not accessible from written records, even permitting the writing of a more 'democratic' history especially of local events, there are inherent problems. These include sampling the population, in data collection and maintaining a critical and objective approach in dealing with people's stories about their own lives.⁵³ Moreover, the practical challenges of identifying potential informants, seeking appropriate permission to

⁵¹ I Ramage, *A Guide to Archives and Records for the History of Medicine and Health Care in South Yorkshire and the North Midlands* (Sheffield, 1997).

⁵² G Prins, 'Oral history' in *New Perspectives on Historical Writing* ed. P Burke (Cambridge, 1991).

⁵³ Marwick, *New Nature of History*, pp. 135-136; L Jordanova, *History in Practice* (London, 2000), p. 53; Prins, 'Oral history', pp. 119 *et seq*; J Tosh, *The Pursuit of History* (Harlow, 1999, 3rd edn), Ch. 11.

interview – which may include gaining ethical approval, conducting the interviews, transcribing tapes, analysing the data and seeking validation of the data transcribed from the interviewees themselves, can take a considerable amount of time.⁵⁴ Furthermore, a chance conversation with a colleague alerted me to the existence of a collection of hospital records that had been presented to the University's Special Collections and Archives. This included more than fifty nursing staff registers of various kinds, minutes of meetings, and other records of nursing at the United Sheffield Hospitals and its precursors from 1901.⁵⁵ Complementing the administrative records already deposited with the Sheffield Archives, this collection of material provided sufficient data to occupy me for longer than the time that was actually available – it would be possible to exploit these documents further. I had to decide whether it would be possible to collect oral testimonies within the context of the present research study and, regrettably, it was apparent that it would be more practical to defer this aspect of the project.

The idiosyncrasies of archival material are well rehearsed and do not require lengthy repetition here. Information may be incomplete because of a desire to protect personal information, because of a lack of money and space to store 'the enormous bulk of modern records' or because their value has not been recognised.⁵⁶ The changing nature of one set of minutes, that of the meetings of the Sheffield Region of the National Association of HMC Secretaries, who met between 1952 and 1974, illustrates another dimension. The records of the group's early meetings are detailed and the topics discussed were wide-ranging. Later records are briefer and narrower in scope. It is likely that participants were initially unsure of their new roles and of the scope of

⁵⁴ Insight from personal experience of undertaking empirical research for an MA dissertation, 1990-1991.

⁵⁵ Now held at the Sheffield Archive, SA: Acc 2001/98.

⁵⁶ E Higgs, J Melling, 'Chasing the ambulance: The emerging crisis in the preservation of modern health records', *Social History of Medicine* 10:1 (1997), pp. 127-136; C B McCullagh, 'Bias in historical description, interpretation, and explanation', *History and Theory* 39:1 (2000), pp. 39-66.

associated responsibilities as NHS administrators and as members of the National Association itself. During the early meetings, they appear to have been telling themselves what they were doing and why. Gradually, the need to do so lessened and the level of detail in the records diminished accordingly. The risk that the available records are not authentic hospital and health authority records is limited – they were deposited with the Sheffield Archives by officers of the bodies from which they originated. In addition, while there are gaps, the availability of records from different hospitals, and from different parts of the hospital service, in Sheffield made it possible to cross-reference material in order to check its validity on most occasions.⁵⁷

Of specific interest here is the availability of records concerning nurses and their work. This is mediated by whether the record was ever made, whether it has been kept and whether it is accessible. Nurses' decisions and actions did not have high status in the occupational hierarchy in the NHS, and their records have not necessarily survived. Conversely, a complete record of the meetings that the Matrons at the Infirmary held with Sisters has survived intact. It is possible that meetings of Matron with Sisters at the General were never recorded - the only information currently available that they took place is a passing reference in the Matron's report to the hospital's House Committee in 1953.⁵⁸

The changing situation of nurses as workers can be traced through the records of the USH, where the two constituent general hospital units retained separate recruitment of nursing staff for most of the period under study, although the organisation of information in each is quite dissimilar to that held by the other. The implementation of specific national policy directives that affected nursing recruitment and retention locally can also be examined through the minuted discussions that took place during

⁵⁷J Platt, 'Evidence and proof in documentary research:1&2' *Sociological Review* 29:1 (1981), pp. 31-66.

⁵⁸SA: SY 569/H1/6, Minute 22, CGH(53)2.

meetings of the hospitals' and health authorities' administrative committees. Staff records allow some insights to recruits' previous work and educational experience, age on joining the hospital, religion, sex, and marital status. Senior nurses' perceptions of what constituted acceptable - and unacceptable - levels of ability and behaviour in students and their junior colleagues can also be inferred. Information about the range and duration of ward and department placements attended by students is included.

Further information about the working environment came from reports on GNC Inspectors' routine visits to the various Schools of Nursing. These provide information about the clinical environments in which Student and Pupil Nurses worked, in addition to observations about the classrooms in which they were taught. Finally, the annual magazine of the Infirmary's League of Trained Nurses, the annual reports of the USH, published from 1949 until 1974, nurse recruitment pamphlets, local newspaper articles in the general and party political press, and the private papers of the first Chairman of the USH, have all added further information.

1. Sheffield's Hospitals and the NHS, 1930-1974

1.1 The Origins of the NHS

On July 5 we start, together, the new National Health Service. It has not had an altogether trouble-free gestation!⁵⁹

It has been argued that even to refer to the NHS's 'creation...can be justified only from a legal or administrative standpoint', given the predominance of the old in the new.⁶⁰ With effect from 5 July 1948 the NHS made access to health care, free at the point of use, available to all British citizens, demonstrating an interpretation of 'citizenship' as entitlement of access to social and economic goods, as well as to political rights, that was largely upheld by governments of both major political parties until the mid-1970s. While governments in countries other than Britain, including France and Germany, intervened to extend the availability of health services to their citizens after the end of World War Two, the NHS was initially uniquely comprehensive among the health care systems of non-socialist countries.⁶¹ The nationalisation of hospitals and the decision to fund the service mainly through general taxation meant that the NHS was also the most radically changed of western health care systems during the period.

An admixture of old and new, the NHS is variously described as having replaced an 'accretion', a 'patchwork', 'ramshackle', 'uncoordinated', 'inadequate and partial' array of services – particularly hospital services.⁶² The hospital surveyors of Sheffield and the East Midlands, for example, observed in 1942 that 'There is no hospital system

⁵⁹ Aneurin Bevan, 'A Message to the Medical Profession from the Minister of Health' *British Medical Journal* 3 July (1948), p. 4565. The punctuation is as it was in the original.

⁶⁰ B Watkin, *The National Health Service: The First Phase: 1948-1974 and After* (London, 1978), p. 1; see also Willcocks, *Creation*.

⁶¹ P Starr and E Immergut, 'Health care and the boundaries of politics' in *Changing Boundaries of the Political*, ed. C S Maier (Cambridge, 1987), Chapter 7.

⁶² A Digby, *British Welfare Policy - Workhouse to Welfare* (London, 1988), p. 60; M A Crowther, *British Social Policy, 1914-1939* (Basingstoke, 1988), p. 32; G Godber 'The origin and the first 25 years: a view from the centre' in *Our NHS: A celebration of 50 years*, ed. G Macpherson (London, 1998), p. 14; D Black 'Socioeconomic deprivation and the NHS' IN *Our NHS*, p. 23; Klein, *Politics* (1989), p. 1.

now, and it would be impossible to classify hospitals in any orderly manner which would have the acceptance of all managing bodies.’⁶³

The founding of the new service has been mythologised, the NHS representative of positive change, freedom from fear of sickness and an end to chaos and confusion. Eckstein suggests that this was the chief reason for the creation of the English health service – a view that Pater echoes.⁶⁴ According to this version of events, seen for example in television documentaries and discussion programmes marking the Service’s fiftieth anniversary in 1998, the creation of the NHS brought a clean break with the inadequacies of the past.⁶⁵ From the Appointed Day, people were able – though not forced - to access all the health care they required from the NHS, without facing either the fear of financial ruin or the humiliation of means testing. Moreover, the NHS offered the possibility of enhancing the working lives of health care professionals and those in complementary occupations as new hospitals and health centres and modern equipment became available, allowing staff to concentrate on caring for their patients without the distraction of coping with inadequate facilities, equipment and funding that those in the voluntary sector had faced previously.⁶⁶

In reality, the creation of the NHS was both more interesting and more complex. It involved highly significant innovations, such as the nationalisation of hospitals, the creation of a new administrative structure and the tax-based funding of the new service. At the same time, the greater part of the NHS was not new. The buildings and equipment it now used had been taken into state ownership from the municipalities and the voluntary hospital organisations. The staff who worked in the hospitals had worked in them before the NHS was established, while those members of the

⁶³ Ministry of Health, *Hospital Survey: Sheffield*, p. 54.

⁶⁴ Eckstein, *English Health Service*, p. viii and p. 178; Pater, *Making*, p. 165.

⁶⁵ BBC, *Look North* (Leeds, 1998); Powell, *Evaluating*, p. 12.

⁶⁶ COI, *Health*; Bevan, ‘Message’, p. 4565.

community who sat on the committees and boards of the new NHS organisational structure had in many cases served on the bodies that ran the hospitals before July 1948. General medical practitioners' working relationships with the NHS differed little from those that obtained under National Insurance panel arrangements established from 1911.

Prior to 5th July 1948, health care was available from a number of different providers. These included local authorities, which had become responsible for an increasing range of community services including provision for midwifery, children's health and welfare from birth until they left school, and the provision of services for the prevention, detection and management of diseases as diverse as cancer and tuberculosis. Local authorities were also responsible for the provision of hospital care, including infectious diseases hospitals, tuberculosis sanatoria and, following the passage of the 1929 Local Government Act, for what had been the Poor Law infirmaries and hospitals. Finally, they also had legal responsibility for the provision of institutional care for people with mental health and learning disabilities.⁶⁷ In all, there were 1545 municipal hospitals, with 320,000 beds, including 78,000 in isolation hospitals and sanatoria and 35,000 for people with various mental illnesses and disabilities.⁶⁸

In addition to the provision of a wide range of services by local authorities, the national health insurance structure that was introduced under the National Health Insurance Act of 1911 made general medical practitioner services available to working people, subject to income. This supplanted and extended earlier provision made under the auspices of trades unions and friendly societies, but its benefits were restricted to

⁶⁷ Lindsey, *Socialized Medicine*, pp. 16-22; Powell, *Evaluating*, pp. 13-14, 18-22; Webster, *Health Service - Volume I*, pp. 5-10.

⁶⁸ J Allsop, *Health Policy and the National Health Service* (Harlow, 1984), p. 25; Pater, *Making*, pp. 148-149.

the insured person, and limited in scope with the exception of the maternity grant payable to the wife of an insured.⁶⁹ Where available, the outpatients departments of hospitals were used as a *de facto* General Practitioner service but for many, especially women, health problems were self-managed at home.⁷⁰

Voluntary hospitals also provided hospital in-patient and out-patient facilities. The majority of these began during the late eighteenth and nineteenth centuries as charitable foundations. There were fewer of these than municipal hospitals, with only 1143 in 1938, many very small, and the total number of beds they contained was, at 78,000, less than a quarter of those in the municipal hospital sector.⁷¹ On the eve of the Second World War, the voluntary hospitals continued to rely in part on charitable donations in cash and in kind. They had been forced to extend their funding base to include private fees, hospital contributory schemes and subsidies from local and national government since the end of the nineteenth century.⁷² The establishment of the Emergency Hospital Scheme during World War Two, into which all hospitals were organised regionally in anticipation of mass civilian casualties from enemy bombing and armed forces battlefield casualties, augmented their income as the state contributed to the cost of this temporary service.⁷³

Discussion over the organisation and resourcing of health services, and the proper role of the State therein, has been traced back to at least the publication of the Minority Report of the Royal Commission on the Poor Laws and Relief of Distress in 1909.⁷⁴ While the Ministry of Health, the British Medical Association (BMA) and the organisation Political and Economic Planning had all made proposals for the reform of

⁶⁹ Lindsey, *Socialized Medicine*, pp. 4-12; Powell, *Evaluating*, pp. 15-17; Webster, *Health Service - Volume I*, pp. 10-12; Jones *Health and Society*, pp. 16-17.

⁷⁰ Jones, *Health and Society*, pp. 123-124; Lindsey, *Socialized Medicine*, p. 473.

⁷¹ Allsop, *Health Policy*, p. 25; Pater, *Making*, pp. 148-149.

⁷² Lindsey, *Socialized Medicine*, pp. 14-18; Powell, *Evaluating*, pp. 17-18; Webster, *Health Service - Volume I*, pp. 2-5; Cherry, 'Accountability'; Cherry 'Before the National Health Service'.

⁷³ Pater, *Making*, pp. 21-22; Titmuss, *Problems*, Chapter 1.

⁷⁴ Pater, *Making*, pp. 2-4; Webster, *Health Service - Volume I*, pp. 17-18.

Britain's health-care arrangements since 1920, serious planning at ministerial level for a coordinated system of health care provision was confined to the seven years before the NHS Act was passed in 1946. By 1939, the various constituencies including health care providers, professionals and political parties agreed on the need for reform, although they disagreed about its optimal direction.⁷⁵ In 1942, the Report on Social Insurance and Allied Services noted that comprehensive health services were central to social welfare, without suggesting how these might be structured.⁷⁶ Between 1943 and 1946, two Ministerial plans, a White Paper, and the National Health Service Bill were published. The former addressed the administrative structure, financial arrangements, basis of access to services and role of health professionals' involvement in the health services. The National Health Service Bill of 1946 built on these, with the notable innovation of the 'nationalisation' of hospitals. Bevan's explanation of this to the House of Commons was that it was designed to permit the Minister of Health to fulfill his duty to provide a comprehensive health service, free at the point of use, while avoiding the risks of 'paper planning or bad execution'.⁷⁷

The nationalisation of the hospitals implied a change of ownership, but was not of necessity incompatible with municipal control. Bevan's experience of the well-organised medical lobby from the time of his appointment as Minister of Health in 1945, and of local government, which he believed to be inadequate to provide a universally high standard of health care, influenced his views. While, Stewart argues, he was 'obliged to work with the powerful BMA' he was prepared to oppose the views of colleagues such as the Labour Party's Deputy Leader, Herbert Morrison, who

⁷⁵Berridge, *Health and Society*, pp. 10-13; A Butler, 'The end of the post-war consensus: reflections on the scholarly uses of political rhetoric' *The Political Quarterly* (1993), pp. 435-446; P Johnson, 'Some historical dimensions of the Welfare State 'crisis'' *Journal of Social Policy* 15 Oct (1986), pp. 443-465; Pater, *Making*, pp. 21-22.

⁷⁶ Great Britain, Parliament, *Social Insurance and Allied Services* Cmd 6404, Chairman: W Beveridge (London, 1942), pp. 153, 158, 159, 169.

⁷⁷ Aneurin Bevan, 'Second reading of the NHS Bill', HC Debates, vol. 422, cols. 46-49, 30 Apr (1946).

favoured local government control of the NHS. The London County Council, in which Morrison spent much of his political life and of which he was Leader between 1934 and 1940, had made great strides in developing its health services, but in spite of substantial achievements in some municipalities elsewhere in the country, the extent of development was uneven and the stigma of association with the Poor Law remained.⁷⁸ Bevan was unwilling to risk handing the NHS over to local government in these circumstances. With the support of both Attlee and the Leader of the House of Lords, Lord Addison, Bevan prevailed and created a new structure for the administrative control of hospitals.⁷⁹

Since the late 1970s and early 1980s there has been a revisiting of the origins of the classic welfare state in Britain and of the NHS as a central part of that. These revisions draw attention to the conflicts that marked reform of health care provision in Britain and of the form it took from July 1948.⁸⁰ While there was consensus on the principles of social policy, there had not been a simple process of forging agreement over details. Even the date for the Appointed Day for the commencement of the NHS was altered on more than one occasion.⁸¹ There were conflicts between different interest groups involved in the formation of the NHS. Furthermore, many were excluded from the debates over the NHS' foundation.⁸² Ideology divided political and professional opinion on the precise form which the health services should take, and the bases on which the medical profession should participate in their delivery and lay people have

⁷⁸ M Foot, *Aneurin Bevan, A Biography – Volume II, 1945-1960*, (London, 1973), pp. 132-133; C H Webster 'Local government and health care: the historical perspective' *British Medical Journal* 310 (1995), pp. 1584-1587.

⁷⁹ Timmins, *Five Giants*, pp. 116-118; J Ramsden, *The Oxford Companion to Twentieth Century British Politics* (Oxford, 2002), pp. 443-444.

⁸⁰ Webster, *Health Service - Volume 1* Chapters I-V, *passim*; Webster, *Political History*, Chapter 1; Berridge, *Health and Society*, Chapter 2; S Cherry *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), Chapter 5; Jones, *Health and Society*, pp. 119-123; Timmins, *Five Giants*, p. 102.

⁸¹ Webster, *Health Service - Volume 1*, p. 120.

⁸² Klein, *Politics* (1989), pp. 10-25; Fox, *Health Policies*, pp. 106-114.

access to them.⁸³ Cartwright's account of Bevan's dispute with the BMA in the two years preceding the Appointed Day notes, from the author's personal experience, that the conflict was such that '...it required moral courage and even some physical bravery to state a case for the Service at meetings...'⁸⁴

While the proposal for state control of hospitals and other health services was regarded with suspicion and even hostility by elements both of the BMA and of local government, a return to the pre-war situation was not feasible.⁸⁵ The extent of the financial difficulties faced by the voluntary hospitals in 1939 is contested but the perception that they faced bankruptcy was an important factor in support for health sector reform, especially on the part of senior Doctors.⁸⁶ Voluntary hospitals had broadened their income base from a narrow reliance on voluntary subscriptions and charitable donations, to encompass private patient and local authority fees, and payments from local savings associations. They had achieved mixed results, with greater success in funding current than capital accounts. Hence Cherry argues that, by 1939, the hospitals were forced into '...dependence upon state finance to meet wartime emergencies'.⁸⁷ This source of income continued during the Second World War as payment for the contribution made to the Emergency Medical Service between 1939 and 1945, but was uncertain in the longer term.

Yet while Webster describes an 'increasingly desperate struggle for survival', Powell's view is that the impression of near-bankruptcy is incorrect, pointing out that hospitals always appear to lack sufficient funds. He argues that voluntary hospitals' financial difficulties were more the result of high spending than low income, and that the fact

⁸³Timmins, *Five Giants*, Chapter 6; Webster, *Health Service - Volume I*, Chapters I-IV.

⁸⁴ F F Cartwright, *A Social History of Medicine* (London and New York, 1977), p. 179.

⁸⁵ Detailed analysis of the negotiations between the BMA and Bevan is provided in Webster, *Health Service - Volume I* (1988), pp. 88-94, 107-120; and Klein, *Politics* (1989), pp. 20-25.

⁸⁶ Klein, *Politics* (1989), p. 4; Webster, *Health Service - Volume I*, p. 4; Cherry, 'Accountability', pp. 215-233; Cherry 'Before the National Health Service', pp. 305-326; Powell, *Evaluating*, pp. 35-6.

⁸⁷Cherry, 'Before the National Health Service', p. 322.

that their income base grew more varied during the interwar period is not necessarily indicative of dire financial straits. Rather, unplanned and ill-considered 'modernisation' was responsible for their difficulties.⁸⁸ Powell based his diagnosis on extensive study of the *Hospital Surveys*, which had drawn attention to the perverse incentives created by competition between health care providers. For example, the surveyors of the Sheffield and East Midland area criticised the purchase of 'lavish equipment' by hospitals that lacked staff with the expertise to operate it, interpret the results of diagnostic tests or understand their clinical application.⁸⁹ More recent research by Gorsky, Mohan and Powell indicates, however, that the finances of some voluntary hospitals were at least 'insecure' by 1939.⁹⁰

Just as the extent of the voluntary hospitals' financial problems before 1939 is subject to debate, so too are the assumed failings of the municipal health authorities. By 1935, the contribution to total health expenditure made by the local authority health services had reached sixty per cent. Webster has argued that between 1930 and 1939 the level of expenditure in the municipal health sector had doubled, so that local authorities were not only assuming responsibility for 'failed' aspects of the voluntary hospital sector, some '...were within reach of a comprehensive health service...' using extant statutory frameworks as the basis for expansion. Such successes were not universal, and Webster has described 'many' of the authorities' health services as '...an abject failure...'⁹¹

⁸⁸ See M A Powell 'Hospital provision before the National Health Service: A geographical study of the 1945 Hospital Surveys' *Social History of Medicine* 5 (1992) pp. 483-504; M A Powell 'How adequate was hospital provision before the NHS? An examination of the 1945 South Wales Hospital Survey', *Local Population Studies* 48 (Spring) (1992), pp. 22-32.

⁸⁹ Ministry of Health, *Hospital Survey: Sheffield*, p. 3.

⁹⁰ M Gorsky, J Mohan, M Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review* LV:3 (2002), p. 554.

⁹¹ C H Webster, 'Confronting historical myths', *The Health Service Journal*, 19 May (1988), Special Supplement 'Thoughts for the Prime Minister's Review', pp. 2-3; C H Webster, 'Local government and health care: the historical perspective' *British Medical Journal* 310 (1995), pp. 1584-1587.

Again, Powell offers a different perspective, contending that the pace of reform in the municipal sector was impressive given the limited time and other pressures on local authorities during the 1930s.⁹² In this, he echoes the opinion of E J Maude, a member of the Guillebaud Committee (1953-1956), who regretted the delay of twenty years between the *Minority Report* on the Poor Law in 1909 and the passage of the 1929 *Local Government Act*. Maude's contention was that this allowed the local authorities a scant decade in which to '...study hospital administration and - more important - to get on terms with the influential members of the medical profession who guided the fortunes of the voluntary hospitals of the day...'⁹³

While there was agreement on the need to reform the health services for pragmatic reasons, the right of the State to intervene in the management of health care and the medical profession in particular, which was implicit if the State were to continue to provide financial support for the hospitals, was less welcome. The plans that developed between 1939 and 1946 included different models for the administrative structure of the health services. Misgivings about the feasibility of combining diverse elements of health care provision in a national structure were challenged by the operation of wartime emergency services. These had successfully co-coordinated hospital services at national and regional levels in Britain. Although it would be unwise to give too much weight to this, since reform of health services and a concomitant increase in State involvement were considered inevitable before this regionalisation, the experience demonstrated the possibility of success in a large-scale, state-mediated system.⁹⁴

⁹²M A Powell, 'An expanding service: Municipal acute medicine in the 1930s', *Twentieth Century British History* 8:3 (1997), pp. 334-357.

⁹³*Report of the Committee of Enquiry into the Cost of the National Health Service*, (Chair C W Guillebaud), Cmd 9663, (London, 1956) - 'Reservation about the structure of the National Health Service' (paragraph 11 quoted here), signed by E J Maude, 16 Nov 1955.

⁹⁴Fox, *Health Policies*, p. 94.

The alternative to local government administration of the new service with the parallel voluntary hospital system continuing alongside it was the creation of an entirely separate administration for hospital services. Bevan's willingness to concede this point in 1946, although it created tensions with certain of his cabinet colleagues, was vital to the success of his negotiations with the BMA, which had actively scrutinised all previous proposals, and maintained a constant antipathy towards any hint that general medical practitioners should become salaried state employees.⁹⁵ The Royal Colleges' approach was somewhat more ambivalent, as their members were likely to be more directly, and adversely, affected than were those of the BMA by the prospect of a return to financial problems in the voluntary sector once the Emergency Medical Service had been stood down after the War. Bevan also made important concessions to them. The preservation of Doctors' access to private practice was effected through the pay bed system within the NHS, and through NHS contracts allowing them to work in both public and private sectors. The Award system of additional merit payments on top of the NHS salary for Consultant grade Doctors was a further incentive to this section of the medical profession.⁹⁶

The NHS represents a considerable political achievement, perhaps the more so when the protracted and difficult negotiations that took place over the preceding seven years are considered. Such a consideration helps to put into perspective the concessions made by Bevan to members of the Royal Colleges, and to the BMA. Between 1948 and 1961, realisation of the outcome of those compromises made to resolve conflicts of interest between national and local government, and between these levels of government and the medical profession, had to be effected. Those parties which were engaged in these conflicts, and who thereafter worked in the NHS, carried these tensions into the service. Furthermore, they did so in the context of dealing with the

⁹⁵ Timmins, *Five Giants*, pp. 116-118.

⁹⁶ Webster, *Health Service - Volume I*, p. 313; Cartwright, *Social History*, p.177.

establishment of a service that carried important political and popular significance, but having to do so with restricted budgets and limited resources. The implications of those restrictions and limitations will now be explored in relation to Sheffield's general hospitals in 1948.

1.2 Pre-NHS Hospital Services in Sheffield

So much has happened that it requires a real effort of will to remember those post-war days, when the city was scarred, shabby and dirty, and the future of industry had to be forecast.⁹⁷

Sheffield is located in the north midlands of England, on the south-eastern edge of the Pennine Hills. An industrial city, Sheffield was long synonymous with the metal-working industries that developed from the Middle Ages onwards, and the cutlery and associated crafts that continued in hundreds of 'Little Mesters' workshops, most importantly in the production of special and alloy steels.⁹⁸ These provided the bulk of employment for the city's population until the mid-1970s.⁹⁹

Sheffield grew rapidly from the beginning of the nineteenth century, its population rising from 45,755 in 1801 to 520,327 in 1971. Its boundaries were extended on eight occasions between 1901 and 1967, increasing its area from 19,643 to 45,332 acres.¹⁰⁰ While its growth did not make Sheffield exceptional, the city possessed other distinguishing features. The concentration of employment in its main industries was greater than in most other cities until after the Second World War.¹⁰¹ Secondly, Sheffield's wealth was more evenly distributed among its population than was the case

⁹⁷ M Walton, *Sheffield, its Story and its Achievements*, (4th Edition, Otley, 1968), p. 265.

⁹⁸ B E Coates, 'The geography of industrialization and urbanization of South Yorkshire, 18th Century to 20th Century', in *Essays in the Economic and Social History of South Yorkshire*, ed. S Pollard and C Holmes (Barnsley, 1976), pp. 14-16.

⁹⁹ G Tweedale, 'The business and technology of Sheffield steelmaking', in *The History of the City of Sheffield, 1843-1993: Volume II, Society*, ed. C Binfield, R Childs, R Harper, D Hey, D Martin, G Tweedale (Sheffield, 1993), pp. 166-176; S Pollard, 'Labour' in *History of the City of Sheffield, Volume II*, pp. 274-277.

¹⁰⁰ A D H Crook, 'Appendix: Population and boundary changes, 1801-1981' in *History of the City of Sheffield: Volume II*, pp. 482-483.

¹⁰¹ Pollard, 'Labour', p. 260.

in other industrial cities. A higher proportion of the population belonged to the manual working classes, according to the Registrar General's classification system, than was common nationally.¹⁰² In addition, in part by virtue of its topography though also deriving from its distinctive economic and social history, Sheffield remained relatively remote from major road and rail communications until after the Second World War.¹⁰³ Until the reorganisation of English local government in 1974 and the creation of South Yorkshire, Sheffield was not important as an administrative centre.¹⁰⁴ Finally, the development of Sheffield's health care provision was idiosyncratic.

Sturdy's study of medical practice in the city between 1890 and 1922 suggests that the relatively even distribution of wealth in the city meant that Sheffield's Medical School lacked local benefactors with sufficient means to support its work and, as one of the poorest such institutions in the country, had therefore to sell its services locally. These included the provision of General Practitioner services by its Doctors, however senior, which practice led to a delay in the development of consultancy, specialism and referral systems compared to the rest of Britain.¹⁰⁵ Honigsbaum argues that the separation of general and specialist medical practitioners in British medicine, and the associated development of the referral system, resulted from a complex mix of factors. These included the aspiration to develop a collaborative referral system between generalists and specialists for the sake of patients, the existence of intra-professional divisions, and Bevan's decision to exploit those divisions in order to assure the establishment of the NHS. The latter contributed to the dominance of the hospitals –

¹⁰² S Sturdy, 'The political economy of scientific medicine: Science, education and the transformation of medical practice in Sheffield, 1890-1922', *Medical History* 36 (1992), p. 131; Pollard, 'Labour', pp. 260, 274-275.

¹⁰³ Coates, 'Geography', p. 19; D Joy, 'Sheffield', in *The Oxford Companion to British Railway History from 1603 to the 1990s*, ed. Jack Simmons and G Biddle (Oxford, 1997), pp. 439-440; W Hampton, 'Optimism and Growth 1951-1973', in *The History of the City of Sheffield, 1843-1993: Volume I, Politics*, ed. C Binfield, R Childs, Roger Harper, D Hey, D Martin, G Tweedale (Sheffield, 1993), p. 122.

¹⁰⁴ Pollard, 'Labour', p. 260.

¹⁰⁵ Sturdy, 'Political economy', pp. 131, 136-137.

and of the specialists within them.¹⁰⁶ The numbers - and organisation - of specialists in Sheffield was considered inadequate by the *Hospital Survey*, and one aspect of hospital provision in need of immediate improvement.

In common with other large cities at the time of the Second World War, Sheffield had hospitals in both the voluntary and municipal sectors. These included eleven voluntary hospitals in total at various times from the eighteenth century, of which the first was the General Infirmary, founded in 1797. A Public Dispensary followed in 1832, and nine further specialist hospitals and dispensaries, eight founded during the nineteenth century.¹⁰⁷ Also during the nineteenth century, Sheffield's local, statutory authorities' established a further nine hospitals for the care of the physically ill. Under the Poor Law Amendment Act, Union, or workhouse, hospital provision was provided at the Ecclesall Union Hospital, founded in 1842, and the Sheffield Union Hospital, founded in 1881. The former became Nether Edge Hospital in 1930, the latter the City General Hospital from the same date, when both became municipal hospitals within the responsibility of Sheffield Corporation's Health Committee, under the Local Government Act of 1929.¹⁰⁸

In addition, the city's municipal authorities had used powers granted under several Acts of Parliament passed during the nineteenth and early twentieth centuries to found seven hospitals to provide care for people with infectious diseases. The first of these was the Borough Hospital, Winter Street, founded in 1881 as a fever hospital. Lodge Moor Hospital, also a fever hospital, followed in 1888. Crimicar Lane Hospital,

¹⁰⁶ Honigsbaum, *Division*, pp. 299-309.

¹⁰⁷ Sheffield City Libraries Department of Local History and Archives, *Local History Leaflet No 7 - The Sheffield Hospitals* (Sheffield, 1959), lists the following : Sheffield General Infirmary, 1797 (from 1897, the Sheffield Royal Infirmary); Sheffield Public Dispensary, 1832 (from 1895, the Sheffield Royal Hospital); Eye Dispensary, 1829; Chest Diseases Dispensary, 1830; Cholera Dispensary, 1832; Eye and Ear Dispensary, 1841; Sheffield Hospital for Women, 1864 (from 1877, Jessop Hospital for Women); Sheffield Children's Hospital, 1876; Sheffield and South Yorkshire Ear and Throat Hospital, 1880, which amalgamated with the Sheffield Public Hospital for Skin Diseases, 1880, in 1892; Edgar Allen Institute, 1911.

¹⁰⁸ *Ibid.* p. 6.

originally a smallpox hospital (1902), Commonsides City Hospital for Consumption (1908), and the Municipal Tuberculosis Dispensary (1911), made provision for the care and treatment of people with pulmonary tuberculosis, which Sheffield made compulsorily notifiable under a local Act of Parliament in 1904.¹⁰⁹ Surgical tuberculosis was treated at the King Edward VII Hospital, founded in 1916, which also served as an orthopaedic hospital. Finally, Ash House School provided care for children with rheumatic heart disease.

Sheffield's Public Health Department acquired responsibility for the management of the General, as well as Fir Vale Infirmary and Nether Edge Hospital in 1930. When the Labour Party extended its majority on Sheffield's City Council in the 1929 elections, they faced 'chaos' in local finances even before, shortly thereafter, they assumed direct responsibility for poor relief.¹¹⁰ Global economic crisis was reflected in a drop in employment in the heavy trades that dominated the local Sheffield economy, from 66,000 to 47,000 in 1931. At this time, the city was already experiencing levels of unemployment above the national average, and a general downturn in the fortunes of Sheffield steel that only reversed from the mid-1930s with the growing demand for armaments.¹¹¹ The country's Labour Government was in disarray and gave way to a National Government in 1930, with repercussions for the Labour Party in Sheffield, where it temporarily lost control of the city council to the Progressives, between 1932 and 1933. Nonetheless, the plans Labour had made for new facilities at the General survived. On the 19th and 20th October 1932 alone, applications were made to the Town Surveyors in respect of new casualty, operating

¹⁰⁹ C Fraser Brockington, *A short history of public health* (London, 1966, 2nd Edition), p. 174.

¹¹⁰ A Thorpe, 'The consolidation of a Labour stronghold', in *History of the City of Sheffield: Volume I*, pp. 89-95.

¹¹¹ J Saville, *The Labour Movement in Britain* (London, 1988), p. 56; M Olive, 'Sheffield's East End', in *Forging the Valley*, ed. D Hey, M Olive, M Liddament (Sheffield, 1997), pp. 89-90; Tweedale, 'The business and technology of Sheffield steelmaking', p. 176; Thorpe, 'Consolidation of a Labour stronghold', p. 90.

theatre, and maternity blocks, and extensions to the nurses' home to provide an additional seventy-eight bedrooms on two four-storey wings with associated amenities. Further developments on the site were proposed for Fir Vale House, for the Public Assistance Committee, and for children's ward facilities at the General in 1935.¹¹² Thus alongside the 1881 buildings at the General, a new maternity department, operating theatres, casualty and out-patients departments, and a large new laboratory were constructed during the 1930s.

By 1938, the city had established a mechanism for the referral of patients to municipal and voluntary hospitals alike. The remaining four voluntary hospitals had created a Joint Consultative and Advisory Hospitals Council, soon joined by local government bodies, which established a contributory scheme for the payment of hospital fees and the coordination of admissions to hospitals in both voluntary and Poor Law hospitals, from 1922.¹¹³ The city in 1938 had one Public Assistance Institution, Fir Vale, which shared a site with the General and had been managed by the city's Public Assistance Committee separately from the eight hospitals for which the Health Committee was responsible since 1930, but to which the municipal and voluntary hospitals referred people according to need.

In 1943, when the Nuffield Provincial Hospitals Trust (NPHT) conducted the region's Hospital Survey under the ægis of the Ministry of Health, Sheffield was 'the major hospital centre in Yorkshire...where reside the largest number of Consultants and...the only medical school in our area of the survey.'¹¹⁴ Sheffield's medical school provided for part of the West Riding of Yorkshire, Nottinghamshire, Derbyshire, Lincolnshire, Leicestershire, and Rutland. The surveyors described thirteen hospitals in the city, of

¹¹² Thorpe, 'Consolidation of a Labour stronghold', pp. 97-99; SA: 34359(3 and 4), 'Plans submitted by W G Davies Architects' (1932-1940).

¹¹³ Sturdy, 'Political economy', pp. 144-151; Cherry, 'Accountability', pp. 226-227.

¹¹⁴ Ministry of Health, *Hospital Survey: Sheffield*, p. 18.

which four were in the voluntary sector the remainder being municipal hospitals. According to a pamphlet issued by the city's Health Committee in 1938 concerning the latter, 'The services which are provided at these hospitals are available to every citizen, without reservation, the hospitals being administered entirely under the provisions of the Public Health Acts and quite outside Poor Law legislation.'¹¹⁵ In 1938, 28% of the Royal's patients, and 37% of the Infirmary's were not Sheffield residents, whereas the majority of patients using the city's municipal hospitals were from Sheffield.

The four voluntary hospitals and three of the municipal hospitals offering full medical and surgical services had been designated Class IA, Casualty Clearing Hospitals, within the wartime Emergency Hospital Service.¹¹⁶ The voluntary hospitals had 775 beds in their main buildings, a further 93 in annexes, and plans to construct a new, 750-bed, teaching hospital on a site near the University and the Medical School with which they had close links. The two general voluntary hospitals, the Royal and the Infirmary, shared dermatologists, radiotherapists and neurosurgeons, if not their general medical or nursing staffs – although they co-operated in the newly founded Sheffield School of Nursing.

However, the surveyors also found that despite the operation of the Joint Hospitals Council and legal union between the two general voluntary hospitals, the Royal and the Infirmary, amalgamated by private Act of Parliament in 1938, there was limited cooperation between their junior Doctors. The number of Consultants in the city was 'too small for the town itself' and these served a wide number of hospitals in the region beyond Sheffield. Despite the formal referral mechanisms, there was also less cooperation between the voluntary and municipal sectors than the surveyors believed

¹¹⁵ Health Committee, *The Public Health Services of the Sheffield City Council*, (Sheffield, 1938).

¹¹⁶ J Rennie, 'Sheffield', in *The Emergency Medical Services – Volume II Scotland, Northern Ireland and the Principal Air Raids on Industrial Cities in Great Britain*, C L Dunn (London, 1953), Chapter 10.

was optimal, and they observed that this adversely affected the access of patients in one sector to services offered in the other.¹¹⁷

Furthermore, the buildings of the three general hospitals were deficient in important respects: location, size, age and appropriateness for contemporary use. The *Hospital Survey* described the Royal as occupying a 'cramped site', bordered on three sides by streets, and on the fourth by commercial establishments. The Infirmary, although built on a larger site, was described as poorly designed.¹¹⁸ The new buildings at the General were said to be 'good', although the casualty and ante-natal departments were described as too small. The *Survey* described the older nursing wards at the General as '...typical of their period, large for acute nursing units, and small wards are lacking...they were to have been replaced by a new Acute Hospital on part of the site...These old buildings will not be suitable for long-continued use.'¹¹⁹ Furthermore, the surveyors found that the Health Committee had not implemented plans to replace the old hospital with a new acute general hospital. Although the report does not explain this failure, it is probable that lack of time rather than will was the key factor. Powell has argued that war and, shortly thereafter, the inception of the NHS curtailed the time available for hospital development by municipalities – as, indeed, was the case for the new teaching hospital planned by the Court of Management of the Royal Sheffield Infirmary and Hospital. The Medical Officer of Health's report on Sheffield for 1947 is indicative of this explanation. It notes that 'for some time prior to the transfer of [Hospital and Specialist Services] to the [Regional Hospital] Board there were certain new schemes of building and other new schemes of a capital nature which

¹¹⁷ Ministry of Health, *Hospital Survey: Sheffield*, pp. 4, 7-8.

¹¹⁸ Ministry of Health, *Hospital Survey: Sheffield*, p. 19

¹¹⁹ Ministry of Health, *Hospital Survey: Sheffield*, p. 19.

were under contemplation to extend and improve the hospitals services... [but] they remain in abeyance as matters of policy to be decided by the RHB.’¹²⁰

A medical superintendent headed the hospital’s medical staff, and there were a resident physician, surgeon and obstetrician at the time of the *Survey*. These senior members of the medical staff were described as of ‘comparable professional standing’ to the Consultants of the voluntary hospitals, and as conducting a similar range of medical and surgical work to that carried out by their counterparts in the voluntary sector, to equivalent levels of responsibility. The hospital also had a full-time Radiologist, and a Pathologist working under arrangement with the University of Sheffield. Consultants in surgery, medicine and dermatology from the local voluntary general hospitals visited the hospital regularly, at the request of the resident medical staff. Consultants of other specialties, including gynaecology, visited less regularly. Conversely, no paediatrician was available, despite the existence of beds for 174 children at the hospital and the ‘very considerable amount’ of paediatric consultant work conducted at the Children’s Hospital.¹²¹ By 1947, the hospital offered specialist medical outpatient clinics in diabetes, pernicious anæmia, gastric, endocrine and venereal diseases. In addition to this, its departments included a professorial medical unit, thoracic unit, psychiatric unit, genito-urinary unit, and orthopædic surgical services.¹²²

The hospital facilities and nascent specialisation described here became part of the NHS, along with the city’s General Practitioner and local health services on 5 July 1948. With strict controls over new development thereafter, they provided the basis of the city’s hospital provision for another thirty years.

¹²⁰ Ministry of Health, *Hospital Survey: Sheffield*, p. 19; Powell, ‘An expanding service’, pp. 334-357; ‘Medical Officer of Health Report, Sheffield, 1947’, p. 10.

¹²¹ In 1940, the Children’s Hospital had 157 beds in the main hospital, with a further 20 at Ryegate Annexe. Ministry of Health, *Hospital Survey: Sheffield*, p. 19; Sturdy, ‘Political economy’, gives a detailed account of the origins of working relationships.

¹²² J Clark, ‘City General Hospital’, in ‘Medical Officer of Health Report, Sheffield, 1947’.

1.3 Establishing the NHS – 1948 to 1962

The NHS Act of 1946 identified five elements of the proposed new service described under five 'Parts' of the legislation. These were the Central Administration; Hospital and Specialist Services, encompassing provisions for the transfer to the Minister of extant hospitals and their endowments, property and liabilities, ancillary services of research, bacteriological, blood transfusion and other services; Local Health Authorities, including health centres, services for mothers and young children, midwifery, health visiting, home nursing, vaccination and immunisation. These also encompassed ambulance services, prevention of illness, care and after-care, and domestic help. Part Four services included general medical, dental, pharmaceutical and supplementary ophthalmic services; and the final Part included special provisions for mental health services.¹²³ Thus, while it provided access to primary health care, hospital care and some continuing care to all, the new service was not completely comprehensive. It did not include either industrial or environmental health, nor did it cover welfare, particularly of older people or of children, and while it offered more to older people than that to which they had been entitled previously, this was limited.¹²⁴

Bevan's message to the medical profession, published in the *Lancet* and *British Medical Journal* on the Saturday before the Appointed Day, was conciliatory in tone. In return for the cooperation of the medical profession, he offered the Doctors 'intellectual and scientific freedom' along with 'all the facilities, resources, apparatus and help' he could provide, participation in the 'administrative framework' and freedom from interference. He described the NHS as '...this comprehensive scheme –

¹²³ *National Health Service* 9&10 George 6 (London, 1946).

¹²⁴ C Fraser Brockington, *History of Public Health; Jones Health and Society*, pp. 123-125; C H Webster, 'The elderly and the early National Health Service', in *Life, death and the elderly: historical perspectives*, ed. M Pelling and R M Smith (London, 1991), Chapter 6; Thane, *Old Age*, pp. 443-444, 449-453; P Bridgen, 'Hospitals, geriatric medicine, and the long-term care of elderly people 1946-1976', *Social History of Medicine* 14:3 (2001), pp. 519-520.

quite the most ambitious adventure in the care of national health that any country has seen...'¹²⁵ Bevan had also assured Consultant medical staff in the hospital sector of the continuation of their right to engage in private practice.¹²⁶

Yet the structure of the early NHS was such that it tended to undermine the very possibility of a comprehensive approach to health care.¹²⁷ During the early years of the NHS, both creation and re-creation of professional working and centre-periphery relationships were necessary if the paper plans for the new service were to be translated into reality. Communication between people working within and between the three parts of the service had to be effective if individual patients were to receive continuity of care between general medical practitioner, hospital and community health services.

The size of this challenge was enormous. Regionalisation of the hospital service had been introduced initially as 'a somewhat reluctant concession' in 1944, but was a central feature of the NHS as interpreted by Bevan.¹²⁸ The incorporation of General Practitioner, Hospital and Local Health Services in a tripartite arrangement was politically expedient, insofar as it removed the spectre of local authority control that had led general medical practitioners to object to the new service, although it was unpopular with some members of the Labour party – notably Herbert Morrison. Yet, 438 new administrative bodies had to be formed in the hospital sector alone. Fourteen RHBs, thirty-six Boards of Governors and 377 HMCs had to be established, their boundaries determined, hospital groups identified, and members appointed. Premises had to be found in which administrators, secretaries, clerical and other staff who

¹²⁵ Bevan, 'Message', p. 4565

¹²⁶ SA: SY 569/H1/5.

¹²⁷ M Baly, 'The National Health Service: thoughts from home and abroad', *International History of Nursing Journal* 3:3 (1998), pp. 44-46.

¹²⁸ Webster, *Health Service - Volume I*, p. 265. Webster describes this as the most innovative feature of the new NHS.

supported these bodies could work. Where a Board of Governors assumed responsibility for administration for a former voluntary hospital, or group thereof, premises might be available to them, but this did not apply in the case of former municipal facilities or the newly created RHBs. As an illustration of this, both the Sheffield RHB and Sheffield Number One HMC (hereafter the HMC), which assumed responsibility for the running of the city's former municipal general hospitals, spent their early months in temporary accommodation.

The NHS Act (1946) made the Minister of Health responsible for the selection of people with established reputations in voluntary service as Chairmen of RHBs. The Act also required the Minister to consult bodies with an interest in the delivery of health care. Part of the settlement that secured the support of the medical profession included their direct representation at all levels of the new service. Political expediency required the Minister to take the views of a variety of different interest groups into account.¹²⁹ Bevan was careful to avoid accusations of bias in his relations with the RHBs. Appointments made by the Ministry to the RHBs were made deliberately without favour to the Labour Party or Trades Union movement. Involving both those with a strong personal history of voluntary work at local level and giving the medical profession a voice in the appointments, Bevan was able to disarm his most vociferous critics and create the basis for positive relations with the new boards and committees. This, however, privileged consultation with the medical profession through the requirement to seek the views of, *inter alia*, universities with medical schools and representatives of medical practitioners. In turn, this had far-reaching implications for the service in the composition of the administrative bodies that ran it, and in underwriting the central influence of the medical profession on its politics.

¹²⁹ Lindsey *Socialized Medicine*, Chapters 2 and 3; Pater, *Making*; Webster, *Health Service - Volume I*, Chapters I-IV; Klein, *Politics* (1989), Chapter One.

The overall structure of the service and the number and general function of RHBs was determined by the Ministry of Health, under the legislation, but Boards were able to interpret their roles and establish the committee structure that they required to execute their functions locally. Sheffield Region established over forty-six committees, while East Anglia had none.¹³⁰ RHBs exercised some planning and advisory functions with respect to the HMCs on behalf of the Ministry of Health. RHBs established the HMCs within their respective regions, after grouping hospitals into units and appointed the HMC Chairs and members. The latter managed the day-to-day functions of hospitals in the NHS. Boards came to expect to be consulted over policy instruments prior to their official publication, although Ham's research in Leeds led him to conclude that this did not really develop until after 1951, when the Conservative Party formed its first post-War Administration.¹³¹

Following incorporation into the new NHS in 1948, the General became part of Sheffield Number One HMC. This also included Nether Edge Hospital and Fir Vale. Three other HMCs were created in Sheffield, the others grouping the former infectious diseases and sanatoria, mental illness and disability, and radiotherapy services respectively.¹³² Teaching Hospitals were granted semi-autonomous status within the NHS structure, being administered by Boards of Governors that communicated directly with the Ministry of Health. This was perceived as a mixed blessing, as the lines of communication descended from, and ascended to, the Ministry.¹³³ The four voluntary hospitals and the Edgar Allen Physical Treatment Unit became the USH,

¹³⁰ Rivett, *Cradle to Grave*, pp. 49-50

¹³¹ Ham, *Policy Making*, Chapter 8; Webster, *Health Service - Volume I*, pp. 282-3; Klein, *Politics* (1989), pp. 45 and 47-48.

¹³² There were anomalies: Number One HMC's units included provision for people learning disabilities, mental illness and pulmonary tuberculosis; Sheffield Number Two HMC included provision for general hospital services, based in 'temporary' accommodation in the grounds of a large, Victorian era, mental hospital.

¹³³ Webster, *Health Service - Volume I*, p. 272

which through their established connections with the University of Sheffield's Medical School were managed by a Board of Governors.

Two days before the Appointed Day, an article published in *The Lancet* suggested that people who had supported 'their own hospital' over a period of years would wish to continue to do so within the NHS. The anonymous author warned though that the changed arrangements for the administration of HMC hospitals might undermine this, by separating spheres of responsibility and placing some patient requirements outside the scope of hospital budgets.¹³⁴ In Sheffield, general medical practitioners joined the NHS with some apprehension, noting that with a deficiency of staff in key grades they could not deliver the government's promises of improved services.¹³⁵ The Sheffield Trades and Labour Council passed a resolution against the removal of local democratic control over hospitals under the proposed NHS administrative structure. However, in general the new arrangements prompted praise rather than blame from the city's councillors, several of whom had been chosen to serve on the hospital boards and committees.¹³⁶

While administrative continuity was particularly evident in the case of the former voluntary hospitals, it can also be discerned in the membership of the HMCs. Although Sheffield municipality had lost control of its hospitals, seven City Councillors and Aldermen who became members of the HMC in 1948 had been on the City's Health Committee during the two years prior to the Appointed Day.¹³⁷ Some people appointed to serve in the NHS at regional and at local level - such as Albert Ballard, the first Chair of the USH Board of Governors, and Sir Basil Gibson, first Chair of Sheffield RHB - had been involved in organising and delivering emergency

¹³⁴ Anon, 'National Health Service - the opportunities', *The Lancet*, 3 July (1948), pp. 24-26.

¹³⁵ SA: LD 2384(7), 18 May 1948; SA: LD 2384(7), 13 Mar 1949.

¹³⁶ SA: SY 333/H1/47, 'Hospitals in Wrong Hands', *Sheffield Telegraph* 22 Dec 1948; Thorpe 'Consolidation of a Labour stronghold 1926-1951', pp. 113-114

¹³⁷ Thorpe, 'Consolidation of a Labour Stronghold', p. 114.

services during the war. Both men were prominent members of the local politico-administrative elite, Ballard being an active member of the Union of Shop, Distributive and Allied Workers (USDAW), and political agent for Sheffield Hillsborough's Cooperative and Labour Party MP, Gibson having been Sheffield's Town Clerk. Thirteen members of the USH Board of Governors also belonged to the Court of the University of Sheffield. Fifteen USH Governors had been on the Court of Management of the Royal Sheffield Infirmary and Hospital; two had served on the Board of Management of Jessop Hospital for Women; three on the Children's Hospital Board of Management; two had been Chairmen of voluntary hospitals outside Sheffield; and nine belonged to the medical profession. 'Others had [a] considerable amount of experience in Local Authority and public work of many kinds.'¹³⁸

This number also included the Chairman of the new HMC, William Yorke, then Lord Mayor of Sheffield, who had been Chairman of the Health Committee in 1946. Membership of the HMC also included Grace Tebbutt, who was Lord Mayor in 1949, and served on one or both of the USH Board of Governors and its Nursing Services Committee until 1957. A link between the former voluntary and municipal hospitals in their new guise was the presence of Miss A Wetherell, Senior Tutor at the General, as a member of the USH Board of Governors and Sheffield RHB.

The interests of those who served on the RHB, HMC and Board of Governors were generally wider than hospital administration; several maintained diverse connections with local industry and commerce, with municipal or local medical politics, or with several fields of voluntary work.¹³⁹ Klein argues that the successful NHS administrator in the early years of the service was one capable of '...running the affairs of his own parish smoothly and effectively', and not over-diligent in the application of

¹³⁸ SA: SY 333/H16/1, 17 June 1948.

¹³⁹ B Fearnside, 'Sheffield Women's Mutual Service Clubs, 1932-1962' (Sheffield, 1966); Anon, '£7000 for Hospital Comforts', *Sheffield Telegraph*, 8 Sept 1948.

central directives.¹⁴⁰ As the people chosen to serve on the new committees and boards were in many cases no more new than were most NHS hospitals, their orientation to local issues is predictable, in Sheffield if not throughout England and Wales.

Ironically, the post-Second World War Welfare State collectivism, epitomised by the NHS, has been interpreted as eclipsing voluntarism.¹⁴¹ The voluntary hospital sector had gone but voluntary work on the part of individuals continued in the NHS.¹⁴² Lay people, including those who served on the health authorities, contributed to patient well-being both directly and indirectly; donations of time and skills, money and gifts in kind to local hospitals continued alongside centralisation and nationalisation, although the latter diminished during the 1950s.¹⁴³ Voluntary service was held by the first Chairman of the USH Board of Governors to be a form of direct democracy - 'Non-participation is the disease of our age - 'service' should be our motto...Let us play our individual parts. These are the ways in which we can create a welfare state which arises from us rather than one which is imposed upon us.'

The minutes of the first meeting of the USH Board of Governors include reference to Ballard's conviction that voluntary effort should play a central role in the work of NHS hospitals. This would provide a counterweight to the tendency to control by the 'deadening hands of bureaucracy' inherent in the Ministry of Health's London-based civil service, which lacked experience of direct delivery of health services and the threat this imposed of turning hospitals into 'mere Government Departments'.¹⁴⁴ Ballard's view of the role of the new hospital boards was that

¹⁴⁰ Klein, *Politic* (1989), p. 46.

¹⁴¹ Digby, *Welfare Policy*, p.89; Frank Prochaska, *The Voluntary Impulse* (London, 1988), p.1.

¹⁴² Prochaska, *The Voluntary Impulse*, p.1; R Levitt and A Wall, *The Reorganized National Health Service* (4th Edition, London, 1992), p. 293.

¹⁴³ Lindsey, *Socialized Medicine*, p. 86.

¹⁴⁴ SA: ABC1; SA: ABC16, 'Speech for Mayoral Inauguration' 22 May 1957, *passim*; W H Greenleaf, *The British Political Tradition: Volume Two - The Ideological Heritage* (London, 1983), p. 413.

There should be the maximum of freedom consistent with efficiency for the individual Units in the organisation, a constant opportunity for initiative, no bureaucracy or over-centralisation but rather co-ordination and the fullest use of voluntary effort. He took it that our ideal was perfect service for the patient.¹⁴⁵

Bevan was apparently keen that boards and committees should foster the creation of House Committees of local people with interest and experience in hospital work, as this would both remind people that they owned their local hospitals and encourage them to feel positively disposed towards them.¹⁴⁶ Although the local councillors and aldermen who served on the committees and boards of Sheffield's hospitals included housewives and trades unionists, they and their medical and legal professional and industrialist colleagues represented a narrow, politically active, section of Sheffield's population.¹⁴⁷

One consequence of the leeway granted to the hospital administrative bodies was a lack of role clarity; hospitals' internal administrative structures varied, largely determined by their status before July 1948. The Central Health Services Council (CHSC), constituted within the Ministry of Health in order to provide general policy advice, established the Bradbeer Committee in 1950 to investigate this situation. Their report, published in 1954, lauded the benefits of locally interpreted administrative style, but recommended that hospitals follow the typical voluntary hospital model of a partnership between Doctor, Matron and Administrator. The Committee also recommended that both medical and nursing staff views be represented within the administrative structure, by Medical Staff and Nursing Committees respectively, and implementation of the report's recommendations resulted in the strengthening of the

¹⁴⁵ SA: SY 333/H16/1, 17 June 1948.

¹⁴⁶ SA: ABC16, notes on a meeting of Chairmen of RHBs, HMCs and Boards of Governors with the Minister of Health, Central Hall, Westminster, 6 Oct 1948.

¹⁴⁷ SA: SY 569/H1; SA: SY 333/H16; SA: SY 709/H1/1-3.

role of the Chief Administrative Officer (Group Secretary), the lay administrator at HMC level, whose primary task was to ensure that services were co-coordinated.¹⁴⁸

The crux of the change in the provision of hospital services from July 1948 was that ultimate control over resources, whether capital funds for the development of premises and major equipment, revenue funding to pay for services and amenities or staff to provide the wherewithal to deliver those services, passed from local boards and committees to the Ministry of Health. Two examples of the effect of this in Sheffield include the imposition of restrictions on local determination of capital developments without referral to the Ministry of Health to uncertainty over whether Fir Vale's staff could continue to give sweets and cigarettes to in-patients, as they had before July 1948.¹⁴⁹

Both the HMC and the USH Board of Governors expected the NHS to facilitate renovation and replacement of old buildings with modern hospital premises. However, post-war austerity limited opportunities for hospital modernisation. Despite the recommendations for renewal and rebuilding of much of the hospital stock, the concomitant redeployment of staff, and the replacement of obsolescent equipment, outlined in the *Hospital Surveys* published in 1945, capital spending in the NHS remained at under 5% of total health expenditure during 1949/50 to 1955/56. Hospital building projects received £10 ten pounds sterling compared to £430 million and £57 million respectively for housing and schools.¹⁵⁰ Thereafter, those capital projects that received Ministry of Health approval received limited additional funds. Money, equipment and people with the skills to effect essential repairs were in limited supply and the rebuilding of hospitals was a relatively low priority compared to the

¹⁴⁸ Ministry of Health, *Internal Administration of Hospitals*, paragraph 22, p. 7.

¹⁴⁹ SA: SY 569/H1/1, 5 July 1948; SA: SY 333/H16/9, Minute A514(50), 21 Aug 1950.

¹⁵⁰ J Hughes, 'The "Matchbox on a Muffin": The design of hospitals in the early NHS' *Medical History* 44:1 (2000), p. 24.

reinvigoration of the economy during the late 1940s and 1950s. The requirement for rapid, large-scale rearmament associated with Britain's foreign policy commitment to support the USA in the 'Cold War', and the development of Britain's atomic warfare capability from the 1950s, further limited the availability of public money for the NHS and other aspects of the Welfare State.¹⁵¹

Sheffield RHB's plans for the development of hospital services for the region, published in 1955, included concentration on five hospital centres in the region. These would contain between four and six hundred beds each to serve the local population, surgery would be performed by Consultants, although some in-patient beds would be retained for use by General Practitioners to better facilitate continuity of care, and therapists would be available to assist in the recovery and rehabilitation process. This followed the general tenor of the 1945 *Hospital Survey*, but reconsidered the role of the hospital because 'the economy of the country could not in our time provide the thousands of beds needed.'¹⁵²

The RHB predicted that this situation would continue and that ambitious schemes would have to be curtailed, with greater emphasis on out-patient care. They also predicted that 'the impact of preventive medicine upon the health of the community may render expansion of the hospitals unnecessary as judged by present needs', although this referred not to the expansion of specialist clinical facilities provided by the hospitals but to the number of beds for in-patient use.¹⁵³ Despite financial constraints, the USH Board of Governors and Sheffield RHB completed, commenced or planned several new hospitals and hospital departments during the 1950s – including the Charles Clifford Dental Hospital (1953), RHB hospital planning

¹⁵¹ SA: ABC 16 'Third Annual Report: 1951'; A Sked and C Cook, *Post-War Britain - A Political History* (Harmondsworth, 1993), pp. 92-95.

¹⁵² SA: SY 709/H2/1

¹⁵³ SA: SY 709/H1/1; SA: SY 709/H2/1; SA: SY 569/H1/6, MC(53)7, 24 Jun 1956.

proposals (1955), USH psychiatric clinic (1958), and the foundation stone of the new Teaching Hospital (1958).¹⁵⁴ However, GNC Inspectors' reports of the 1950s and 1960s indicate that the condition of many of the HMC unit hospitals' clinical areas required further improvement.¹⁵⁵

Furthermore, rebuilding and development of hospital premises was slow to take place until after publication of the *Hospital Plan* of 1962. Even thereafter, the expansion was not as great as the *Plan* anticipated, but the Ministry of Health made an early commitment to specialisation in medical care, and thereby reinforced the hegemonic position of the hospital in the NHS. Fox observes that the attention given to the development of specialist medical services in hospitals is interesting because civil servants' observations of the clinical activities and management of Consultants' caseloads, rather than the insights of those clinicians, informed the calculation of requirements for hospital facilities. Thus, in their calculations, the RHBs greatly reduced the number of beds required when compared to the estimates of the *Hospital Surveys*. Fox argues that British Consultants adjusted their workloads to available resources – starkly apparent in the despairing observation on the part of the Infirmary's medical staff in 1963, for example, that they had to base the work they did on the number of nurses available.¹⁵⁶ In 1962, the year of the *Hospital Plan*, the USH's *Annual Report* complained that the increase in patient numbers without an associated increase in bed numbers 'is evidence of the great pressure under which the medical and nursing staffs, in particular, are working.'¹⁵⁷

¹⁵⁴ SA: SY 709/H2/1.

¹⁵⁵ SA: Acc 1994/64, Report of the GNC Inspector on the fourth visit to the City General Hospital, 1955; SA: SY 569/H1/8, Report of the GNC Inspector on the sixth visit to the City General Hospital, 1967.

¹⁵⁶ Fox, *Health Policies*, p. 184; SA: SY 333/J6/14, 1963.

¹⁵⁷ SA: SY 333/H16/5, 1962, p. 13.

The NHS acquired an early reputation for financial profligacy, after the anticipated costs of its operation were consistently exceeded until 1950/51 when the original and final Parliamentary Estimates harmonised for the first time. Even when the Select Committee on Estimates exonerated the NHS of charges of extravagance on three occasions between 1949 and 1957, as did the 1956 report of the Guillebaud Committee, the NHS' requirements for essential modernisation were still treated as though unworthy of sympathetic consideration.

Moreover, the hospital sector was identified early on as the root cause of the NHS' financial problems. During the early years of the service, hospital authorities were able to determine precise resource use within their allocated budgets, and fix their own staffing establishments. This, combined with increased staff remuneration following Whitley Council pay agreements in 1949, resulted in an increase of £103.8 million in hospital costs between 1949/50 and 1955/56, of which very nearly seventy-two per cent was accounted for by increases in pay, prices and 'other unavoidable costs'.¹⁵⁸ The NHS did not guarantee treatment in hospital, although it did guarantee access to the primary gatekeepers, the general medical practitioners. Ironically, while the rate of increase in spending in the hospital sector, and in the service as a whole, slowed from 1953, it was the costs triggered by referrals to hospitals made by general medical practitioners that were persistently the least easy to control.¹⁵⁹ This activity attracted less scrutiny than did that of the hospitals, possibly because of the political sensitivity of challenging the professional autonomy of the General Practitioners, and their relationship with patients, but also because of the greater visibility of the Hospital Services, which continued to command most of the NHS budget.

¹⁵⁸ Webster, *Health Service - Volume I*, p. 258.

¹⁵⁹ Klein, *Politics* (1989), p. 371.

Thus, concerns about the level of revenue funds available to finance everyday delivery of health care are discernible throughout the period and this is another example of continuity between the old and new health care systems. During the 1950s, there was a growing, if reluctant, acknowledgment that actual demand for health services was greater than had been anticipated during the mid-1940s. Increasingly, this could not be met from the generally inadequate and unevenly distributed resources that the NHS had inherited, or from the budgets available to the service.¹⁶⁰

The most visible aspects of the new system were the newly created administrative structure, based on HMCs and RHBs, and the new guarantee of access to hospital care for all those deemed by their general medical practitioner to be in clinical need. Yet the decision to create a new administration for health care, rather than a local government administration of health services, tended to reinforce the extant dominance of the hospital specialist in the medical profession.¹⁶¹ It also underwrote an emphasis on attainment of an ideal bed to population ratio as the guiding principle behind a modern service, and the consequent generation of budgetary estimates by the peripheral hospital authorities.¹⁶² This contributed to the disparity between anticipated and actual health service expenditure during the first five years of the service.

Paradoxically, while the Treasury criticised it for being unnecessarily expensive, from early in the life of the NHS hospital authorities in Sheffield considered that the level of income they received was insufficient. Webster states that there was 'no excuse for innocence' amongst politicians and civil servants at national government level over the cost involved in delivering the NHS.¹⁶³ Yet Ballard's address to the USH Board of Governors two weeks before the Appointed Day indicates that he certainly expected

¹⁶⁰ Webster, *Health Service - Volume I*, pp. 133-241 *passim*

¹⁶¹ J Lewis, *Women in England 1870-1950* (Brighton, 1984), p. 339.

¹⁶² Fox, *Health Policies*, pp. 141-143.

¹⁶³ Webster, *Health Service - Volume I*, pp. 257-262.

that resources would be available once the NHS began. 'As he saw it the Teaching Hospitals would have increased financial resources, not new responsibilities except those consequential to a growing service, but a new relationship through the Minister to Parliament and the People.'¹⁶⁴

Yet in 1949, the Ministry of Health asked the USH Board of Governors to make a cut of eight percent in their capital and maintenance estimates for 1949 to 1950 and they in turn asked the House Committees of the respective unit hospitals to identify ways in which the required cuts could be made. The Infirmary's House Committee sent their revised estimates on the understanding that the Board of Governors 'should not feel that the Royal Infirmary house were recommending that any of these reductions should take effect. They were in fact strongly opposed to any cuts which would have the effect of reducing the work of the Infirmary in any way'. In each case, the committee's records note that any cuts in revenue would adversely affect the standard of service to patients, potentially involving the closure of two wards and reductions in the clinical staff in each general hospital unit. The Board's response to the Ministry of Health in September 1949 was that, although they submitted revised estimates, not only were they unrealistic, but in the light of new information they considered their original capital and maintenance estimates to have been too low.¹⁶⁵

The minutes of the Sheffield RHB Establishment Committee reveal that within the first three months of the operation of the NHS, the Board was in dispute with the Ministry of Health over Revenue estimates. Hospital authorities within the Sheffield Region submitted revenue estimates to the Ministry of Health in October 1948, based on their calculations of what it would cost to provide the level of service expected between

¹⁶⁴ SA: SY 333/H16/1. The Chairman elect, Albert Ballard, was addressing an informal meeting of the United Sheffield Hospitals' Board of Governors, held at the Royal Hospital.

¹⁶⁵ SA: SY 333/H1/33, Minute H232, 15 Mar 1949; SA: SY 333/H3/27, Minute I.199, 11 Apr 1949; SA: SY 333/H16/1, Minute B.414, 5 Sept 1949.

1949 and 1950. The Ministry of Health subsequently asked all hospital authorities to review and reduce those estimates. On the 14 October 1948, the RHB resolved:

That the Ministry of Health be informed that after full and careful consideration the Board are satisfied that it is impossible to administer the Hospitals of the Region to the same degree of efficiency as heretofore for the sum allocated to the Region, and that it is inevitable if the reduction made by the Ministry is maintained that the interests of the patients in the hospitals will be detrimentally affected.¹⁶⁶

It is implicit in the reactions recorded in early 1949 that the RHB and USH Board of Governors had assumed that the NHS would provide them with a secure income and opportunities for modernisation.¹⁶⁷ The RHB's Establishment Committee noted that restrictions on capital expenditure would probably have adverse effects on the Board's capital works commitments. They noted, in particular, that they had been warned by HMCs that hospitals might be 'forced to close beds.'¹⁶⁸ Sheffield RHB nonetheless agreed to reduce its estimates by £375,584. When, in March 1949, RHBs were asked to make further reductions in their revenue estimates averaging 6.22%, Sheffield Region was required to make an additional cut of only 2.15% (£221,200).

In 1949, five members of the USH Board of Governors and the Chair of the HMC were also members of Sheffield RHB, and it is unlikely that they would have been unaware of each other's position on the issue of estimate cuts.¹⁶⁹ The fact that all three bodies shared key members probably helps to explain their willingness to question the requirement to cut expenditure, although ultimately they were not successful in persuading the Ministry of Health to retract its demands.¹⁷⁰

¹⁶⁶ SA: Acc 1987/55, Sheffield RHB, Volume 2, Dec 1948 to Mar 1950.

¹⁶⁷ SA: Acc 1987/55, Sheffield RHB, Establishment Committee, 28 Mar 1949, p. 15; SA: SY 333/H16/3-8, Annual Reports 1949 to 1974, *passim*.

¹⁶⁸ SA: Acc 1987/55, Sheffield RHB, Establishment Committee, 28 Mar 1949, p. 15.

¹⁶⁹ Mrs G Buxton, Sir Basil Gibson, Mr A R Martin, Lieutenant Colonel N G Pearson, and Mr T Pearson all belonged to the RHB and to the USH Board of Governors; Alderman W E Yorke chaired the Number One HMC and belonged to Sheffield RHB. SA: Acc 1987/55, Sheffield RHB, Establishment Committee, 28 Mar 1949, p. 15; SA: SY 333/H16/3, p. 16.

¹⁷⁰ SA: SY 333/H16/3.

These hospital authorities publicly expressed their opposition to restrictions on expenditure through the USH Board of Governors' Annual Reports and through local newspaper articles.¹⁷¹ For example, the 1954 Report refers to the 'budgeting straitjacket' within which they had operated the Hospitals' services '...over a period of years.'¹⁷² Their responses indicate genuine surprise and disappointment that they were not to be enabled to establish the level of health care provision they had anticipated, and instead that they would now have to work within stringent financial limits. The USH Board of Governors reported that 'It is obvious that within the period of the first nine months of the new NHS, it was not possible to give full effects to the requirements of the National Health Service Act of 1946 and the policies involved therein.'¹⁷³ The concern was even expressed that the USH Endowment Fund might 'become a temptation' to the Chancellor of the Exchequer or the Ministry of Health – that the hospitals might eventually be expected to raise at least some of their own funding in a partial return to the situation that obtained before July 1948.¹⁷⁴

Ballard blamed financial and other resourcing problems, along with the sometime 'antagonism' of the Civil Service towards voluntarism in the NHS, for the difficulties faced by the service from 1948.¹⁷⁵ The ability of the USH hospitals 'to go the other mile in meeting more than the merely physical requirements of our patients' came to depend nonetheless on voluntary donations of money and time.¹⁷⁶ Sources of funding included single donations from individuals and organisations, regular subscriptions, and legacies. The NHS Act allowed teaching hospitals to keep any endowments they held on 5 July 1948, and they were free to spend this income on a range of purposes

¹⁷¹ SA: SY 333/H11/47, 'Hospitals exceed Ministry budget' *Sheffield Telegraph*, 2 Apr 1949; SA: SY 333/H16/3-8.

¹⁷² SA: SY 333/H16/4, 'Report of United Sheffield Hospitals Board of Governors for the Year Ending Dec 1954'.

¹⁷³ SA: SY 333/H16/3, p. 19.

¹⁷⁴ SA: ABC16, notes for the second report of the Board of Governors, 1950.

¹⁷⁵ SA: ABC16, notes for the third report of the Board of Governors, 1951.

¹⁷⁶ SA: ABC16, notes for eleventh report of the Board of Governors and Annual General Meeting, 28 Apr 1960.

including amenities for staff and patients, minor building works and upgrading of facilities. Half the £84,000 cost of refurbishing the George Woofindin Rehabilitation Centre as a psychiatric clinic in 1957 was met from the USH Endowment Fund.¹⁷⁷

However, former municipal hospitals had to surrender their endowments to a central Hospital Endowment Fund in 1948; thereafter they received a regular share of this in the form of 'Free Money' distributed according to the number of beds in the hospital on 5 July 1948. They could use this income for the same range of purposes as the Endowment Funds controlled by the Teaching Hospitals. The average received in Free Money was approximately thirty shillings per bed annually during the 1950s, according to Lindsey.¹⁷⁸ The balance on the USH Endowment Fund at the end of March 1949 was £490,075, worth over £354 per bed. Although during the financial year 1948 to 1949 little more than one pound per bed was spent on patient amenities, in subsequent years the Board was able to fund projects ranging from improvements to its nurses' homes to curtains around patients' beds.¹⁷⁹

Annual Reports of the USH show that the group also benefited from Trust funds from the Sinclair White Trust, specifically established to benefit staff, disbursements from the city's Church Burgesses, Zachary Merton Charity, Women's Voluntary Service and other less regular donors. The sums derived from this group of sources alone contributed at its lowest point £6,545 between 1952 and 1953 and reached £29,568 in 1972 to 1973. The additional funds raised through voluntary donations, subscriptions and legacies were used to fund research, staff study tours and courses, and for amenities for patients and staff, the purpose sometimes being specified by the donor

¹⁷⁷ SA: SY 333/H16/4, 'Report of United Sheffield Hospitals Board of Governors for the Year Ending Dec 1957'.

¹⁷⁸ Lindsey, *Socialized Medicine*, p275.

¹⁷⁹ SA: SY 333/H16/3, 'Report of United Sheffield Hospitals Board of Governors for the Year Ending 1949'.

although often the Board of Governors was able to exercise its discretion. General and special trusts and funds also included the Hospital Sunday Fund, the Royal Hospital Linen League - which contributed in kind as well as financially - and the Talbot Cuff Fund, originally established to provide assistance 'for specific objects connected with the work of the Royal Infirmary'. The latter contributed over £9000 towards meeting the convalescence costs for patients of both the Infirmary and Royal during the first year of the NHS's existence. From 1970, the Talbot Cuff Fund obtained approval in principle from the Charity Commissioners to include the other Sheffield hospitals in the scheme for the benefit of patients, as they had a fifty per cent underspend.¹⁸⁰

Hospitals retained donations or legacies received after the Appointed Day. Sheffield Hospitals Council, founded in April 1921, had established the Sheffield Penny in the Pound contributory scheme that allowed free treatment in the city's voluntary hospitals to any subscriber. Ninety-six subscribers remained in 1948, although their number and the amount of money derived from this source lessened considerably by 1965. Legacies, in contrast, remained an important source of additional income until 1974. The USH received £436,263.57p in legacies alone between July 1948 and March 1973.¹⁸¹

Sheffield Hospitals Council continued in a modified form as the Sheffield and District Convalescent and Hospital Services Council after the establishment of the NHS. The Council's espoused aim was to enhance the operation of the NHS by publicising its work and making financial provision to meet expenditure either unsupported or insufficiently so from Treasury Funds.¹⁸² This facilitated the provision of

¹⁸⁰ SA: SY 569/H1/12, FGP(70)11, Minute 180, 30 Dec 1970.

¹⁸¹ £400, 473.11s.5d between July 1948 and March 1970; £35,790.12 between April 1970 and March 1973 - pre-decimal have been converted to decimal values taking 1 shilling to be equivalent to 5 pence.

¹⁸² SA: SY 333/H16/3, 'Report of United Sheffield Hospitals Board of Governors for the Year Ending Dec 1950'.

convalescence and amenities for USH patients, as well as helping to fund research and some staff training.

People recognised that the hospitals needed more money than could be provided by the Treasury in order to fund amenities and research. Yet a greater number of donations and legacies were made to the former voluntary hospitals than to the former municipal hospitals. The HMC hospitals did not attract legacies, and did not have trusts and funds to support amenities for patients. After 1948, its hospitals received mainly gifts in kind – for example, free entertainment for patients and staff by local musicians and dancers, flowers, theatre tickets, and preserves.¹⁸³

The fear that the existence of the NHS would undermine local interest in hospitals proved unfounded and voluntary contributions to the NHS continued after 1948.¹⁸⁴ In addition to the membership of boards and committees, volunteers ran lending libraries for in-patients and cafeterias for out-patients and visitors, operated trolley sales of sweets and sundry toiletries and broadcast sports commentaries on hospital radio. They sometimes donated radios so that the patients could listen to these broadcasts, or gave televisions. They also raised funds for a variety of specific and general amenities funds. The second Quinquennial Report of Sheffield RHB, covering the years 1952 to 1957, noted that during that period the number of hospitals in the region with formally organised voluntary support, in the form of a League of Friends, had increased from ten to ninety-two, with only fourteen not having any voluntary activity. The report noted that this was ‘unrivalled in peacetime’ and was in addition to the voluntary work of RHB and HMC members.¹⁸⁵

¹⁸³ SA: SY 569/H1, *passim*.

¹⁸⁴ Prochaska, *Voluntary Impulse*, p. 1; Digby, *Welfare Policy*, p. 89; SA: SY 333/H16/1, 17 Jun 1948; SA: SY 333/H16/4 ‘Report of United Sheffield Hospitals Board of Governors for the Year Ending Dec 1958’.

¹⁸⁵ SA: SY 709/H1/2, ‘Quinquennial Report 1952-1957’.

The HMC had other sources of income, on a more modest scale than those enjoyed by the USH, although these did not survive long in the NHS. Fir Vale Infirmary ran a bakery that supplied bread not only to the patients but also to local authority hostels during the first few months of the NHS' existence. The General owned a farm, Longley Hall, which supplied the hospital and Fir Vale Infirmary with milk, eggs, vegetables and fowls to supplement the patients' diet, as well as money from the sale of livestock at market and milk to the public in the local neighbourhood. Although the hospitals were not self-sufficient in food, the sale of pigs and cattle to the Ministry of Food in 1954 alone raised £9,922.¹⁸⁶

However, the income that the General derived from the farm was limited compared to that which the USH received in donations. In 1954, hospitals with farms were instructed that they could no longer retain them, under the terms of circular HM(54)23. The HMC owned land in two parts, the farm proper which was separate from the hospital, and land within the curtilage of the hospital, which was 'grazed over or cultivated by the farm as a matter of convenience' so that the grass would not have to be mown.¹⁸⁷ Representatives of the HMC met at a special subcommittee of the RHB, with a Ministry of Food representative present, in October 1954, to discuss the future of the farm. The hospital was able to retain some land as a 'cordon sanitaire', between the hospital and any of the farmland that might be sold for building land after the farm closed. The HMC's representatives argued unsuccessfully that they would require an additional £5000 income annually to purchase food heretofore supplied by the farm. The Ministry informed the HMC that profits from the sale of pigs 'had been unusually

¹⁸⁶ SA: Acc 1994/64, CGH(54)5, 13 May 1954.

¹⁸⁷ SA: Acc 1994/64, CGH(54)5, 13 May 1954 and 4 Oct 1954; L Howsam, *Memories of the Workhouse and Old Hospital at Fir Vale* (Sheffield, 2002).

high recently and in future profits would be much lower'. The hospital's records indicate that the farm continued to operate for at least two years after this meeting.¹⁸⁸

The adequacy of its finances was but one aspect of resourcing the NHS. Publicity for the new service promised that patients with complex health care needs would be referred to appropriate specialists. In reality, these were limited in number and unevenly distributed in 1948. The Ministry of Health issued policy guidance to Regional Hospital Boards (RHBs) on the development of Consultant and Specialist services as circular RHB(48)1 in January 1948. This was reissued in 1950 as a pamphlet in which the Ministry of Health predicted that regional planning of services would facilitate the introduction of a rational approach to the development of medical specialisation, although this should be based on general principles rather than on centralised control.¹⁸⁹ Notwithstanding such *caveats*, Webster describes this policy as 'one of the rare excursions of the Ministry of Health into the arena of idealistic planning.'¹⁹⁰ The document was brief and – consistent with its expressed concern to avoid central direction - vague as to details. The document accepted, in principle, that medicine and surgery were becoming more specialised, and acknowledged that each subspecialty would have to provide training and that each would require a range of facilities and support staff.¹⁹¹ However, the full implications of this for resource allocation and staff training were not explored. The potential effects of the development of Consultant and Specialist services for the recruitment and training of Nurses, as well as Consultants' junior professional colleagues, and other health care occupations, were not considered in the original guidance. Parry and Parry argue that junior Doctors' long hours of work, and relative low pay compared to their senior

¹⁸⁸ SA: Acc 1994/64, CGH(55)5, 12 May 1955; SA: Acc 1994/64, Box 2, CGH(56)2, 16 Dec 1956.

¹⁸⁹ Ministry of Health, *Consultant Services*.

¹⁹⁰ Webster, *Health Service - Volume 1*, p. 305.

¹⁹¹ Ministry of Health, *Consultant Services*.

colleagues, effectively underwrote the development of a professional élite of Consultants who led the burgeoning specialist departments.¹⁹²

For people admitted to hospital during the late 1940s, the range of effective therapeutic interventions available was limited. Specialisation was 'in its infancy' and Consultants were primarily available only in the larger centres or on a visiting basis at smaller hospitals.¹⁹³ Furthermore, contemporary articles in the *British Medical Journal* and the *Lancet* of the late 1940s and 1950s began to suggest that care that was based on bed-rest in the hospital could actually prove dangerous to the patients.¹⁹⁴ Those who did not acquire an infection in the ward may yet fall victim to one of the many problems imposed by bed-rest - the very therapeutic intervention at the heart of hospital care.¹⁹⁵

Nonetheless, contemporaneous with the first decade of the service there were advances in therapeutic technologies, both pharmaceutical and technical.¹⁹⁶ Estimates of the cost of the English and Welsh NHS, published in 1956, noted an increase in the cost of drug therapies, in actual prices, of £11.8 million between 1949 and 1954. Of this, £11.5 million was accounted for by an increase in the cost of ingredients. The authors noted that it was not possible to determine the contribution made by new preparations in the increased cost to the NHS of pharmaceuticals, but stated that 'Such information

¹⁹² N Parry and J Parry, *The Rise of the Medical Profession – a study of collective social mobility* (London, 1976), pp. 231-233.

¹⁹³ Rivett, *Cradle to Grave*, p. 5.

¹⁹⁴ D Armstrong 'Decline of the hospital: reconstructing institutional dangers', *Sociology of Health and Illness* 20:4 (1988), pp. 445-457.

¹⁹⁵ R A J Asher 'The dangers of going to bed', *British Medical Journal* ii (1947), pp. 967-968.

¹⁹⁶ Rivett, *Cradle to Grave*, pp. 53-80.

as is available indicates that the part they have played is an important one.'¹⁹⁷ Clinical and pharmaceutical research continued to benefit from the existence of the NHS.¹⁹⁸

While one Medical Officer of Health in 1947 looked forward to a relatively evenly balanced 'friendly war of rival enthusiasms' engaging the three wings of the NHS, and to a lesser place for hospitals, Bevan always envisaged that they would play a central role in the new service.¹⁹⁹ There is little direct evidence in Sheffield's records that the absence of formal co-ordination between hospitals, GP services and local health authority services directly disadvantaged patients, although Pater states that neither of the first two could have been entrusted to the third in 1948.²⁰⁰ The challenge to effective communication that this arrangement posed became the object of CHSC attention, and an aspect of the Guillebaud Committee's investigations. The latter's 1956 report concluded that the structure should be left intact to allow the health authorities sufficient time to develop long-term health care planning strategies. However, the committee was divided on this issue. Maude held that the consequence of tripartism had been 'administrative divorce between curative and preventive medicine' and the establishment of 'the predominant position of the hospital service'. The former had resulted in 'overlaps, gaps and confusion' while the latter threatened to lead to the eclipse of preventative and social medicine. He also believed that only

¹⁹⁷ B Abel-Smith, R M Titmuss *The Cost of the National Health Service in England and Wales* (Cambridge, 1956), Appendix E 'An analysis of the rise in the cost of the pharmaceutical service 1949/50-1953/4', pp. 40, 130.

¹⁹⁸ D Weatherall, 'The NHS and medical research: uncertainty and excitement', in *Our NHS: A Celebration of 50 Years*, ed G Macpherson, (London, 1998); Frank Wells, 'The pharmaceutical industry: clinical saviour or commercial villain?' in *Our NHS*, ed. Macpherson.

¹⁹⁹ C Fraser Brockington, '59th Annual Report of the County Medical Officer' (West Riding County Council, 1947); Fox, *Health Policies*, p. 134.

²⁰⁰ Baly, 'Thoughts from home and abroad'; J Lewis 'Providers, 'consumers', the state and the delivery of health-care services in twentieth-century Britain', in *Medicine in Society - Historical Essays*, ed. A Wear (Cambridge, 1992), p. 330; Pater, *Making*, states that 'Neither hospitals nor general practitioner services could have been entrusted to local authorities in the then climate of professional opinion; on the other hand, local government could not be denuded of all its personal health services as well as of its hospitals', p. 169.

radical reform of local government could facilitate the ultimate goal, transfer of NHS administration to local government.²⁰¹

The NHS Act of 1946 juxtaposed administrative change with the retention of the key staff of the old hospital management structures at all levels of the new; with pre-NHS patterns of hospital and health care provision; and with extant local socioeconomic and health conditions. The period was one of transition as the NHS health care system was established and the voluntary and municipal hospitals, Local Authority health services and General Practitioners became absorbed into it. Administrative structures, the funding of health services and key figures in Sheffield's local health politics and management changed. Of those who had brought Sheffield's voluntary hospitals into the NHS, several either died or retired during the first decade. The former voluntary and municipal hospitals had strengthened their links, including the presence of medical students on the wards of all three general hospitals, Consultants from USH who visited patients on the HMC hospitals' wards, joint sponsorship of rheumatology services at Nether Edge Hospital and, from the 1960s, increasing exchange of nurse learners between the two hospital groups. Yet these changes were gradual, and resource constraints – financial, staff and physical – imposed significant limitations on innovation of thought or deed.

1.4 Building on the Foundations – 1962 to 1974

The period from 1962 to 1974 started with cautious optimism in the NHS, reflecting general trends in the UK. Full employment, the availability of an increasing range of affordable consumer goods and services, and scientific and technological

²⁰¹ Klein, *Politics*, p. 58; Guillebaud, *Cost of the National Health Service*, paragraphs 109-111 and 735(4); Maude, 'Reservation', in *Cost of the National Health Service*, paragraph 13. The 'Reservation' offers a critique of the development and consequences of the tripartite structure of the NHS.

developments promised improvements in the quality if not the quantity of life.²⁰² Nonetheless, this optimism was also increasingly subject to serious challenges during the 1960s. Firstly, while incomes increased even faster than prices, it was impossible to ignore the persistence of poverty within the welfare state.²⁰³ Secondly, for those who had been recruited from the Caribbean and South Asia to work, for example, in the NHS, the experience of life in Britain was often one of racial hostility, social exclusion and barriers to career progress.²⁰⁴ Thirdly, a series of economic problems faced the Labour Government between 1964 and 1966, which continued during their second administration from 1966 to 1970.²⁰⁵ Economic and political difficulties continued into the 1970s, deepening after the 1973 October War in the Middle East and OPEC-induced increases in world oil prices.

During the 1960s, the efforts of government departments concerned in its administration were directed towards optimising the ability of the welfare state to manage social and economic problems. Resources were also made more readily available than had earlier been the case, in order that those problems could be addressed as efficiently as possible.²⁰⁶ This represented an important shift in policy for all sectors of the welfare state, but had particular significance for the NHS. By the late 1950s, there was growing official recognition that the NHS was underfunded. At constant prices, using 1950 as the base year, Webster has calculated that during the 1950s, expenditure on the NHS fell to a low point of 88.4% of its 1950 level in 1952, and gradually rose to 1.9% above the 1950 level in 1957. The actual public

²⁰² A Marwick, *British Society Since 1945* (Harmondsworth, 1996, 3rd Edition), Chapter 7; K O Morgan, 'The Wilson Years, 1964-1970', in *From Blitz to Blair, a New History of Britain Since 1939*, ed. N Tiratsoo (London, 1998).

²⁰³ K Coates and R Silburn, *Poverty the Forgotten Englishmen* (Harmondsworth, 1970).

²⁰⁴ C Holmes, *A Tolerant Country? Immigrants, refugees and minorities in Britain* (London, 1991), pp. 44-63; J Walvin, *Passage to Britain: immigration in British history and politics* (Harmondsworth, 1984), pp. 117-198, *passim*; C Baxter, *The Black Nurse: an endangered species* (London, 1988); Morgan, 'The Wilson Years', p. 145.

²⁰⁵ Sked and Cook, *Post-War Britain*, pp. 202-209 and pp. 220-231; Morgan, 'The Wilson Years', pp. 136-144.

²⁰⁶ Klein, *Politics*, p. 62 *et seq.*

expenditure on the service during those three years was £459.9 million in 1949/50, £493.9 million in 1951/52, and £651.2 million in 1956/57. The NHS budget increased, as did the range of services provided, during the 1960s. However, internal and external scrutiny of NHS resource use intensified. Despite this, between 1962 and 1974, expenditure rose from 125% to 244.7% of the 1950 level.²⁰⁷

Rational planning approaches promised the means to husband scarce resources to meet demands for public services, and, for the NHS, the publication of the *Hospital Plan* in 1962 was the key exemplar. With origins dating back to 1958, the *Hospital Plan* provided guidelines on the future development of hospital services, which would henceforth be based mainly in District General Hospitals (DGH) serving populations of between 100,000 and 150,000, in units of six hundred to eight hundred beds, at a ratio of 3.3 beds for every 1000 people. The DGH would meet the full range of hospital care requirements of the average community, with the exception of specialist services, such as those provided in regional burns or spinal injuries units. There would also be smaller hospitals offering a more limited range of services.²⁰⁸

The *Hospital Plan* promised greater levels of investment, although scrutiny of NHS expenditure intensified concomitantly. The imbalances in the distribution of healthcare facilities inherited in 1948 had been largely unaddressed during the 1950s, when tight budgets had given little opportunity for re-allocating funds into under-resourced areas of the health service. The *Hospital Plan* challenged patterns of resource allocation established before 1948, through its introduction of a national, standard bed ratio and DGH model to be attained by every HMC. The Ministry of Health provided plans for hospital units and their equipment, so that nationally there

²⁰⁷ Webster, *Health Service - Volume II*, pp. 802-803.

²⁰⁸ Ministry of Health, *A Hospital Plan for England and Wales*, Cmd 1604 (London, 1962); A Harrison and S Prentice, *Hospital Policy in the United Kingdom - Its Development, Its Future* (New Brunswick and London, 1998), pp. 1-2.

would be standardisation of the level and range of service provision, and even in the design of the very buildings from which health care was to be delivered.²⁰⁹ The espoused aim of the *Plan* was to update the hospital service with the facilities necessary to deliver and further the development of the best and most modern hospital-based treatment.²¹⁰ In all, 224 hospitals, 32.5% of all hospitals in England and Wales, would either be newly built or undergo extensive modernisation, over a ten year period. Nonetheless, publication of the *Plan* did not open the Treasury to hospitals. During the 1962/3 financial year, the USH experienced a £26,000 reduction in its allocation for buildings maintenance, although following representations to the Ministry of Health the sum was increased for the following year.

The *Hospital Plan* was never fully implemented, in part because it was constantly vulnerable to the fortunes of the economy and thus to vagaries in the NHS budget. In part, this was because of the political complexity of relations between the Ministry of Health and RHBs, between party and medical politicians, and between the NHS and the public, all of which tended to undermine the ability to translate policy into practice.²¹¹ In 1975, the Resource Allocation Working Party identified the persistence of inequities in health care provision both between and within the Regions of the NHS.

Between 1952 and 1972, notwithstanding the recognition that out-patient and preventive health care would have to be expanded, plans for NHS services were essentially predicated on a continued central role for hospital services. Within Sheffield, this was to include the new Teaching Hospital, close to the University, expansion of the range of clinical specialist work undertaken at the General, and the rebuilding of that hospital, and the construction of a brand new general hospital in the

²⁰⁹ Ministry of Health, *Hospital Plan*; for example: Ministry of Health, *Hospital Equipment Note – 1 Equipping a Hospital Building*, (London, 1962); Ministry of Health, *Hospital Design Note – 1 Dimensional Coordination and Industrialised Building*, (London, 1964).

²¹⁰ SA: SY 333/H16/5, p. 15.

²¹¹ Klein, *Politics* (1989), pp. 74-79; Powell, *Evaluating*, p. 67.

south of the city on its borders with Derbyshire. Execution of the plans was delayed repeatedly because of restrictions on hospital building imposed by the Ministry of Health, although the new Teaching Hospital, the Hallamshire Hospital, was agreed in 1952 at a meeting between representatives of the Ministry of Health and USH Governors.²¹² The building of the Hallamshire Hospital was nearing completion in 1974, and The General had begun a lengthy process of rebuilding, though the general hospital in the south of the city, envisaged in the RHB's 1955 proposals, had not been started. In addition, in 1967 The General and Fir Vale were amalgamated to form the Northern General Hospital, while two years later, the HMC attained University HMC status. This recognised increasingly close collaboration between the HMC and the USH.

Provision of amenities for patients continued throughout the period from 1948 to 1974, funded out of 'free monies'. The NHS and Public Health Act of 1968 changed the basis for sharing of the money from the national Hospital Endowment Fund to that of 'present beddage', rather than the number of beds in the hospital on the Appointed Day. As the HMC had been reducing the number of beds in its wards, in part to improve the working environment for staff and in response to changing patterns of hospital admission and length of stay, this was greeted with some alarm by the Executive Subcommittee.²¹³ This encouraged the establishment of a League of Friends at the General, strongly supported by local politicians and the local press, as well as by the hospital's lay administrators. The latter were officially discouraged from belonging to such an organisation but they could provide assistance. The difference between what the USH and the HMC could achieve in patient and staff amenities was cited as a key factor in the establishment of the League.

²¹² SA: SY 333/H16/1, Minute 164(52), 3 Nov 1952.

²¹³ SA: SY 569/H1/10, Exec(69)3, 24 Mar 1969.

Prior to the establishment of the NHS, municipal hospitals had not needed to appeal for voluntary contributions and while they had received donations and gifts, these had 'never reached the proportions which are enjoyed by many ex-voluntary hospitals.'²¹⁴

An anonymous commentator claimed that the hospital had taken a long time in establishing its League. The reason given was that '(h)istorically, I think our Nursing staffs at both hospitals have been against help on the wards by outside bodies, but the new brief from the Ministry of Health suggested that there were many other ways in which the League of Friends could help a hospital, and it was on this basis that the recommendations were made by the committee.'²¹⁵

The League of Friends did not raise as much money as did donors to the USH hospitals, and at most their bank balance stood at £346.0s.1d. The funds that they raised from public events, including an annual fair, wine tasting and fashion shows, allowed them to purchase medical and therapeutic equipment. The limits to their role were defined in part by statute, partly by what they were able to achieve with limited funds and voluntary assistance.²¹⁶ The League considered it inappropriate to provide a receptionist service in the General's Accident and Emergency department when requested. Conversely, they provided other services that the hospital could not – such as a hostess scheme for the Day Hospital for older people and for the out-patients department.²¹⁷ They were also prepared to provide specific assistance during strikes in 1971 by postal workers, when they helped deliver letters to patients about admission

²¹⁴ SA: LD 2535/3/2, 24 Dec 1968.

²¹⁵ SA: LD 2535/1/1, 5 Sept 1969.

²¹⁶ SA: LD 2535/1/1, Minute 130, 28 Apr 1971; Minute 184, 26 Jan 1972; Minute 195, 23 Feb 1972; Minute 199, 29 Mar 1972; Minute 212, 26 Apr 1972.

²¹⁷ SA: LD 2535/1/1, Minute 46, 24 June 1970. NB This is the date given in the records, although it may be incorrect, as two sets of minutes bearing the same date appear.

and appointments, and in 1973 when hospital ancillary staff struck, although the nature of the assistance they provided then is not clear.²¹⁸

Between 1962 and 1974, voluntary service continued to complement the work of the NHS. Organisations such as the Women's Royal Voluntary Service (WRVS), and National Hospital Service Reserve (NHSR) supported the provision of trolley services and ward duties respectively in the HMC hospital units. Schoolchildren and university students wrote letters for patients, spent time talking with them and helped to tidy their flowers.²¹⁹ The University of Sheffield's Union of Students established a language bank at the end of the 1960s and offered free translation of documents and interpreting for patients.²²⁰ Voluntary work and donations made it possible for hospitals to provide for more than the physical needs of the patient but, by crossing the boundaries between professional and lay aspects of the hospital, they were also providing a counterweight to its institutional character. Volunteers' work in the ward areas contributed to patient care by providing social interaction and personal care, particularly for those without relatives to visit and those on the wards for frail elderly people at the Nether Edge Hospital and Fir Vale who were permanently 'resident' in the hospital.²²¹ This was encouraged, and indeed the opportunity to relieve nurses of non-nursing duties was one of the General's objectives for the League of Friends, in addition to fund-raising in such a way that their work 'complements' the work of the Convalescent and Hospital Services Council.²²²

Hospitals were always more than physical buildings and equipment. As a human enterprise, they were part of the community in which they stood. Their continued

²¹⁸ SA: SY 569/H1/12, MC(71)2, Minute 112, 8 Feb 1971; SA: LD 2535/1/1, Minute 104, 20 Jan 1971; Minute 110, 24 Feb 1971; Minute 274, 24 Jan 1973.

²¹⁹ See, for example, SA: LD 2535, letter by C W Dickinson – 'What kind of voluntary help is needed in a District General Hospital?' 10 May 1968; SA: Acc 2001/98, Matron's records and reports, *passim*, 1963-1967.

²²⁰ SA: SY 569/H1/11, GMC(70)1, 27 Jan 1970.

²²¹ SA: SY 569/H1/9, NGH(68)10, 14 Nov 1968.

²²² SA: LD 2535/3/2, Letter by C W Dickinson concerning the League of Friends, 10 May 1968.

existence derived from funding raised from the community whether voluntarily or compulsorily. Most members of staff, as well as patients and visitors, lived nearby, whether in nurses' homes and staff residences on the hospital site or nearby, and looked to the hospital to provide them with treatment and care when required. In these respects at least, without the 'community' in its broadest sense the hospital could not have existed.

Yet hospitals as institutions were also separate from the community. The physical barriers of walls, gates and even fields that separated the General, Fir Vale, and the Infirmary from their immediate surroundings exemplified this. Maps of the hospital site at Fir Vale show that between 1905 and 1937, to the west, north-west and east of the hospital, farmland was built over to provide housing, creating the Longley estate and Firth Park, and expanding Fir Vale. The hospital's grounds were not encroached upon. Much of the area to the north-east and east of the site had only been brought within the city boundaries following the 1900 Sheffield Corporation Act. This land mainly provided housing and social amenities for those working in the nearby industrial areas of the lower Don Valley, much of which was complete before or during the early years of the Second World War, with the focus of housing development moving to other parts of the city thereafter.²²³ However, walls surrounded the hospital site. The Infirmary was similarly encircled, and the character of the perimeter wall as more than simply a physical barrier is illustrated by attitudes to people who were neither staff nor visitors. When a large development of local authority high rise flats opened and were occupied across the road from the hospital in

²²³Director General at the Ordnance Survey Office, *Yorkshire [West Riding] Sheet CCLXXXVIII. 16.* [Surveyed in 1890; revised and resurveyed in 1902], (Southampton, 1905); Director General at the Ordnance Survey Office, *Yorkshire [West Riding] Sheet CCLXXXVIII. 16.* [Revised 1934-1935] (Southampton, 1937); A M Craven, 'Housing before the First World War' in *History of the City of Sheffield – Volume II Society*, pp. 71-74; A D H Crook, 'Needs, standards and affordability: Housing policy after 1914', in *The History of the City of Sheffield, 1843-1993: Volume II, Society*, pp77-84; R J Marshall, 'Town planning in Sheffield' in *The History of the City of Sheffield, 1843-1993: Volume II, Society*.

1969, the nursing staff noted that the hospital grounds were increasingly being used 'as a public thoroughfare', and that children were sitting on the walls and looking into the wards.²²⁴

The tripartite structure of the NHS was a compromise that allowed the new service to become a reality, with little real disruption to prior administrative arrangements. It was not until the Porritt Report was published in 1962 that serious and widespread consideration of the possibility of unification of the three sectors, began. Kenneth Robinson, Minister of Health in Wilson's Labour Government of 1964, was initially reluctant to act on the report's suggestions. This set the tenor of the reorganisation process, which proceeded haltingly, through two green and one white paper, between 1965 and the defeat of the Labour Government in the 1970 general election. The incoming Conservative Secretary of State for Health and Social Security, Keith Joseph, was enthusiastic about the idea of reorganisation, but critical of the plans that he inherited from the Labour administration.²²⁵ In particular, there was a lack of commitment to either strong management or unification between health and social services. By the 1970s, economists, the 'keepers of the faith of efficiency', had emplaced themselves firmly at the Ministry of Health, and exerted a continuing influence on resource management within the service.²²⁶

By 1974, the search for rational solutions to the question of how to administer and deliver health services as efficiently as possible had secured the first structural reorganisation and unification of the service. The new structure of the NHS proposed unification of the three parts into one organisational structure, with the creation of a new tier of ninety Area Health Authorities, sandwiched between the Regional Health

²²⁴ SA: SY Acc 2001/98, Meetings with Sisters, 14 Oct 1969.

²²⁵ In 1968, reforms of central government administration led to the creation of the super-department, the DHSS (Department of Health and Social Security).

²²⁶ Klein, *Politics*, p. 64.

Authorities and District Management Teams. These were to ensure co-terminosity and liaison between the NHS and Social Services Departments at local level. The reorganised NHS also included a formal, if ill-defined, voice for patients, in the form of the Community Health Councils.²²⁷

The implementation of the NHS contained inherent contradictions. It simultaneously changed the funding and administration of health services, particularly those based in hospitals, while retaining all the essential features of the health care systems that preceded it. The development of the NHS to the Appointed Day had been fraught with conflict, yet from 5th July 1948 those involved in working for the NHS did not appear to question its principles, even if they challenged their ability to realise them within the limited resources available to them USH, indicates continuing support for the service. While the NHS made significant use of voluntary effort in diverse ways, its capacity for the delivery of patient care relied on the work of several occupational groups, clinical and non-clinical. Nurses formed the largest single occupational group, and their presence in sufficient numbers, with an appropriate range of skills and knowledge was critical to the successful operation of the NHS. The following chapter analyses the overall relationship between nursing and the NHS, in order to develop further the framework for analysis of specific aspects of nursing and nursing work in Sheffield's three major general hospitals between 1948 and 1974.

²²⁷ Klein, *Politics*, pp. 94-99; Webster, *Health Service - Volume II*, Chapters II-VI, *passim*.

2. Nursing in the NHS, 1948 to 1974

2.1 Nursing Availability, 1948-1974

If we return again and again to the problems of nursing, it is because the coming effort to improve the medical services in this country will be wholly frustrated unless there are enough nurses properly trained for their work.²²⁸

Throughout the period from 1948 to 1974, hospital authorities faced challenges in maintaining an adequate level of nursing staff of all grades, prompting them to try a variety of solutions including labour substitution, innovative approaches to recruitment, training, retention strategies and management of workload. Concern over nurse recruitment and retention preceded the NHS – and persisted beyond 1974.²²⁹ Nurse recruitment difficulties did not affect all areas of the country evenly; larger centres were relatively protected. Various fields of nursing practice were differently affected: psychiatric, mental handicap and tuberculosis nursing, for example, experienced greater recruitment problems than did general nursing.

Between 1931 and 1971, the absolute number of nurses increased, reflecting a trend towards greater levels of female participation in the workforce. The *Census* returns on the proportion of occupied females in all categories of employment outside the home increased gradually from 34.16% in 1931, to 34.85% in 1951, when the next census was taken following the disruption of World War Two, and 37.66% in 1961.²³⁰ Recent research by Hatton and Bailey, contrary to earlier assumptions, indicates that there may have been over-counting of women in the decennial censuses of 1891 to 1931,

²²⁸ 'First things first' [Leader], *The Lancet* 15 Mar (1947), p. 333.

²²⁹ Bradshaw, *The Nurse Apprentice*, pp. 82-113, *passim*.

²³⁰ *Census of England and Wales 1931 - Occupation Tables*. (London, 1934); *Census of England and Wales, 1951. Occupational Tables*. (London, 1956); *Census of England and Wales, 1951. General Tables*, (London, 1956); *Census of England and Wales, 1961. Occupational Tables* (London, 196).

which if adjusted for would mean that the overall rate of increase in the participation of women in paid employment from 1931 would be steeper.²³¹

According to the 1931 *Census*, the proportion of occupied females in England and Wales of working age who were engaged in working as sick nurses was 21.2 per thousand.²³² However, in 1930, the medical journal *The Lancet* had established a Commission to investigate the causes of what was widely felt to be a shortage of nursing staff.²³³ Subcommittees of the Committee of Imperial Defence considered the potential impact of additional requirements for nurses that would arise in wartime in the context of extant peacetime shortages in 1927 and again in 1936.²³⁴ Three years later, the *Interim Report of the Inter-Departmental Committee on Nursing* also noted this apparently intractable problem, and Scott notes that nursing shortages during the Second World War were sufficiently severe to prompt the Ministry of Health to consider making nursing a 'National Service'.²³⁵

Minutes of meetings held at Sheffield's voluntary general hospitals between 1938 and 1945 indicate that recruiting and retaining enough nurses was hard even without the loss of nursing staff to Territorial Army Nursing Reserve units and to Forces Nursing service duties during the Second World War.²³⁶ Following the end of the War, emergency measures restricting labour mobility were lifted with the short-term result that the number of nurses in active employment fell. This reflected broader patterns in

²³¹ T J Hatton and R E Bailey, 'Women's work in census and survey, 1911-1931', *Economic History Review* LIV:1 (2001), pp. 87-90.

²³² Prior to the 1944 *Education Act*, the working age for women was from 14 to 60; thereafter it became 15 to 60 years of age.

²³³ *The Lancet*, *The Lancet Commission on Nursing*, Chair: The Earl of Crawford and Balcarres (London, 1932).

²³⁴ K Watt, 'The Civil Nursing Services in War-Time', in *The Emergency Medical Services – Vol I England and Wales*, ed. C L Dunn (London, 1952).

²³⁵ Ministry of Health, Board of Education *Inter-Departmental Committee on Nursing Services. Interim Report* Chair: The Rt Hon the Earl of Athlone (London, 1938); Scott, 'Policies for Nursing', pp. 118, 134; Rafferty, *Nursing Knowledge*, p. 157.

²³⁶ SA: SY 333/H3/38, Report of Interview of Staff Representatives and the Matron, 3 Mar 1940; SA: SY 333/H14/2, 27 Jan 1940 and 28 Apr 1941.

women's workforce participation. The proportion of women in work, whether paid or voluntary, reached an unprecedented level during the war, fell once the war ended, but thereafter began to increase again during the early 1950s, largely because of greater opportunities for married women to work, often though not exclusively in traditional female roles.²³⁷

Comparing the census data on the number of people engaged in nursing in 1931 and 1951 is challenging because, by the later date, the occupational categories in which nurses were enumerated had expanded to include midwives, while unqualified students and assistants were now excluded. The proportion of occupied females in England and Wales, aged fifteen and over, who were working as qualified nurses or midwives in 1951 was 20.75 per thousand. Adjusting the 1931 figure to include midwives and mental attendants, and the 1951 figure to include students and assistants, the numbers of women and men working in nursing and midwifery were 24.7 per thousand in 1931 and 30.4 per thousand in 1951.

A series of leading articles published by *The Lancet* during early 1947 warned that the new NHS would founder if the related questions of the number and training of nurses were not successfully addressed.²³⁸ However, the Ministry of Labour *Gazette* noted in 1949 that 'There are more nurses and midwives in practice now than before the War, and many others are in training. Yet there is a big demand for still more nurses and midwives.'²³⁹ Despite the fears expressed by *The Lancet* in 1947, between 1949 and 1956 the number of full-time nurses employed in NHS hospitals in England and Wales increased by nearly 16%, and the number of part-time nurses by over 54%; the rate of

²³⁷ A Myrdal and V Klein, *Women's Two Roles: Home and Work* (London, 1956), pp. 51-58; J Tomlinson, 'Reconstructing Britain: Labour in Power 1945-1951', in Tiratsoo, ed. *From Blitz to Blair*, p. 96.

²³⁸ 'Why no nurses?' [Leader], *The Lancet*, 4 Jan (1947), pp. 29-30; 'The nursing crisis', [Leader], *The Lancet*, 1 Feb (1947), p. 181; 'First things first' [Leader], *The Lancet*, 15 Mar (1947), p. 333; the theme was taken up in correspondence to the journal during these weeks.

²³⁹ *Ministry of Labour Gazette*, Volume 57:12 (1949), pp. 409-410; Baly, *Nursing and Social Change*, p. 207.

increase being higher in the first half of the period.²⁴⁰ In the next census year, 1961, occupational tables drawn on a ten per cent sample of the population indicate that 37.7 per thousand women classed as occupied in England and Wales were defined as nurses. In 1971, the numbers of both female and male nurses, based on a one per cent sample of Great Britain, was given as 431,700. The figures for 1961 and 1971 should be treated more cautiously than those for 1931 and 1951, which were based on a total sample of the population. Although a number of caveats concerning intercensal changes in the categorisation of nursing and related occupational groups must be borne in mind, it can tentatively be suggested that the proportion of women of working age who reported themselves as belonging to nursing and related occupations increased over the period of the study.²⁴¹

However, the census data do not provide information about requirements for nurses to work in the NHS. Notoriously, matching health care resources to need has been a political problem dressed as a technical one, though one lacking a solution. Estimates of how many beds would be required to run the proposed health service, and how many Nurses, Doctors and other staff needed to ensure that those beds could be utilised, were made by the writers of the *Hospital Surveys*. Agreement on the optimum methodology for calculation was disputed then, and has proved elusive since.²⁴² Rafferty argues that the availability of nurses in sufficient numbers to provide care to patients was early recognised as crucial to the success of the NHS, and that it was this that prompted the appointment of the *Working Party on the Recruitment and Training*

²⁴⁰ Anon, 'A Ministry of Labour Review – Staffing the Health Service', *Nursing Times* 23 June (1951), pp. 619-621.

²⁴¹ *Census of England and Wales, 1931 - Occupation Tables; Census of England and Wales, 1951 - Occupational Tables; Census of England and Wales, 1951 - General Tables; Census of England and Wales, 1961 - Occupational Tables.*

²⁴² K Grumbach, M Ash, J A Seago, J Spetz, J Coffman, 'Measuring shortages of hospital nurses: how do you know a hospital with a nursing shortage when you see one?' *Medical Care Research and Review* 58:4 (2001), pp. 387-403.

of Nurses under the Chairmanship of Sir Robert Wood in 1946.²⁴³ However, Scott notes that while the surveys of hospitals and of the nursing workforce undertaken during the War underscored such concerns in relation to preparedness to run a National Health Service, the *Working Party* was not established until January 1946, after the NHS Bill had been drafted. Furthermore, she contends that, even before the *Report* was published, the Ministry of Health established committees to consider aspects of nurse training and organisation.²⁴⁴ This betrayed a profound lack of attention to views held by senior nurses, whose views of the *Report* were critical of most of its key contentions in spite of nursing's internal divisions.

The lack of attention given by the *Working Party* itself to the central role that changes in the role of the hospital would have for the requirement for nurses led Cohen to publish a *Minority Report* in 1948. He argued that the 'function of the hospital' had to be considered before that of the nurse.²⁴⁵ The latter's role, and training, was dependent on the former. Moreover, Cohen's view was that the number and mix of nurses required by the new NHS must be calculated before effective recruitment and retention strategies could be developed.²⁴⁶

Senior nurses working in hospitals and officers of the Hospital Boards and the Ministry of Health approached the notional ideal nursing establishment – and how far this should be funded – from different perspectives.²⁴⁷ Different statistics were thus collected for different reasons. Official statistics on the numbers of nurses employed and required by the NHS whether at national or at local level, should be treated with caution. As the statutory bodies responsible for nursing, the General Nursing Councils kept the names of nurses on the Register and the Roll, and indexed the names of

²⁴³*Working Party - Majority Report*; Rafferty, *Nursing Knowledge*, p. 157.

²⁴⁴Scott, 'Policies for Nursing', p. 135.

²⁴⁵*Working Party - Minority Report*, p. v, paragraph 7.

²⁴⁶*Working Party - Minority Report*, p. 1, paragraph 9.

²⁴⁷Scott, 'Policies for Nursing', pp. 157-159, 219

people entering nurse education, so allowing calculation of the numbers in these categories. These returns were sent to the Ministry of Health and, for example, contributed to the calculation of funding levels for nurse education through Area Nurse Training Committees under the terms of the 1949 *Nurses Act*. However, the returns did not reflect the numbers of nurses actively employed as Registered or Enrolled Nurses. They also omitted the growing number of Nursing Auxiliaries and Assistants who were employed in the NHS to deliver aspects of nursing care. When Sir Arthur McNalty was charged with arranging for the Civil Nursing Reserve in 1938, it was to the RCN, and not the GNCs, that he advised the Ministry of Health to turn to compile the register of trained and assistant nurses.²⁴⁸

Finally, the Ministry of Labour and National Service's published figures of nursing and midwifery vacancies should be seen as partial. The Ministry claimed to provide a complete picture, which allowed the locally based Nursing Appointments Officers to 'know the location and nature of all the vacancies that are waiting to be filled'.²⁴⁹ However, the Sheffield Region of the National Association of HMC Group Secretaries noted in December 1955 that the figures on nursing vacancies published in the *Ministry of Labour Gazette* were 'in fact misleading', because not all hospitals were asked to complete returns on nursing vacancies.²⁵⁰ Such uncertainty appears to have persisted – in 1970, the use of the 'Cornish Formula' for the estimation of nursing staff requirements was discussed by HMC Group Secretaries, which identified that there was no certainty as to whether it had been adopted – or whether 'in fact there was a uniform method applied throughout the Region.' Even if a formula had been agreed, it had not been implemented.²⁵¹

²⁴⁸ Watt, 'Civil Nursing Services', p. 438.

²⁴⁹ *Ministry of Labour Gazette* 57:12 (1949), p. 410.

²⁵⁰ SA: SY 291/H1/1, 3 Dec 1955.

²⁵¹ SA: SY 291/H1/2, Minute 617, 25 Sept 1970.

The lack of accurate records was remarked upon by the *Working Party on the Recruitment and Training of Nurses* in 1947. Criticism of the poor data on nursing requirements and availability was also raised in 1969, when MacGuire's research into the recruitment and retention of Student Nurses highlighted inherent problems with the records kept by hospitals and schools of nursing, which she argued were 'inadequate for research purposes,...[and]...inadequate as a basis for policy decisions at both national and local levels'.²⁵²

While the overall numbers of people employed in nursing of various kinds do appear to have increased, there were recurrent concerns that the availability of people with appropriate skills to work in particular branches of nursing and clinical specialities remained insufficient. Nurse recruitment was not a simple matter of striking a balance between supply of staff and demand for nursing care. The reported perceptions of contemporaries were of continued, if sporadic, difficulties in recruitment, rather than of increasing numbers. In a series of articles on the 'crisis in nursing' published by the *Nursing Times* in 1961, Brian Abel-Smith observed that 'shortage' and 'wastage' of nurses had been subjects of discussion for a century. His diagnosis, similar to that of the *Minority Report* of the *Working Party*, published by Cohen in 1948, was that a more realistic appraisal of what nurses could and should do, greater willingness to use appropriately trained enrolled and auxiliary nurses, and to use any strategy short of central direction of labour to move nurses to understaffed areas, was required.²⁵³ In 1962, the Ministry of Health felt it necessary to 'declare a public war on the myth of shortage of nurses'. In response to a question about the shortage of nurses, Braines,

²⁵² *Working Party – Majority Report*; J MacGuire, 'Research findings on recruitment and withdrawal 1', *Nursing Times* 20 Feb (1969), pp. 29-31.

²⁵³ B Abel-Smith, 'Crisis in Nursing 1 - The Sociologist's View', *Nursing Times* 29 (1961), pp. 1262-1263.

Minister of Health, stated that there was no shortage of nurses, and that recruitment continued within the financial allocations to the various health authorities.²⁵⁴

The disparity between the absolute increase in nursing numbers and the difficulties in recruiting at times and to specific clinical specialities were variously attributed to a number of causes. Cohen's suggestions ran counter to the tenor of the *Majority Report*, which stressed the primary importance of radical change in the training of Student Nurses, as well as reiterating recommendations made in earlier reports that the key to successful recruitment and retention of nurses lay in improving the terms and conditions of nurses' work and living arrangements in hospital accommodation.²⁵⁵

Although the *Inter-Departmental Committee* had suggested that exaggerated media reports exacerbated nursing recruitment problems, the *Working Party* identified genuine cause for concern. They observed for example that, though some students were inherently unsuited to the occupation, there were others who left because '...they are expected to work under conditions which even many of those suitably equipped are not prepared to tolerate.'²⁵⁶ These included low pay, poor conditions in the clinical areas, the requirement to undertake non-nursing work, long and irregular hours of work, split duties, limited off-duty time, poor relations between different grades of staff, unnecessarily harsh discipline and the requirement to be resident in a nurses' home that often had poor facilities.

However, the problems identified notwithstanding, various accounts and analyses suggest that the problem of staffing NHS hospitals was less the result of insufficient numbers of recruits than of the greater rate at which demand for nurses grew with the overall expansion of health services, modern treatment methods, and increasing need

²⁵⁴Hansard - House of Commons Debates, 5th Series, Volume 669, 1962-1963. Columns 12-18. Oral Answers, 10 Dec 1962.

²⁵⁵ *Lancet Commission; Interdepartmental Committee; Working Party - Majority Report.*

²⁵⁶ *Interdepartmental Committee*, p. 3; *Working Party - Majority Report*, p. 35, paragraphs 89 and 91, and p. iii; White, 'Nursing Profession', p. 14.

for social care after World War Two.²⁵⁷ Between 1948 and 1950, the ratio of trained staff to beds improved from 13.14 to 14.55, with ratios of all staff to beds improving from 35.47 to 40.13.²⁵⁸ During 1950 alone, for example, there was an increase of eleven thousand, four hundred and seventy staffed beds in the NHS.

Conversely, the availability of nursing time reduced in real terms between 1948 and 1974, in part because of changes in hours and conditions of work and the approach to nurse training. Nurses' weekly working hours during this time fell in stages from fifty-six hours or more to forty per week, with two days off each week by the end of the period as opposed to one when the NHS was first established. In addition, the availability of training grade nurses to the hospitals on a daily basis was reduced by the introduction to training programmes of blocks of study time or of specific clinical experiences for nurses in training. This meant that groups of nurses were removed from the wards and departments, and by 1974 all general Student Nurses in Sheffield spent between two and three months, at least once in their training period, in another hospital in addition to time spent in education blocks.²⁵⁹

However, recruitment of nursing staff was also constrained by both general and specific factors. Firstly, while the number of women entering the workforce rose steadily worldwide after 1945 and in Britain the proportion of women in the workforce rose above the level it had attained before the Second World War, the rate of increase slowed during the late 1940s and 1950s in comparison to that during the war years.²⁶⁰

²⁵⁷ *Working Party – Majority Report*, paragraph 28; J Spritzer, 'A Matron retires', *The Sheffield Spectator*, 1:8 (1965), p. 44.

²⁵⁸ Anon, 'Ministry of Labour – Review of Staffing the Health Service', *Nursing Times* 23 June (1951).

²⁵⁹ SA: SY 333/H16/1-2, 1948-60, *passim*; SA: SY 333/H16/9, Minute F207 27 June 1949, Minute F225 26 July 1949; SA: SY 569/H1, *passim*.

²⁶⁰ E Hobsbawm, *Age of Extremes: The Short Twentieth Century 1914-1991* (London, 1994), pp. 310-311; S Bruley, *Women in Britain Since 1900* (Basingstoke, 1999), pp. 117-120; S Rowbotham, *A Century of Women: The History of Women in Britain and the United States* (Harmondsworth, 1997), p. 243.

Yet the revival of the general economy and the expansion of employment in the Welfare State relied on an increase in the number employees, including women.²⁶¹

While the exigencies of war meant that cultural norms regarding acceptable roles for women could be suspended, this was a temporary and ambivalent situation. There is little indication that women were relieved of their domestic obligations and social and political expectations were that women would resume their roles of 'mother' and 'housewife' once hostilities ceased in 1945.²⁶² An overt expression of this was the cessation of subsidies to local authority nurseries in 1946. This made participation in the workplace a more difficult prospect for women with children – although in reality during the War they had only provided places for a minority of children aged less than five years.²⁶³

During the 1950s and 1960s, the trend was towards earlier marriage than in previous decades. Pay parity between the sexes was partly endorsed by the *Royal Commission on Equal Pay* in 1946, though not implemented by the Labour Government, and it still fell primarily to women to fulfil the role of homemaker with its associated responsibilities for shopping and domestic labour.²⁶⁴ Although marriage and employment were increasingly viewed as compatible, research by Myrdal and Klein identified that many women in the British workforce experienced a 'bimodal' career structure, with their employment trajectory interrupted by childrearing, and a return to work only taking place once children had become relatively independent.²⁶⁵ Rationing and queuing for foodstuffs continued until autumn 1950, and the availability of labour-saving devices was slow to reach most working class households. Although

²⁶¹ L Hall, *Sex, Gender and Social Change in Britain Since 1880* (Basingstoke, 2000), p. 146; A Oakley, *Social Welfare and the Position of Women* (London, 1987), pp. 1-5.

²⁶² D Riley, "'The Free Mothers': pronatalism and working women in industry at the end of the last war in Britain', *History Workshop Journal* 11 (1981); Bruley, *Women*, pp. 120-123.

²⁶³ Rowbotham, *Century of Women*, p. 234.

²⁶⁴ Bruley, *Women*, p. 120.

²⁶⁵ Myrdal and Klein, *Women's Two Roles*, pp. 51-58, Chapter Four; Lewis, *Women in England*, p153.

by the early 1970s it has been suggested that aspects of women's domestic role were beginning to change, the domestic workload was greater for women than for men.²⁶⁶

The raising of the school leaving age in 1947 affected male and female workforce participation alike.²⁶⁷ However, changing social attitudes towards women and their role in both home and the workplace gradually opened up new opportunities for careers in both traditional and non-traditional areas of work, as well as contributing to a slow increase in the numbers of young women entering higher education.²⁶⁸ Furthermore, such alternatives offered tangible and intangible benefits that nursing did not, including better pay and regular hours of work and time off. The discourse of nursing work as vocation exhorted nurses to service and to care, as it had done during the earlier years of the twentieth century, but the reality was that most nurses were not sufficiently privileged to eschew material rewards in favour of spiritual ones.²⁶⁹ It is likely that the increasing and persistent engagement of women in paid employment owed something also to rising standards of living – at least for some of those in work – and increasing levels of consumption and the wider availability of goods, services and leisure facilities for which disposable income and time were required.²⁷⁰

In addition to competition from broadening opportunities for young women, the cost of providing nurses increasingly constrained additional recruitment. As noted above, Cohen had called for the establishment of a method of calculating nursing needs based

²⁶⁶ D Simonton, *A History of European Women's Work* (London, 1998), Chapter 9; Marwick, *British Society*, pp. 70-71.

²⁶⁷ Jones, *Health and Society*, p. 128.

²⁶⁸ G Joseph, *Women at Work* (Oxford, 1983); Marwick, *British Society*, pp. 64, 111-112, 189; Hobsbawm, *Age of Extremes*, p. 311; Rowbotham, *Century of Women*, pp. 291-293, 348-352.

²⁶⁹ S Reverby, *Ordered to care: the dilemma of American nursing 1850-1945* (Cambridge, 1987)

²⁷⁰ M Hilton, 'The Fable of the Sheep, or, Private Virtues, Public Vices: The Consumer Revolution of the Twentieth Century', *Past and Present*, 174 (2002), pp. 222-256; D Porter, "'Never-Never Land' – Britain under the Conservatives, 1951-1964', in *From Blitz to Blair*, ed. Tiratsoo, p. 112; Marwick, *British Society*, Chapter 7.

on the requirements of the NHS, but this was not acted upon.²⁷¹ When the NHS was established, the method in general use for estimating the number of nurses required in any setting was professional judgement – not the objective criteria for which Cohen argued.²⁷² This approach appears also to have been used to plan for immediate and long-term recruitment, and related training requirements.²⁷³

The cost of the NHS exceeded the estimates from the first year of its operation, and the hospital service accounted for much of this, with staff costs accounting for the largest single item on the budget. Webster notes that, while given scant attention initially, control of establishments quickly became a central tension in relations between the Ministry of Health and the Treasury from 1948. Once the part they had to play in the overall cost of the NHS was appreciated, ‘the Treasury engaged in an unremitting struggle with the Ministry of Health over control of hospital staff numbers’.²⁷⁴

From March 1949, the Treasury asked the Ministry of Health to control the high relative costs of hospital care through control of the numbers of staff employed. This was contrary to the policy of allowing local autonomy in the matter of staff establishments that Bevan had hitherto pursued and ran counter to the promise he had made to the medical profession in 1948 that the role of the Ministry of Health and of the NHS administration was to support them in their clinical work. Bevan was reluctant to comply with the Treasury’s requirement beyond the collection of statistics on the numbers of staff employed by the NHS.

²⁷¹ Ministry of Health, Department of Health for Scotland, Ministry of Labour and National Service, *Report of the Working Party on the Recruitment and Training of Nurses. Minority Report* Author: J Cohen (London, 1948).

²⁷² Kirby, ‘Municipal Model’, pp. 17-23.

²⁷³ SA: SY 333/H3/28, 12 May 1954.

²⁷⁴ Webster, *Health Service - Volume I*, p. 137.

However, detailed control of establishments was already implemented in Scotland, which added strength to the Treasury's argument that it was feasible.²⁷⁵ The Treasury's desire for urgent action to control hospital costs led the Ministry of Health to send teams to the regions to advise on staff establishments in hospitals from September 1950. Having imposed a freeze and then a reduction in numbers of non-clinical staff during 1951 and 1952, the Ministry of Health under the second Minister of Health of the Conservative government, Iain Mcleod, froze all staff establishments as they were on 5 December 1952 and imposed stringent conditions on HMCs seeking an increase.²⁷⁶

Controversial attempts to place the calculation of staff establishments throughout the NHS on a surer footing during the 1950s eventually came to naught. Sheffield RHB complained in 1955 of a lack of support from the Ministry of Health for the use of a formula to calculate bed needs, in relation to addressing the 'nursing problem' within its hospital planning proposals.²⁷⁷ 'Economy in Manpower Regulations' introduced in 1959 devolved responsibility for controlling establishments within financial limits to RHBs.²⁷⁸ The control of NHS costs and associated control of staff establishments continued to constrain senior nurses' opportunities to manage the availability of nurses in specific numbers and grades throughout the period to 1974.

An early national response to nurse recruitment problems was the removal, in 1939, of general educational entry qualifications and the concurrent suspension of the GNC entrance test that had hitherto been administered to prospective students who did not hold the School Leaving Certificate. Such entry requirements were considered by the Ministry of Health to be an unnecessary barrier to the recruitment of suitable

²⁷⁵ Webster, *Health Service - Volume 1*, pp. 298-300; SA: SY 333/H16/3, 1962, p. 15.

²⁷⁶ Webster *Health Service - Volume 1*, pp. 301-302

²⁷⁷ SA: SY 709/H2/1, 1955.

²⁷⁸ SA: SY 291/H1/1, Minute 313, 15 Nov 1954; Webster, *Health Services - Volume 1*, p. 301.

candidates for nursing.²⁷⁹ The Ministry's action is significant for two key reasons. First, resultant tension in relations between the profession and officials in the Ministry persisted until 1962, when the GNC succeeded in persuading the Ministry of Health to reimpose a minimum educational standard for entry.

Secondly, research carried out into the impact of the removal of educational entry requirements suggested that the rate of student wastage increased after the suspension of the educational entry requirement.²⁸⁰ Paradoxically, nurses regarded educational entry qualifications with ambivalence. While the majority of hospital Matrons were supportive of the removal of barriers to recruitment, the value of which they viewed with ambivalence, other members of the profession feared that a lowering of the educational standard would harm the status of nursing and depress wages.

Indeed, the restoration of educational entry requirements to schools of nursing was agreed by the Ministry of Health only when it was reported that schools of nursing which operated an informal entry requirement had lower attrition rates than did those without.²⁸¹ Levels of Student Nurse wastage increased again during the 1960s. Yet both White and Davies note that the standard of the educational entrance test used by the GNC was low, and that the difference between the multi-subject School Leaving Certificate and the single subject General Certificate of Education (GCE) Ordinary Levels which had replaced it by 1962 was not appreciated by the GNCs. The GCE allowed a candidate sitting a number of papers in consecutive years to build up a

²⁷⁹ C M Davies, 'Professional Power and Sociological Analysis: Lessons from a Comparative Historical Study of Nursing in Britain and the USA' (Warwick, 1981), Chapter Four. Scott argues that recruitment and retention issues were, from the perspective of the Ministry of Health, the most important issues affecting nursing throughout the lifetime of the Ministry, 1919-1968, See: Scott, 'Policies for Nursing', p. 209.

²⁸⁰ Davies, 'Professional Power and Sociological Analysis', Chapter Four.

²⁸¹ Davies, 'Professional Power and Sociological Analysis', Chapter four; White, 'Nursing Profession', pp. 34-35; R White, 'Educational entry requirements for nurse registration: an historical perspective', *Journal of Advanced Nursing* 10 (1985), pp. 583-590.

profile of passes, whereas the School Leaving Certificate had to be attained within a single examination period.

Increasingly, Matrons, local careers committees and the NHS at a national level also sought recruits from beyond the traditional sources. The first example of this was the creation of the 'second portal' of entry in 1943. The Nurses Act of that year gave Assistant Nurses the legal status that underscored their *de facto* recognition by the Rushcliffe Committee in April 1943. It also instituted controls over the operation of Nursing Corporations, which offered preferential salaries, terms and conditions of service, and had been able to recruit both Assistant Nurses and students away from the hospitals. Staff previously employed as Intermediate Assistant Nurses were admitted to the Roll once it opened in 1944, providing they met certain criteria on length of training undergone and experience acquired, which the General Nursing Council stipulated. The initial impact of the legislation was greatest in areas providing long term, chronic nursing care, to which it was more difficult to attract students.

Although the *Working Party* recommended the abolition of the State Enrolled Assistant Nurse (SEAN) grade when it reported in 1947, it was apparent that 'the Assistant Nurse grade was likely to become a permanent feature of the nursing service in many hospitals and particularly in the chronic sick hospitals'. Women who wished to return to work after having a family were often specifically encouraged to take the Pupil Assistant Nurse training that led to the qualification.²⁸² From 1961, the term 'Assistant' was removed by the Nurses (Amendment) Act. By 1967, 20% of Enrolled Nurses were working in acute hospitals, and ten per cent had been accorded the new

²⁸² Department of Health for Scotland – Standing Nursing and Midwifery Advisory Committee, *The State Enrolled Assistant Nurse in the National Health Service* (Edinburgh, 1955), p4, paragraph 5; M Dixon 'People at work - what nursing means to mature pupils' *The Guardian* 5 Mar 1968, p10; Sheffield Number One HMC *A Simple and Practical Course of Training as a State Enrolled Assistant Nurse*, (Sheffield, ?1960).

status of Senior SEN, with similar responsibilities to those of the SRN, albeit without the promotion and career progression enjoyed by the latter.²⁸³

These developments were not universally endorsed, as the Standing Nursing Advisory Committee (SNAC) reported in 1971. There was still considerable variation in the work the SEN was expected and allowed to do. In part, this was attributed to inconsistent recruitment and training policies but the attitudes of some senior nurses and medical staff were held to be important. While SENs provided safe, trained pairs of hands to do the essential nursing work, their presence in the general wards was the result of necessity rather than choice, pragmatism rather than strategy.²⁸⁴

The role of the SE(A)N was restricted in scope and jobs were concentrated in undervalued areas of health care, such as care of older people and those with chronic or infectious diseases, with little opportunity for career progression. These limitations were perceived by the profession to be justified by the shorter, practical training. During the first eighteen years of the existence of the Roll, there was little incentive to undertake this route to a nursing qualification. Between 1948 and 1960, only sixteen per cent of all recruits to nursing jobs were destined for the Roll, with three-year student training offering the more popular route to a nursing qualification.²⁸⁵ With no minimum educational entry requirement for Student or Pupil Nurse training until 1962, and limited rewards on qualification, Pupil Nurse recruitment lacked strong incentives.²⁸⁶ Furthermore, Pupil Nurse training was considered less prestigious for a hospital than was student training, and the salary of the Matron as head of the training school reflected this difference in status. Hence, hospitals would offer Pupil Nurse

²⁸³ Department of Health and Social Security (DHSS), *The State Enrolled Nurse: a report by the Sub-Committee of the Standing Nursing Advisory Committee* Chair: Miss A M White (London, 1971)

²⁸⁴ DHSS, *The State Enrolled Nurse*.

²⁸⁵ E R D Bendall and E Raybould, *A History of the General Nursing Council for England and Wales, 1919-1969* (London, 1969), p. 138.

²⁸⁶ The Royal College of Nursing and National Council of Nurses of the United Kingdom, *First Report of a Special Committee on Nurse Education: A Reform of Nursing Education* (The Platt Committee), (London, 1964), Section I, Paragraphs 15-18, p. 6; White, 'Nursing Profession', p. 115.

training only if they could not gain recognition as a training school for students, by virtue of a lack of the range of experience required by the GNC rules.

Another strategy used to ensure that the work of nursing was carried out was the employment of increasing numbers of untrained auxiliary grade nurses and non-nursing ancillaries. The former divided nurses as while the employment of more non-training auxiliaries meant that qualified and learner nurses could concentrate on 'technical' nursing work, it appeared to give tacit approval to the idea that much 'basic' nursing did not require any specific training. The redefinition of several aspects of the clinical and non-clinical care of patients also involved the employment of ancillaries such as ward housekeepers, clerks and others without a clinical role. Such redefinition of the boundaries of spheres of responsibility was not new. Skills including the assessment of vital clinical signs, the administration of medications, and the dressing of wounds had originally been the province of medical staff before passing to the nursing staff, the process sometimes involving boundary disputes between the different occupational groups.²⁸⁷

In addition to the employment of staff in new grades, hospitals introduced greater flexibility in employment practices, including part-time contracts and facilities to attract women with children into the workplace, as well as acceptance of men in nursing on a basis equal to that of women. Sixty-two per cent of married nurses surveyed in 1956 were not in paid employment, whether nursing or other work.²⁸⁸ Part-time nursing work was accepted reluctantly by senior medical and nursing staff, and essentially because there was little choice for those who wished to staff the nursing services. In 1961, a CHSC report on *The Pattern of the In-Patient's Day* suggested

²⁸⁷ Dan Mason Nursing Research Committee, *Marriage and Nursing – A Survey of State Registered and State Enrolled Nurses (Fifth Report of the Dan Mason Nursing Research Committee for the National Florence Nightingale Memorial Committee of Great Britain and Northern Ireland)*, (London, 1967); E R Anderson, *The Role of the Nurse* (London, 1973).

²⁸⁸ 'Staff Nurses – Nursing Research Report' [editorial], *Nursing Times* 30 Nov (1956), p. 1217.

that, while reorganisation of the pattern of nursing work was important, accepting part-time staff was the only realistic way to make effective use of nurses to bridge the gap between nursing needs and staff availability.²⁸⁹

The suggestion that more part-time nurses should be welcomed by the health service was reinforced by the publication in 1967 of the Dan Mason Nursing Research Committee's report on *Marriage and Nursing*. This reported on a survey of registered and Enrolled Nurses conducted in order to find out what proportion of them was not working because of marriage or other reasons and to discover whether they would be likely to return to nursing and what facilities and amenities would encourage their return. The survey achieved a sixty per cent response rate, and found that 50% of registered and 40% of Enrolled Nurses who responded were working either full or part-time. The majority of those who were working part-time reported that they were 'welcomed and accepted by full-time nursing and medical staff', although some senior nurses did not share this positive attitude and terms and conditions of service and further training were not as favourable for part-time as for full-time staff.²⁹⁰ Nonetheless, the report suggested that employers could do more to enable those who were not actively employed to return to nursing.

An important disincentive to student recruitment was held to be the poor salaries, terms and conditions of service in hospitals. In 1941, the then government appointed the Rushcliffe Committee to establish salary scales for nursing staff. The Committee widened its remit to include terms and conditions of service. It faced a daunting task because of the variation in salaries, terms and conditions of service in the voluntary and municipal hospital sectors. However, the preferential salaries, terms and

²⁸⁹ Ministry of Health, Central Health Services Council, *The Pattern of the In-Patient's Day Chair*: Muriel B Powell (London, 1961).

²⁹⁰ Dan Mason Nursing Research Committee, *Marriage and Nursing*, pp. 8-11.

conditions introduced for the Civil Nursing Reserve by the Ministry in order to attract recruits made its task necessary. The Committee first reported in 1943.

In 1948, the Whitley Council machinery replaced the Rushcliffe Committee on the inception of the NHS. Each Whitley Council comprised two groups of people, the management and staff side representatives respectively. This was the official negotiating machinery for salaries, terms and conditions of service within the NHS, the nursing and midwifery Whitley Council being paralleled by others for the various professionals employed by the service. By the late 1960s, remuneration for nursing staffs lagged behind that in comparable occupations, such as teaching. A combination of the need to ensure that pay and conditions of service stimulated recruitment and retention and public sympathy for nurses helped them in pursuing claims for salary increases.²⁹¹

In May 1974, the Earl of Halsbury was appointed to head a Committee of Inquiry into the pay and related conditions of nurses and midwives in the NHS. Representing the first occasion on which nurses' pay had been fully evaluated, the Halsbury Committee focused primarily on resolving a pay claim that had been under consideration since January 1972. Nurses' representatives had challenged a pay offer then but, before the dispute could be resolved, the government introduced counter-inflationary measures that included a five-month pay standstill restricting the amount that could be awarded to eight percent in April 1972 and 11% in April 1974. The Halsbury Report recommended that nurses should receive on average 30% increases in salaries.²⁹²

²⁹¹ C Balfour, *Incomes Policy and the Public Sector* (London, 1972), pp. 160, 227-228.

²⁹² Department of Health and Social Security, *Report of the Committee of Inquiry into the Pay and Related Conditions of Service of Nurses and Midwives*, Chair: Rt. Hon, The Earl of Halsbury (London, 1974)

2.2 Nursing Knowledge and Skills, 1948-1974

Although the Assistant Nurse and Auxiliary grades were officially sanctioned during the Second World War, the recruitment of students to nurse training schools acted as the main source of hospital nursing personnel. They were cheaper to employ than the professionally qualified State Registered Nurses (SRN) who supervised their work. The approval of a hospital for nurse training was thus an important contributory factor in its success in providing the nursing workforce and controlling its costs. The remuneration of the Matron was also linked to her responsibility for the nurse training school, and to whether the School was approved by the General Nursing Council for Student or Pupil Nurse training. Approval of the hospital for student training was more prestigious, and brought greater financial reward to the Matron, than did approval for Pupil Nurse training.²⁹³

The terms of reference given to the *Working Party* in 1946 required the examination of all aspects of nurse recruitment and training.²⁹⁴ In addition to their analysis of the contribution of terms and conditions of service to problems in nurse recruitment and retention, their *Majority Report* recommended that Student Nurses' educational needs should be accorded precedence, and that training curricula should be reformed. The *Majority Report* recommended a two-year training period, during which students should concentrate on acquiring nursing skills, and that orderlies should be appointed to undertake domestic and other non-nursing duties. These changes would render the further recruitment of SEANs unnecessary, and the report proposed that the Roll should be closed. Student Nurses should work only five days each week with a shorter working day and be entitled to more annual leave. The *Majority Report* also recommended that full student status should be facilitated by reform of the funding and

²⁹³ White, 'Nursing Profession', p. 31.

²⁹⁴ *Working Party - Majority Report*, p. iii.

administration of nurse education, and the transfer of control of nurse education from the hospitals to a new, separate administrative structure of Regional Nurse Training Boards.

These recommendations prompted widespread comment in the nursing press.²⁹⁵ Contemporary critiques noted that Student Nurse attrition caused hospitals less concern than the loss of qualified nurses on completion of training. The King Edward's Hospital Fund for London favoured leaving decisions over the details of nurse training programmes to those concerned with delivering nurse education, and was critical of the emphasis in the *Majority Report* on public health nursing rather than bedside nursing skills. The RCN objected to the recommendation that, with better support and the removal of domestic duties from their role, students could become nurses within two years. They were also hostile to the notion of student - rather than apprentice worker - status for students.²⁹⁶

The *Report's* proposals for reform of the control and funding of nurse training were especially controversial. The RCN's view was that the profession should continue to control nurse training through the GNC, though they and the NPHT favoured the creation of a regional administrative structure to effect this. The GNC favoured Student Nurse status, but was opposed to reducing the duration of courses and surrendering its own responsibilities in relation to nurse training. They also opposed closing the Roll, and the introduction of Orderlies.

Ten anonymous nurses, writing in the *Nursing Mirror*, observed that the quality of tutors had been neglected in the *Majority Report*, and suggested that the training of nurse tutors and nurse managers should be expanded, with suitable candidates being

²⁹⁵ *Nursing Mirror* (1948), series of articles as listed here: King Edward's Hospital Fund (10 Jan, p. 260); Voluntary Hospitals Committee (31 Jan, p. 315); Nuffield Provincial Hospitals Trust (28 Feb, p. 390); ten anonymous nurses (10 Apr, pp. 25-26); Royal College of Nursing (17 Apr, p. 42).

²⁹⁶ Dingwall, Rafferty and Webster, *Social History*, pp.116-118.

sent on degree courses in subjects such as sociology. The NPHT recommended that there should be an increase in the representation of nurses in hospital administrative structures. Like them, the Voluntary Hospitals Committee supported improving the working and living conditions of nurses to encourage more to join and stay in the profession. The RCN changed its position by 1964 when the Platt report called for separation of student education from service provision, and the reform of the 'training allowance' paid to students.²⁹⁷ Nonetheless, even in 1974 the question of student status for learner nurses remained contentious.

The extent of opposition to the recommendations of the *Majority Report* appears to have surprised the Ministry to Health.²⁹⁸ However, Bevan appears to have decided that it would be politically damaging to oppose the nursing profession over the *Majority Report*, and compromised in the 1949 Nurses Act.²⁹⁹ This created Area Nurse Training Committees (ANTC), and so separated nurse training schools from hospital finance; it also reformed the GNCs and enabled them to approve experimental courses. The ANTCs should have enjoyed a measure of independence. However, shortage of funds, and reluctance to embrace the implications of student status for Student Nurses, undermined this intention. Nurses continued to leave nursing after 1949; attrition levels worsened during the following decade.³⁰⁰

The combined effect of specific provisions in the 1949 *Nurses' Act* and the relaxation by the Minister of Health in 1951 of the requirement that the nursing syllabus had to appear in the Nurses' Rules was to remove statutory barriers to innovation in nursing programmes, although the syllabus of subjects studied by Student Nurses remained unrevised between 1939 and 1952. The GNC for England and Wales was able to

²⁹⁷ Dingwall, Rafferty and Webster, *Social History*, p. 120.

²⁹⁸ Scott, 'Policies for Nursing', pp. 152-153.

²⁹⁹ B Abel-Smith, *A History of the Nursing Profession* (London, 1960), p. 227.

³⁰⁰ Abel-Smith, *Nursing Profession*, p. 224; Baly, *Nursing and Social Change*, pp. 206-207.

approve experimental schemes which included bachelor's degree programmes that incorporated preparation for registration as a nurse, shortened programmes for graduates of non-nursing disciplines, and special schemes for A-level candidates, designed to broaden the appeal of nursing to people who might otherwise choose alternative careers.³⁰¹ Nursing degree courses commenced at three Universities and Polytechnics between 1950 and 1968, with a further three approved to commence in autumn 1969 when two others were in an 'advanced state of preparation'. Experimental schemes commenced during the 1950s that gave final year students the opportunity to study aspects of either management or clinical care that would traditionally have been studied following registration. Three shortened programmes for graduates were established between 1963 and 1966, at St Thomas', St George's and the USH respectively, although in 1968 the GNC decided not to approve any more experimental schemes until those already in existence had been evaluated. This appears to have been influenced by the warning of the Ministry of Health that there was insufficient money available to support all schemes proposed.³⁰²

By 1968, only thirty-one graduate students had completed an accelerated pre-registration course, and only ten students had graduated from the University of Edinburgh's nursing degree programme.³⁰³ Schools of Nursing were slow to depart from the traditional three or four year training model.³⁰⁴ These offered a workforce under the control of the hospital's nursing hierarchy, with training that could be structured around the requirement to provide a nursing service primarily. The alternatives either would be located in the University system, or would involve

³⁰¹ M Jolley, V H Darling, and M E Lee, 'General Nursing', in *Nursing, Midwifery and Health Visiting Since 1900*, ed. P Allan and M Jolley (London, 1982), Chapter Four.

³⁰² TNA: PRO DT 34/304, General Nursing Council of England and Wales, 'Experimental Training Syllabuses'.

³⁰³ J McGuire 'Nursing: None is held in higher esteem...Occupational Control and the Position of Women in Nursing' IN *Careers of Professional Women*, Ed. R Silverstone and A Ward (London, 1980).

³⁰⁴ Dingwall, Rafferty and Webster, *Social History*, Chapter 5; Davies, 'Professional Power and Sociological Analysis', Chapter Four.

students having to follow a programme dictated as much by the educational needs of the students as the service needs of the hospital. Either might challenge the control which the Matrons held over nurse education, and thus over the immediate staffing requirements of the hospital and over the socialisation of students and pupils.

As noted in the preceding section, the question of what the educational standard of nurse education – and thus the entry requirement - should be remained controversial, both within the profession and outside it. While the majority of hospital Matrons and the RCN supported the removal educational entry requirements in 1939, the value of which they viewed with ambivalence, other nurses feared that the result would be to harm the status of nursing and depress wages.³⁰⁵

In 1960, the Ministry of Health conceded to GNC demands for the reintroduction of a minimum entry standard, to take effect from 1962.³⁰⁶ The entry standard was set at two GCE 'O' level passes, one to be in either English or Welsh language, plus evidence of at least five years of full-time education and attainment of satisfactory standards in five other general education subjects.³⁰⁷ For prospective candidates who were unable to meet the minimum entry standard, an entry test was reintroduced by the GNC.³⁰⁸

The Platt Committee on nurse education, commissioned by the RCN, observed that this low educational requirement blurred the distinction between Student and Pupil Nurse status.³⁰⁹ One effect was almost certainly to limit the appeal of Pupil Nurse training, while another was that students rejected for training in schools that imposed

³⁰⁵ White, 'Nursing Profession', pp. 94-95.

³⁰⁶ Anon, 'Selection and training of student nurses', *British Medical Journal* 9 Apr (1960).

³⁰⁷ Hansard House of Commons Debates, Volume 518, 30 July 1953, Oral Answers; Rosemary White, 'Pluralism, professionalism and politics in nursing', *International Journal of Nursing Studies* 20:4, (1983), pp. 231-244; Abel-Smith, *Nursing Profession*, pp. 224-225.

³⁰⁸ McGuire, 'None is held in higher esteem'.

³⁰⁹ Royal College of Nursing and National Council of Nurses of the United Kingdom, *First Report of a Special Committee on Nurse Education. A Reform of Nursing Education* (The Platt Committee, Chair Sir Harry Platt) (London, 1964).

higher entry criteria were able to secure a place at a school that could not afford to be so discriminating. Contemporary press accounts complained that the resulting wide ability range undermined teaching.³¹⁰

Notwithstanding the rationale for the reintroduction of the minimum educational entry requirement, high student wastage rates persisted. In 1968, the sixtieth report of the National Board for Prices and Incomes (PIB) focused on *Pay of Nurses and Midwives in the National Health Service*. The Report noted that approximately 34% of entrants to nurse training left before completing their training programme. They noted predictions that the number of young female school-leavers holding the minimum educational entry requirements would decrease until 1975, posing potential problems for nurse recruitment. The PIB recommended a reduction in the age of entry to training, from eighteen to seventeen years, the creation of group training schools, independent of hospital nursing management structures, and longer study blocks for students. They also recommended the introduction of aptitude tests for Pupil Nurses.³¹¹

The Report met with a mixed response, marked by particular hostility to the proposed reduction in the age of entry to nurse training. The recommendation that group training schools should be created had been made before, but other events coincided to favour its implementation. The Salmon Report of 1966, the first Green Paper on NHS Reorganisation of 1968, and the Bonham-Carter Report on the Functions of the District General Hospital, published in 1969, all favoured the establishment of larger, group training schools as presaged in the report.

³¹⁰ A Lapping, 'A society at work - training our nurses' *New Society*, 26 Oct (1967), p. 589.

³¹¹ National Board for Prices and Incomes, Cmd 3585 *Pay of Nurses and Midwives in the National Health Service - Report Number 60* (London, 1968)

In late 1969, in the context of changes occasioned by the implementation of the Salmon Report, and influenced by the Prices and Incomes Board Report's recommendations and the impending reorganisation of the NHS, Professor Asa Briggs was asked to chair a Committee on Nursing. Dingwall, Rafferty and Webster note that this was primarily established in order to manage the potential embarrassment to the Labour Government of dealing with nurses' grievances over the pay awards offered to them under its prices and incomes policy. They argue that the terms of reference given to the Briggs Committee restricted it to making recommendations within extant workforce limits. The Committee constrained itself further by its decision to avoid making detailed estimates of the costs of implementation, instead concentrating on unifying the structure of the statutory regulatory bodies for nursing and recommendations for the reform of nurse education.³¹² Its recommendations included a common portal of entry to nursing, a two part nurse training programme commencing with a 'Common Foundation Programme' for all, followed by a specialisation programme, each of eighteen months' duration before registration with the new central, statutory body.³¹³

The USH Nursing Committee welcomed the Report 'in principle' and described three aspects of it as 'particularly desirable'. These were the retention of nurse training under the control of the profession, the division of pre-registration training into two parts that would allow 'the nurse who has a licence to practice at the end of 18 months to form a stable part of the profession for the future', and the proposal for a recognised training for Nursing Auxiliaries.³¹⁴ They noted that there must be sufficient funds available for implementation – an issue that the Briggs Committee had deliberately avoided considering in detail. Furthermore, the newly formed Trent Regional Health

³¹² Dingwall, Rafferty and Webster, *Social History*, pp. 205-209.

³¹³ Green, 'Nursing education – "Reports are not self-executive"' in *Nursing and Social Change*, Baly, pp. 304-305; Dingwall, Rafferty and Webster, *Social History*, p. 207.

³¹⁴ SA: SY 333/H16/11-12, Nursing Committee Report, 27 Nov 1972, and Minute GP3, 29 Jan 1973.

Authority raised concerns both about the length of time envisaged for implementation and, in view of the emphasis on changes in nurse education, the lack of commitment to training nurse teachers. The GNC indicated in July 1974 in response to a request for improved arrangements that it would not be considering establishment of a Nurse Teacher Training Course in the Trent Region.³¹⁵

2.3 Nursing Practice, 1948-1974

The role of the nurse varies according to the field in which she works, but a nurse can be defined as caring for people in both sickness and health. In sickness, she brings the skill and expertise to carry out procedures not possible within the family. In health, she encourages and promotes good health by education, advice and support to problem families.³¹⁶

Nursing is an overwhelmingly female occupation, particularly in settings where individuals with physical illness, disability or frailty require care that cannot be provided by family or other informal carers. It involves work predominantly directed by others and associated with femininity and women's social roles of nurturing, 'caring for' people, and generally with maintaining the 'boundaries' of the body.³¹⁷

Within the general term 'nursing', the 1953 report of the NPHT on *The Work of Nurses in Hospital Wards* controversially described two categories of nursing care, 'basic' and 'technical'.³¹⁸ 'Basic' nursing involves meeting and supporting the physical, emotional and psychological requirements of individuals whose illness, disability or frailty renders them unable to meet their own needs. 'Technical' nursing involves the delivery of specialist and supportive nursing care associated with specific medical and paramedical diagnostic, therapeutic and rehabilitative interventions, for example X-

³¹⁵SA: Acc 1987/55, Trent Regional Health Authority (RHA), 10 June and 22 July 1974.

³¹⁶SA: SY 569/H1/12, NAC(70)6, 'Report prepared by the CNO with the Matrons and the Principal Nurse Tutor of the Group, with the Terms of Reference of the Asa Briggs Committee on Nursing'.

³¹⁷J Littlewood, 'Care and ambiguity: towards a concept of nursing', in *Anthropology and Nursing*, ed. P Holden and J Littlewood (London, 1991), pp. 170-189; M Miers, *Gender Issues and Nursing Practice* (Basingstoke, 2000), pp. 92-127.

³¹⁸Nuffield Provincial Hospitals Trust, *The Work of Nurses in Hospital Wards – Report of a Job-Analysis* (London, 1953); Bradshaw, *The Nurse Apprentice*, pp. 117, 142; Starns, *March of the Matrons*, p. 147.

Rays, blood tests, the administration of medication, surgical operations, and occupational and physiotherapy. For the individual hospital in-patient or outpatient, the two categories may appear to be indivisible; the very interventions designed to diagnose, cure or palliate disease may undermine the capacity for self-care either temporarily or permanently.

However, as the number of people admitted to hospital and the number of nursing hours available to provide their care failed to keep pace during the 1950s and 1960s, the possibility of redefining nursing and non-nursing responsibilities was subject to reiterative discussions. Goddard, who was then Chairman of the Nursing and Midwifery Whitley Council, had been director of the NPHT's *Job Analysis Enquiry* into the work of hospital nurses, and was also a member of Oxford RHB, noted in 1953 that nurses themselves appeared to be unaware of the actual, as opposed to the supposed, content of their daily work. '...[N]ot only did the nursing observations prove conclusively that the actual work content of a ward differed from what it was supposed to be, but the nurses themselves were surprised to find that their own ideas of what they were doing were not always correct.'³¹⁹ The NPHT's recommendations that nurses should be encouraged to leave non-nursing duties to others were perceived by contemporaries to be a threat to senior nurses' control over nursing work, although Goddard rebuffed such concern.³²⁰

In October 1958, the *Nursing Times* carried a statement by the RCN on nursing duties that outlined the College's '...concern at the general and rapid increase of duties allocated to nurses.' The statement alleged that 'additional duties' were 'making inroads into the time which nurses should more properly devote to their true nursing function.' Furthermore, the nurse's professional position was compromised when

³¹⁹ H A Goddard 'Is manpower used to the best advantage?', *Nursing Times* 21 Nov (1953), p. 1184.

³²⁰ H A Goddard, 'The Nursing Structure: comments on 'Observations and Objectives' (Section II)' *Nursing Times* 38 Dec (1956), pp. 1339-1342; Starns, *March of the Matrons*, p. 147.

'...she is called upon to undertake duties outside the routine scope of nursing. The college feels that there will be general agreement that certain duties are wholly outside the province of the nurse and should only be undertaken in a grave emergency.'³²¹

Despite the publication of this statement, McGhee's research into *The Patient's Attitude Towards Nursing Care*, published in 1961, found that nurses continued to undertake 'non-nursing' duties, including ward cleaning. Furthermore, '[t]he effect of these 'non-nursing' duties on the patient was that he hesitated to make his needs known... The nurses' will to help was a point recognised and appreciated by patients, and where some need was perceived by a patient to be unfulfilled, this was generally attributed to a faulty system rather than an unwilling nurse.'³²²

Between 1948 and 1974, the development of medical specialisation affected the pattern of demand for nursing care both directly and indirectly. Specialisation was largely in its infancy when the *Hospital Surveys* were published in 1945. However, the pace of pharmaceutical and technological advances in the therapeutic management of disease, such as hypertension, renal failure and coronary heart disease, increased after the Second World War.³²³ In parallel with those treatments that preserved life, rehabilitative therapies designed to restore function and enhance life were developed. Nurses' roles were already intricately bound up with and largely determined by patterns of work set by the Doctors. The introduction of therapeutic interventions that not only enabled patients to recover from acute diseases more rapidly in some respects meant that they required less intense, supportive nursing care, and Baly argues that this reinforced the primacy of the diagnostician and of their role in prescribing treatment. In turn, this influenced the development of nursing work, and nursing training,

³²¹ 'Controversial duties', *Nursing Times* 24 Oct (1958), p. 1237

³²² A McGhee, *The Patient's Attitude to Nursing Care* (Edinburgh and London, 1961), p. 37.

³²³ Rivett, *Cradle to Grave*, pp. 134-162, *passim*; Baly, *Nursing and Social Change*, Chapter 16, *passim*.

throughout the period under discussion.³²⁴ Therapeutic changes increased the requirement for nurses to develop specialist technical nursing skills at pre-registration and postgraduate level, and created a concomitant need to retain those nurses with such knowledge and skills.

While the requirement for an increase in the overall number of nurses to staff the new service was appreciated immediately by Bevan, it took longer for either the Ministry of Health or the profession to act on the implications of technological and medico-administrative change for nursing work and the training that would be required to undertake it.³²⁵ While demand for nurses increased beyond the capacity of recruitment to keep pace, an important corollary was that the role and boundaries of nursing work were contested.

However, Baly also notes that the care of frail older people and of those with incurable conditions requires a high degree of skill, but this work is of relatively low status both within the nursing profession and within other health professional groups from which nurses have sought status and recognition. This appears to be reinforced by the concomitant low esteem in which the nursing of chronically sick people, those whose homes were the wards of the former public assistance institutions, was evidently held. It is also to be found in various aspects of the employment of SEANs, including their recruitment to these low status areas of health care, and the priority given in the 1962 *Hospital Plan* to development of acute, general hospitals, over the development of facilities for people with continuing health care requirements.³²⁶

³²⁴ Baly implies that the introduction of such a range of administrative and therapeutic innovations created uncertainty over the role of nurses and doctors. See: Baly, *Nursing and Social Change*, pp. 189-190.

³²⁵ Although these forces acted to reinforce the primacy of the hospital in the structure and resourcing of the new service, at the expense of the public health and primary care sector.

³²⁶ Rafferty has suggested that a sociological history of the relationship between nursing and medical knowledge - the husbanding of 'knowledge' being the essence of trait theories of professional status - should be developed as a contribution to the establishment of a critical dialogue between the sociology

2.4 Nursing Organisation, 1948-1974

While the participation of all occupational groups in the NHS was essential, the Ministry of Health dealt with their concerns in significantly different ways during preparation for the implementation of the new service.³²⁷ The relationship between the Ministry and the medical profession involved well-matched protagonists, each of whom recognised the mutual benefit of working together, in spite of the conflicts that attended the final stages of the development of the NHS. By contrast, the Ministry treated nurses as an administrative problem, rather than as partners in the political process of health policy development.

Yet criticism of the Ministry of Health for allegedly failing to involve nurses appropriately in discussions over matters pertaining to nursing, let alone broader health policy issues, has been subjected to revision following research by Scott into the relationship between nurses and civil servants at the Ministry of Health between 1919 and 1968.³²⁸ This indicates a consistent failure of nursing leadership, obtuse to ready chances to influence health policy, rather than inimical attitudes on the part of the Ministry's medical or lay civil servants to the involvement of nurses in decision-making.³²⁹ Nonetheless, while Scott's research offers a vital counterbalance to the notion that medical and administrative staff have deliberately undermined nurses in England, it is still important to discover why nurses failed to realise their latent political power.

of the professions and empirical data from NHS nursing history. See: Rafferty, *Nursing Knowledge*, 'Conclusion', pp. 182-192.

³²⁷ Willcocks, *Creation*, *passim*.

³²⁸ Rafferty, *Nursing Knowledge*, p. 173.

³²⁹ Scott, 'Policies for Nursing', pp.1, 134 *et seq*, 144; Jane Robinson, 'Introduction: Beginning the study of nursing policy' in *Policy Issues in Nursing*, ed. Jane Robinson, Alistair Gray, and Ruth Elkan (Buckingham, 1992), pp. 7-8; Rafferty, *Nursing Knowledge*, pp. 189-192; Jane Salvage, *The Politics of Nursing*, (London, 1985), Chapter 3, especially p. 53.

In the NHS, nurses were represented on both the Central Health Services Council and the professional advisory committee, the SNAC. The latter was established on the authority of the CHSC to provide it with specific professional advice.³³⁰ While it met on a regular basis, the SNAC did not enjoy the undivided support of the nursing profession, and remained vulnerable to criticism from the medically dominated Standing Advisory Committees that it paralleled.³³¹ White suggests that as an occupational group, nurses have experienced disadvantage as a result of being divided against themselves. The existence of different groups within NHS nursing, with incompatible goals, means that to speak of 'nursing' creates the illusion of unity where there is none.³³²

Before the establishment of the NHS, the voluntary hospitals were administered along broadly similar lines to each other, with lay administrators taking responsibility for the general and financial administration of the institution, and the honorary medical staff providing advice on the clinical life of the hospital. The Matron was responsible for the nursing and domestic staff, as well as other housekeeping concerns, and was head of the nurse training school if the hospital had GNC approval for the training of nurses. Municipal hospitals were, by contrast, more hierarchical, with a medical superintendent in charge of all other staff, including the nurses.

Following the establishment of the NHS, administrative arrangements for the internal management of hospitals became the subject of experiment and debate. It did not appear that the two systems outlined above could be amalgamated, and the CHSC established the Bradbeer Committee to investigate possible solutions to the problem, and make recommendations for the NHS. The Committee's report to the CHSC in

³³⁰ White, 'Nursing Profession', pp. 52-53 and 65; Webster, *Health Service - Volume I*.

³³¹ Webster notes that 'The Nursing SAC, although consistently active, remained weak and was treated by professional bodies 'with contempt'.' See: Webster, *Health Service - Volume I*, p. 248

³³² White, 'Nursing Profession'.

1954 supported a system largely based on the voluntary hospital model. Thus, the Matron was to be accorded the same status as her medical and lay administrator colleagues, although at Group level, the Group Secretary, an administrative officer, was to be senior to both nursing and medical staff. The *Bradbeer Report* also recommended the reconstitution of Nursing Advisory Committees (NAC) at group level, with the Matrons of the hospitals in the group to replace lay representatives, and that hospitals should establish nursing staff committees.

While the Ministry of Health accepted similar suggestions in relation to the medical profession, it did not accept those made concerning professional nursing advice. Furthermore, the Matrons were only to have contact with the HMC via their place on the House Committee. The latter was responsible for the day-to-day administration of each individual hospital, not for strategic decision-making. Matrons were not to be entitled to direct representation on the HMC, and this gave the lie to the equal status they were supposedly to enjoy in hospital administration. Furthermore, this situation was exacerbated by policies that depressed the Matrons' salaries, and inhibited the development of an administrative nursing career structure. This was partly the result of deliberate restrictions on salary increases for Matrons and other senior nursing posts, and the operation of the Whitley Council, which based the calculation of remuneration and conditions of service on a relatively narrow range of nursing positions set in 1943. By 1960, these were increasingly unable to reflect the administrative complexities of the NHS.³³³

Between 1961 and 1963, the nursing and medical professions, through the RCN and BMA respectively, proposed a review of nursing salaries, education and administration. In this, they followed a lead taken in 1959 by the CHSC, which had

³³³ White, 'Nursing Profession', Chapter 4, *passim*.

established two working parties, on nursing salary structures and on nursing administration respectively. The professional nursing and medical bodies were preempted by the Ministry of Health, which established a committee under the chairmanship of Brian Salmon in 1963 to 'advise on the senior nursing staff structure in the hospital service (Ward Sister and above) the administrative functions of the respective grades and the methods of preparing staff to occupy them.'³³⁴ This committee comprised ten people, including the Chair, of whom five held nursing qualifications. In itself, the composition of the committee represented a significant change from that of committees of the 1940s, on which nurses had minimal representation.

The *Report of the Committee on Senior Nursing Staff Structure* was published in 1966 and recommended the creation of a functional management hierarchy for nurses, with specific preparation for those in senior administrative grades, whose roles were described in detail in the Report's appendices. The hierarchical structure was designed to ensure that reporting relationships to other professionals were clear.³³⁵ The Ministry of Health accepted the report's recommendations and established nineteen pilot schemes during 1967 and 1968, but in the latter year decided to implement the Salmon scheme throughout England and Wales. This was done before the pilot schemes had been assessed.³³⁶ Although the Committee was not expressly asked to examine pre-registration nurse education, it recommended that the GNC's curricula for students in the different branches of nursing should include an introduction to theories of

³³⁴ Quoted in, Department of Health and Social Security and Welsh Office, *Progress on Salmon: A Report by the Department of Health and Social Security and Welsh Office*. (London, c.1972 - stamped 'Received - 3 Oct 1972. Chief Nursing Officer'), p. 3.

³³⁵ Ministry of Health/Scottish Home and Health Department, *Senior Nursing Staff*, p. 1, Appendix 6 - 'Organization Charts'.

³³⁶ DHSS/Welsh Office, *Progress on Salmon*, p. 7. It is interesting to note one particular comment in this report, 'Experience of the pilot schemes showed that the staff and total organisation of a group can only cope with and absorb a certain amount of change while continuing to maintain a good service for patients.' The original Report had advised the gradual implementation of the proposed changes, because of the coincidence of other major changes attendant on the implementation of the *Hospital Plan*.

management and health policy, and practical experience in ward management should be required for all Student Nurses.

The committee noted the influence of the 1962 *Hospital Plan* on their discussions and proposals. They also appear to have been influenced by contemporary ideas about hospital administration, later exemplified in proposals for reform of the NHS as a whole. In these, relationships between different levels of responsibility and accountability were clearly mapped out, and consensus management between professionals of equal standing was adopted in preference to either the Bradbeer model that preceded it or the general management model adopted during the mid-1980s.³³⁷ Although the new structure involved important changes for the organisation of NHS nursing, it preceded wider change in the structure of the service. Its reform of the nursing hierarchy and clarification of nursing roles and responsibilities was thus effected within the tripartite NHS established in 1948.³³⁸ The most important immediate effect of the implementation of Salmon was the introduction of professional nursing representation on the administrative committees of the hospitals in Sheffield, which will be analysed in Chapter Six.

Four key elements of nursing – availability, knowledge and skills, practice and organisation – were of central importance in determining the capacity of the NHS to deliver the comprehensive care that its creation promised. All were influenced by a complex of factors emanating from national health policies and politics, nursing occupational politics and local health and professional politics, which in turn influenced the development of nursing as an occupation. The chapters that follow move the focus of the analysis from the national to the local level in order to examine the several ways in which hospital-based health care influenced and was influenced by

³³⁷ S Harrison, *Managing the National Health Service - Shifting the Frontier* (London, 1988), pp. 16-17.

³³⁸ Webster, *Political History*, p. 62; Harrison, *Shifting the Frontier*, pp. 62-63.

continuity and change in nursing. The nursing workforce, nurse training and education, the work that nurses did and the way in which the hospital nursing hierarchy interacted with other aspects of hospital and health service administration are considered in turn.

3. 'The same old difficulty' - Recruiting and Retaining Nurses to Work in Sheffield's General Hospitals, 1948-1974³³⁹

Thirdly, and most importantly, there is the nursing problem...the barrel has been scraped pretty clean...it is unlikely that nursing recruitment will rise to any substantial degree on account of the increased employment of women in industry.³⁴⁰

In setting out its plans for the region's hospitals in 1955, Sheffield RHB considered how the existing Specialist and Consultant medical staff – or their time - might best be deployed between its hospital centres and peripheral services. Webster notes that the Ministry of Health's guidance for the '*Development of Consultant Services*' assumed that the numbers of Consultants and of beds were interdependent; the Sheffield Region was relatively deprived of Consultants and acute beds during the early years of the NHS by comparison with others, and the Ministry of Health recommended increases in each.³⁴¹ Gaining agreement to the re-organisation of work done by senior medical staff in the NHS might appear to have been the biggest hurdle to the successful reconfiguration of hospital services for the RHB. Instead, the Region's planners identified that the chief reason why they could not expand the number of hospital beds in the Region, even had there been 'money and labour to build [new hospitals]' and no threat of war, was that the supply of potential nursing recruits had already been virtually exhausted.³⁴²

In 1955, Elizabeth Cockayne, Chief Nursing Officer at the Ministry of Health, addressed the Association of HMCs' Annual General Meeting, and predicted that difficulties in recruiting nurses would persist until the mid-1970s. This proved essentially to be the case for the Sheffield hospitals, as it had been before 1948 and

³³⁹ SA: Acc 1994/64, Box 4, Exec(55)8, Report of AGM and Conference of the Association of HMCs Combined with Group Secretaries' Conference, 6 Sept 1955.

³⁴⁰ SA: SY 709/H2/1, paragraph 9.

³⁴¹ Webster, *Health Service - Volume I*, p. 305; SA: SY 709/H2/1, pp. 10-11, 13; Ministry of Health, *Hospital Plan*, p. 59.

³⁴² Between 1952 and 1959, there are references in the RHB, HMC and Board of Governors' records to preparation for atomic warfare.

would continue to be after 1974.³⁴³ The General reported difficulty in recruiting nursing staff in 1937, and while the establishment of a Preliminary Training School in 1939 was found to be beneficial to the recruitment of students, in 1946 insufficient nursing staff was described as the hospital's 'greatest trouble' and standards of care, particularly in the maternity department, were held to be correspondingly low.³⁴⁴ Contemporary records of Sheffield's voluntary hospitals indicate that they also faced recruitment problems during the early 1940s.³⁴⁵

The availability of sufficient nurses was of central importance to the functioning of the NHS. This chapter examines the changing size and structure of the nursing workforce in Sheffield, and analyses those factors that influenced - or were believed by senior nurses to influence - the availability of nurses in Sheffield. It then examines factors that affected the demand for nurses in Sheffield between 1948 and 1974. Recurrent difficulties in recruiting and retaining nurses not only caused Sheffield Region's health service planners to restrict their ambitions for the NHS in the region, they could restrict the service available to existing patients. The final section of the chapter considers how senior nurses and their non-nursing colleagues in medicine and administration managed shortages of nurses in general and specific areas of hospital work.

3.1 The Nursing Workforce in Sheffield, 1948-1974

In the Sheffield Region, between 1949 and 1952 alone there was a 20.7% increase in the number of nurses employed. The absolute number of nurses available was not the only concern, however, and the RHB's records note that 'unfortunately' (*sic*), the biggest increase was in untrained staff.³⁴⁶ While nursing care had to be delivered, the

³⁴³ SA: Acc 1994/64, Box 4, Exec(55)8, Minute 250, 16 Sept 1955.

³⁴⁴ Medical Officer of Health Report, *Sheffield*, 1937, 1939, 1947.

³⁴⁵ SA: SY 333/H3/38, Report of Interview of Staff Representatives and the Matron, 3 Mar 1940; SA: SY 333/H14/2, 27 Jan 1940 and 28 Apr 1941.

³⁴⁶ SA: SY 709/H1/1, p. 80.

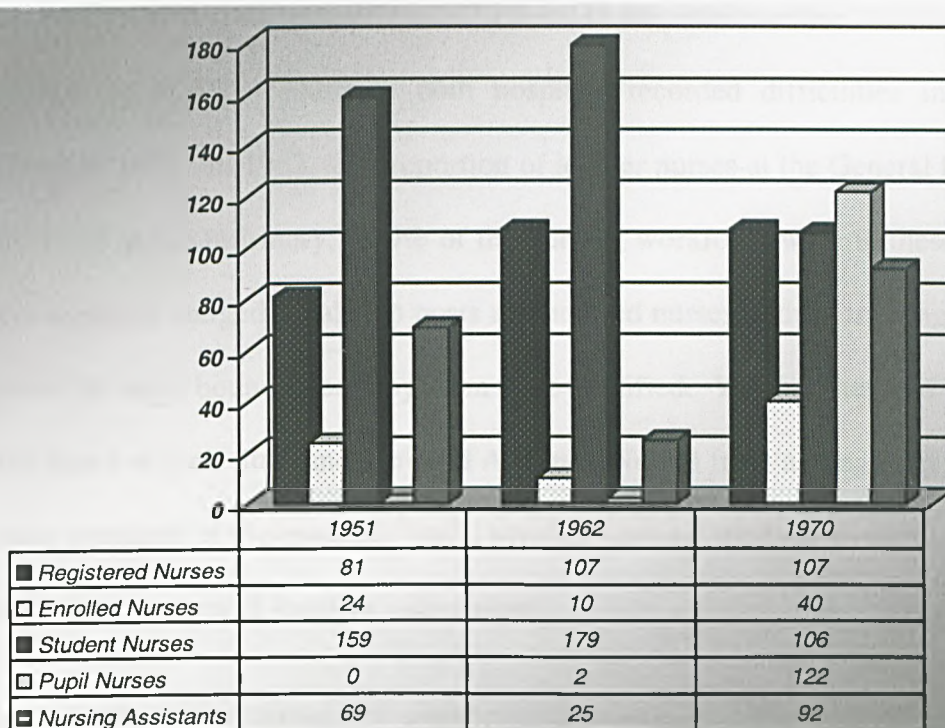
quality of that care was also important to nurses, administrators and medical staff alike. Reflecting this, the records of the hospitals indicate that the composition of the nursing workforce was of as much concern as were overall numbers. Sheffield's hospital records between 1948 and 1974, especially the Matrons' reports to hospital House Committees, indicate that Matrons of the general hospital units often found it hard to recruit and retain sufficient staff to provide the care required, especially as the demand for nursing care, in both quantity and quality, rose relentlessly. Moreover, some wards and departments were harder to staff than were others, and these included operating theatre departments.³⁴⁷

Although The General was able to increase the proportion of trained - Registered or Enrolled - nurses employed from 31.5% to 36.2% between 1951 and 1962, the proportion had returned to nearly its 1951 level in 1970, when it was 31.4%. At the Infirmary, the proportion of professionally qualified nurses on the staff was consistently higher than that at the General, at 38.4% in 1951, 37.8% in 1962 and 39.9% in 1970.³⁴⁸ There was a clear difference between the former municipal and voluntary hospitals in the proportion of professionally qualified nurses that each employed, although in neither case did this rise above 40%.

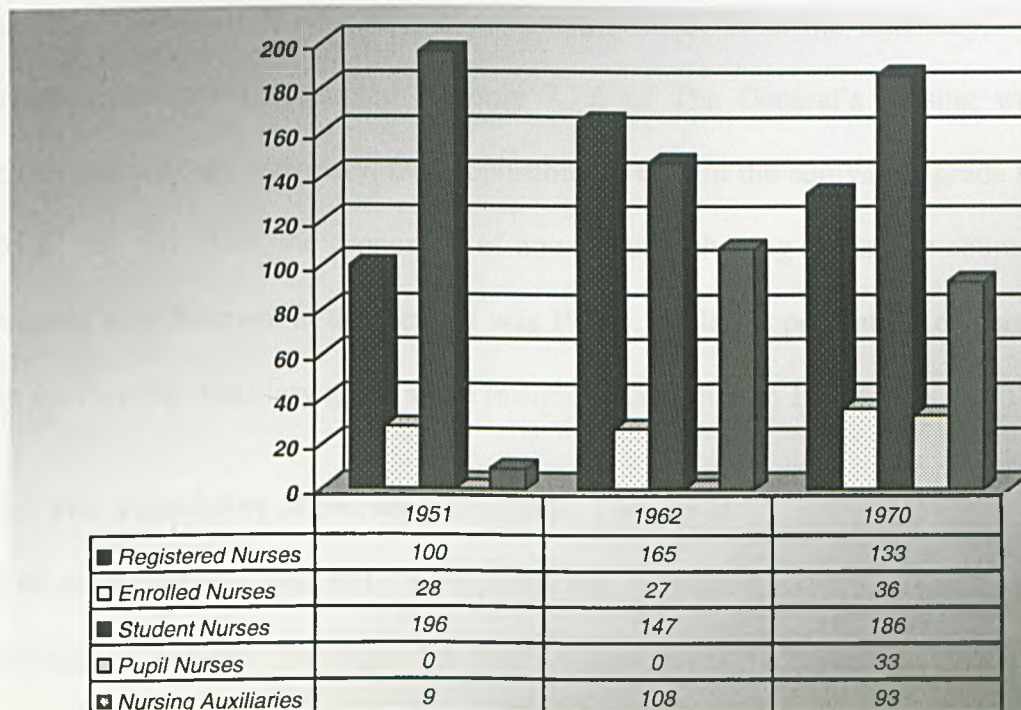
The majority of nursing staff working in the hospitals thus comprised people who were not professionally qualified. The other broad categories of nursing staff were the learner nurses - Students and Pupils - and Nursing Auxiliary (Infirmary) or Nursing Assistant (General) grades. Between 1951 and 1970, the proportion of learner nurses

³⁴⁷ SA: SY 569/H1 *passim*; SA: Acc 2001/98, Matron's Records and Reports, 1950-1972, *passim*.

³⁴⁸ SA: SY 569/H1/ 5, MC (52)1, 14 Jan 1952; SA: SY569/H1/8, Report on the Sixth Visit of the GNC Inspector, 15 Feb 1967; SA: SY 569/H1/12, NGH (71)1, 14 Jan 1971; SA: Acc 2001/98, Matron's Records, *passim*.



3.1 Nursing Staff in Post, The General – General Nursing Wards, 1951, 1962 and 1970.³⁴⁹



3.2 Nursing staff in Post, The Infirmary, 1951, 1962 and 1970.³⁵⁰

³⁴⁹ SA: SY 569/H1/ 5, MC (52)1, 14 Jan 1952; SA: SY569/H1/8, Report on the Sixth Visit of the GNC Inspector, 15 Feb 1967; SA: SY 569/H1/12, NGH (71)1, 14 Jan 1971.

working at the General increased from 47.7% to 48.8%, while at the Infirmary it fell from 58.8% to 45.5% - although both hospitals recorded difficulties in student recruitment in 1951. In 1962, the proportion of learner nurses at the General had risen to 56%, while at the Infirmary, 32.9% of the nursing workforce were in these grades. Learners were not obliged to take up posts as qualified nurses at their training hospital - nor were the latter bound to employ them once qualified. Yet the Sheffield hospitals recruited many of their Staff and Enrolled Assistant Nurses from among their learners, and senior members of the hospitals' staff, whether nursing, medical or administrative, viewed falling numbers of learners with concern.

Nursing Auxiliaries or Assistants were not in training to become professionally qualified as nurses, and the range of duties they were employed to perform was correspondingly limited. Nonetheless, their contribution to the nursing function within the hospitals was significant. In 1951, the proportion of the nursing workforce in this grade at the General was 20.7%, compared with 2.7% at the Infirmary. In 1962, Nursing Assistants accounted for only 7.7% of The General's nursing workforce. Conversely, at the Infirmary, the proportions of staff in the equivalent grade had risen to 24.2%. By 1970, the proportion of non-training Nursing Assistants counted in the nursing establishment at the General was 19.7%, while the percentage of nursing staff in the Nursing Auxiliary grade at the Infirmary had fallen to 19.3%.

3.2 The Availability of Nurses in Sheffield, 1948-1974

The authors of Sheffield RHB's *Hospital Plan*, published in 1955, blamed a projected shortage of nurses in the region for their decision to restrict expansion in bed numbers for hospital in-patients. The planners noted that by 1955 the Ministry of Health had abandoned the use of a formula to calculate the population's bed needs, so instead they

³⁵⁰ SA: Acc 2001/98, Matron's Records, *passim*.

adopted the Hospital Surveyors' approach, which gave a ratio of four acute beds to every thousand people, as the basis for their estimate. 'Cutting their coat to suit their cloth', in view of a lack of nurses and money, the planners reduced their target for the ratio of acute beds that would be provided in the Region by the year 1971 to 3.2 per thousand.³⁵¹ Although this was only slightly below the level of 3.3 per thousand suggested by the *Hospital Plan* in 1962, it represented a substantial reduction from the 6.56 per thousand suggested for the Region by the Ministry of Health in 1948.³⁵²

In fact, the number of nurses increased throughout the period from 1948 to 1974 but, to the senior nurses who were responsible for the provision of the hospital nursing service, the supply of nurses in Sheffield appeared to be limited. Sheffield's hospitals had experienced shortages of nursing during the late 1930s and 1940s, reflecting national trends.³⁵³ Shortages of nursing staff were specifically discussed by the various administrative committees of one or all of Sheffield's general hospitals during at least one month every year between 1948 and 1974, except 1963 and 1967. These shortages affected all grades of hospital nursing staff, although on occasion Matrons reported particular difficulty in recruiting to posts, usually in specialist departments.

The Infirmary reported a shortage of Student Nurses during 1951, both for the three-year training programme and for the shortened programmes offered to Students already qualified in other fields of nursing. This was exacerbated by the loss of twenty-eight 'senior nurses'; a term here used to describe third year Students rather than qualified staff.³⁵⁴ The Matron at the General reported staffing shortages, recruitment difficulties and high levels of Student Nurse attrition to every meeting of the hospital's House

³⁵¹ SA: SY 709/H2/1, Paragraph 9; Ministry of Health, *Hospital Plan*, Paragraph 14.

³⁵² Ministry of Health, *Hospital Plan*, Paragraph 14.

³⁵³ SA: SY 333/H3/38, Report of Interview of Staff Representatives and the Matron, 3 Mar 1940; SA: SY 333/H14/2, 27 Jan 1940 and 28 Apr 1941; Medical Officer of Health Report, *Sheffield*, 1937, 1939, 1947.

³⁵⁴ SA: Acc 2001/98, Matron's records, 18 June 1951.

Committee between April and September 1952, yet in October, she stated that the number of nurses in post allowed the reduction of nurses' hours to ninety-six per fortnight without the need to close beds.³⁵⁵ Between 1950 and 1953, the number of Student Nurses at the General increased from 133 to 170 and the number of Staff Nurses had risen from twenty-one to thirty. Nonetheless, the minutes of the Executive Committee meeting in February 1953 indicate that the hospital still experienced nursing shortages, and that bed closures had been 'instrumental' in ameliorating these.³⁵⁶

In July 1953, in spite of general increases in the number of nurses employed in the Sheffield region, each ward in the Infirmary was 'at least one nurse short of the establishment'.³⁵⁷ Yet from October, the GNC training syllabus required students to spend twelve weeks in the School of Nursing, increasing the number of students absent from the wards in 'block' at any time from between eight and ten to between eighteen and twenty. The Matron of the Infirmary suggested that more SEANs might be employed to replace the nurses lost from the general wards, while nursing numbers on the 'special wards' could be augmented by 'other grades of staff'.³⁵⁸ Efforts to address the shortfall had a limited impact. The medical staff were noted to be 'seriously concerned' by the revelation of the general shortage of nurses, but particularly worried by the anticipated drop in the number of students that the Matron predicted would occur by October 1954. In their view, the number of ward nurses was already 'the absolute minimum necessary' to maintain the standard of care for the number of

³⁵⁵ SA: SY 569/H1/5, CGH(52)4-9, *passim*.

³⁵⁶ SA: SY 569/H1/6, Exec(53)2, 23 Feb 1953.

³⁵⁷ SA: Acc 2001/98, Matron's records, 13 July 1953.

³⁵⁸ SA: Acc 2001/98, Matron's Records and Reports, 9 Nov 1953.

patients who could then be accommodated; any further reduction in staffing levels would lead to bed closures.³⁵⁹

Problems in nurse recruitment did not always affect all hospitals in Sheffield simultaneously. Fir Vale's House Committee, facing recruitment problems in February 1955, noted that 'It is difficult to get the right type of person.'³⁶⁰ Yet the Matron of the General, which shared the same site, reported that she had experienced no difficulty in recruiting students during the previous twelve months.³⁶¹ Problems persisted for Fir Vale during 1955, exacerbated by nurse absenteeism – 'which is a feature of service today...the whole being further aggravated by a majority of married nursing staff whose lives are affected by the school holidays and show difficulties I am obliged to recognise in view of our needs'.³⁶²

The Infirmary House Committee discussed nursing shortages at meetings in September and October 1955, the second quarter of 1956, November 1957 and February 1958. In the financial year 1957/58, the outturn expenditure on nursing salaries at the Infirmary indicates that the hospital spent only £132,251 of the £141,140 allowed in the estimate, suggesting that recruitment was difficult that year.³⁶³ Echoing a situation that had obtained at the General in 1951, the medical staff of the Infirmary noted in 1963 that 'the position has now been reached where the work had to be equated to the number of nurses, as it seemed to be impossible for the nurses to be equated to the work.'³⁶⁴

During 1958, 1960, 1964 and 1965, both the General and the Infirmary discussed shortages of nurses at their House Committee meetings, as they did again in autumn

³⁵⁹ SA: SY 333/H3/28, Minute 54/51, 8 Mar 1954.

³⁶⁰ SA: Acc 1994/64, Box 4, FVI(55)2.17, 11 Feb 1955.

³⁶¹ SA: Acc 1994/64, Box 4, CGH(55)2, Matron's report, 2 Feb 1955; SA: Acc 1994/64, Box 4, FVI(55)2, Minute 17, 11 Feb 1955.

³⁶² SA: Acc 1994/64, FVI(55)8, Matron's Report, 16 Sept 1955.

³⁶³ SA: SY 333/H3/30, 13 Apr 1959.

³⁶⁴ SA: SY 333/H6/14, 1 Oct 1963.

1966. The number of nurses working at the General fell between 1951 and 1962, before recovering. The Infirmary meanwhile saw an increase in nursing numbers, but in 1962, the number of students on its wards reached a low point, although during late 1968 the Infirmary claimed to have its lowest student numbers since 1963.³⁶⁵

This can be compared with concerns about shortages of nurses, and difficulties in recruiting nurses, in the NHS as a whole during the early 1960s, and the claim made in the PIB report in 1968 that there had been no shortage of either student or of Pupil Nurse recruits 'in recent years'.³⁶⁶ The PIB Report suggested that the problem was one of poor distribution, rather than insufficiency, and recorded that shortages of nurses had been seen in specific grades and specialities. Their *Report* noted that acute general hospitals were more likely to experience shortages of trained than of untrained staff, a situation that was likely to worsen over the following three years. Indeed, this is reflected in the records for the committee meetings in the Sheffield acute general hospitals in 1969 and 1970.

In addition to general difficulties, the House Committees of the various hospitals discussed specific problems in recruiting nurses to work in operating theatres, intensive care units, and renal units. Problems in staffing areas of specialist practice had been evident since the 1950s. In particular, it was frequently difficult for the three acute hospitals to staff their operating theatres, during the 1950s and 1960s.³⁶⁷ Matrons occasionally found it difficult to recruit to other wards offering specialist clinical care:

³⁶⁵SA: SY 333/H1/31; SA Acc 2001/98, Matron's records, *passim*. There were more students on the Infirmary's wards in 1968 than in 1963, a mean average of 202.4 in each calendar month, as opposed to 133.6.

³⁶⁶National Board for Prices and Incomes, *Report Number 60 - Command 3585. Pay of Nurses and Midwives in the National Health Service* (London, 1968), p. 8, Paragraph 30.

³⁶⁷SA: Acc 1994/64, Box 4, CGH(55)4, Matron's Report, 14 Apr 1955; SA: Acc 1994/64, CGH(55)6, 14 June 1955; SA: SY 333/H3/28, Minute I.55/315, 14 Nov 1955; SA: SY 333/H6/14, Minute 3, 2 Dec 1958; SA: SY333/H3/31, Minute 66/65, 13 June 1966; 333/H3/31, 10 Oct 1966; SA: SY569/H1/11, MC(70)5, 'Report of the Working Party to Examine the Methods of Staffing the Operating Theatres', 13 Apr 1970.

I am now informed that the Dermatological Ward will be completed on the 16th December...I have advertised for a Sister to take charge of this Department for approximately a year and have been entirely unsuccessful. With regard to the other staff, I have not been able to recruit a Staff Nurse, the Student Nurse situation in the Hospital is such that I cannot possibly add to the present problems, and at the present moment there is absolutely no possibility of opening the ward on this date.³⁶⁸

There is little indication in the Sheffield records as to why specialist wards and departments should have been less attractive to potential recruits. However, the Matron of the Infirmary reorganised one group of wards in 1965, to the approval of nursing and medical staff alike, after she found that: 'Because of the lack of sufficiently interesting work on Ward 24, it was impossible to keep a happy, stable staff.'³⁶⁹

Successful recruitment and retention of nursing staff may in part have depended upon convincing potential employees that the work was interesting, but there were several additional challenges to be met. From March 1949, the Treasury asked the Ministry of Health to seek to reduce the high relative costs of hospital care through control of the number of staff employed. During March and April 1949, at the request of the USH Board of Governors, the two unit general hospitals' House Committees had examined a range of possible options for reducing financial estimates for the year ending 31st March 1950 by 8%. Although neither nursing nor medical staff numbers were to be reduced, the potential loss of ancillary staff was likely to affect nurses' workload.³⁷⁰ The early imposition of stringent financial limits, and the control of staff establishments as a central aspect of their implementation, to which the RHB and the

³⁶⁸ SA: Acc 2001/98, Matron's Records, 14 Nov 1960.

³⁶⁹ SA: Acc 2001/98, Matron's Records, May 1965.

³⁷⁰ SA: SY 333/H16/13, Minute E142/50, 27 Feb 1950; SA: SY 333/H1/33, Minute H232, 15 Mar 1949; SA: SY 333/H3/27, 'Special Report on Proposed Cut in Budget of Estimated Expenditure for Year Ending 31 Mar 1950', 11 Apr 1949.

Board of Governors objected strongly, ensured that managing nurse recruitment would be an enduring challenge for the hospitals.³⁷¹

While the Infirmary was unable to spend its nursing budget fully in 1957/58, indicating that difficulties in attracting recruits were as much to blame for the hospital's staffing problems as were funding constraints, restrictions on expenditure were a more pressing concern by the later 1960s. The USH hospitals experienced increasing difficulties in balancing the funding available to staff the different units against the demand for staff. In June 1971, the General Purposes Committee noted that the group's revenue allocation would be exceeded 'if the policy of uncontrolled recruitment' particularly of trained nurses and auxiliaries continued. Expenditure on nursing staff salaries already exceeded funding agreed in March 1971 in the following two months.³⁷² USH reserves would cover overspending on either salaries and wages or other headings, but not both. Staffing levels at the Infirmary were 'still dangerously low, but the Chief Nursing Officer (CNO) was asked to attempt to contain expenditure by reducing the number of Nursing Auxiliaries employed at the Royal and the Children's Hospitals, where numbers of trained staff had increased. However, she felt that this 'would inevitably lead to the closure of beds.'³⁷³

During the early 1970s, the NGH experienced similar difficulties to those of the USH in balancing available revenue against staffing costs. The hospital's Nurse Staffing Report of January 1973 observed that until 1970 the hospitals of the HMC had never managed to recruit staff to their financed strength. It had been 'necessary to recruit Nursing Auxiliaries to supplement the shortage of trained nurses and learners', until there were nearly twice as many auxiliaries as trained staff working in the Geriatric

³⁷¹ Webster, *Health Service - Volume I*, p. 137; SA: Acc 1987/55, SRHB Special Meeting of Finance Committee, 28 Mar 1949; SA: SY 333/H16/1, 5 Sept 1949.

³⁷² SA: SY 333/H16/10, Minute GP94, 28 June 1971.

³⁷³ SA: SY 333/H16/10, Minute GP115, 26 July 1971.

Division, and the equivalent of more than one auxiliary for every trained nurse in the General Division. The recruitment of trained staff had begun to increase in 1971, which allowed the CNO and Group Treasurer to agree in January 1972 to start replacing Nursing Auxiliary vacancies with trained nurses until they reached the authorised financed establishment agreed with the RHB.³⁷⁴

The number of staff employed in each grade represented a compromise between three factors. The first of these was the ideal ('Objective') staffing level in each grade. The second was the number of posts in each grade that the RHB was prepared actually to fund ('Funding of Objective'). Third was the number that the RHB permitted the hospital to employ in the light of recruitment patterns and current budgetary constraints ('Authorised Financed Strength'). The number of staff the hospital actually had in post was represented by a fourth category - 'Staff in Post'. If the hospital's budget allowed, and if they could not recruit to authorised limits in specific grades, the RHB might allow the hospital to employ more staff in other grades in order to address a deficit in overall staff numbers.

The General's general ward and department nursing staff in whole time equivalents at the end of January 1974 numbered 289, excluding learners, an excess of nineteen above the extant 'Authorised Financed Strength', but below the minimum staffing level of 342 agreed with Sheffield RHB in May 1973 let alone the 'Objective' of 401. This global figure masked considerable variations between grades. The number of senior qualified nurses at Sister grade and above met, and that for SENs was little short of, the hospital's Objective. However, that for Staff Nurses and Senior SENs was well below either the Objective, Funding or Authorised Financed Strength, as was that for

³⁷⁴ SA: SY 569/H1/14, MC(73)1, Nurse Staffing Report.

Nursing Auxiliaries, while the number of Learners exceeded the Objective by nearly 84.

The CNO and Acting Treasurer noted that while they were attempting to achieve the revised staff numbers, the total Authorised Financed Strength was itself below the minimum staffing level of 401, excluding learners, agreed in the Objective.³⁷⁵ Yet there was 'no scientific way to my knowledge' of assessing the nursing requirements, according to the Chief Nursing Officer, in spite of the existence of DHSS guidelines.³⁷⁶ When the RHB reviewed the HMC's nursing staff objectives in February 1972, they noted only that 'account would be taken' of workloads, of the DHSS' recommendations on the number of nurses required in particular clinical areas, ward geography and qualified nurses' teaching duties.

The hospital and RHB's agreed objectives meant that the ratio of qualified staff to learners should have been 1.08 to one, excluding administrative grade nurses, with 126 Nursing Auxiliaries in post to facilitate the accomplishment of the routine work. Instead, the ratio was 0.58 qualified members of staff to each learner, with fewer than 86 Nursing Auxiliaries to support the nursing team.

Financial constraints also led to the operation of perverse incentives in the distribution of scarce resources. Nurse staffing levels and the standard of nursing in geriatric hospitals were of particular concern to Sheffield RHB. Although the agreed Regional staffing objectives for these units was above the DHSS minimum, set in March 1972, of one member of staff for every 1.9 patients, the money allocated by Sheffield RHB to individual HMCs was not earmarked for spending in a particular pattern beyond its overall designation to meet staffing costs. 'Although it was accepted that the Board could not provide sufficient finance to allow recruitment up to the full nursing

³⁷⁵SA: SY 569/H1/15, TR/213, 20 Feb 1974.

³⁷⁶SA: SY 569/H1/14, TR/152, 19 Apr 1972; SA: SY 569/H1/14, MC(73)1, 'Nurse Staffing Report'.

objective, there was evidence in some cases that the geriatric service was not receiving its fair proportion of the finance available.³⁷⁷ This referred to the overall numbers of staff employed, but senior nurses felt that the proportion of qualified staff was as important. The Principal Nursing Officer (PNO) of the Geriatric Division of the HMC reported in 1973 that:

The quantity of nursing staff, as governed by the authorised financial establishment figure, has been reached, but the quality leaves much to be desired. There are far too many staff in the Nursing Auxiliary grade in both Areas of the Division and, whilst a start has been made in gradually reducing this number, an even greater effort requires to be made in the recruitment of trained staff.³⁷⁸

This is consistent with indications from contemporary reports, and some more recent studies, concerning limitations in the quality of NHS provision for older people during the early period of the service and the impact of the *Hospital Plan* on the development of such services.³⁷⁹

Restrictions on expenditure thus provided one constraint on recruitment. In addition, hospital authorities were attempting to recruit nurses from a pool of potential employees that the expanding paramedical occupations of physiotherapy, radiography and occupational therapy also wished to exploit.³⁸⁰ All shared the problem that the overall number of potential recruits was limited. Intermittent problems in recruitment of staff to other occupational groups exacerbated the predicament that Matrons faced in matching the amount of nursing time available to demands, especially where demarcation between occupational groups or the assignment of clinical responsibilities

³⁷⁷SA: Acc 1987/55, SRHB Nursing Committee, 'Nurse Staffing in Geriatric Hospitals', 19 Mar 1973.

³⁷⁸SA: SY 569/H1/13, 'Policies and Priorities 1972/1973 – Division of Geriatric Medicine'.

³⁷⁹B Robb, *Sans Everything, A case to answer*, (London, 1967), p. xiv and *passim*; B Isaacs, M Livingstone, Y Neville, *Survival of the Unfittest: A study of geriatric patients in Glasgow* (London, 1972), pp. 93-103; Webster, 'The elderly and the early National Health Service', p. 178; Thane, *Old Age*, p. 452; Bridgen, 'Elderly people', *passim*.

³⁸⁰SA: Acc 1994/64, Box 4, FVI(55)2, Minute 17, 11 Feb 1955; SA: Acc 1994/64, Box 4, FVI(55)3, Matron's report, 18 Mar 1955; SA: Acc 1994/64, Box 4, Exec(55)8, Minute 250, 16 Sept 1955.

was unclear, and nurses compensated for deficiencies.³⁸¹ With few exceptions, nurse recruitment problems were more likely to hinder hospital work than were shortages in other staff groups, and to do so repeatedly.³⁸²

Although they blamed nurse recruitment difficulties on issues similar to those cited by the *Lancet* Commission in 1932 and the *Working Party* in 1947 – long hours of work, the physical condition of the wards and the inadequacies of the nurses' homes – Sheffield's hospital authorities also held the condition of the local labour market partly responsible. In 1954, the Secretary of the Infirmary's Medical Staff Committee wrote to his counterparts in Newcastle, Leeds, Manchester and Liverpool seeking information about their contemporary experience of nurse recruitment. The Matron had warned that the Infirmary faced continuing nursing staff shortages but the Secretary noted that as 'none of these comparable Provincial Teaching Schools were in any difficulty...the problem in Sheffield must therefore be due to local conditions.'³⁸³ The medical staff suggested that these might be the absence of unit nurses' homes and the centralisation of the School of Nursing, but at the General, other factors were identified. In February 1955, the General's House Committee recorded that 'It would appear that all available labour in Sheffield is being absorbed by industry who can offer better pay, shorter hours which includes a five-day week and better working conditions.'³⁸⁴

The Sheffield labour market was generally difficult for NHS employers between 1948 and 1974. Maintenance of the grounds and gardens of the HMC hospitals had to be simplified and made less labour-intensive in 1954; while in 1959 low levels of

³⁸¹ SA: Acc 2001/98, Meetings with Sisters, Minute 314, 3 Dec 1956; SA: SY 333/H3/30, Minute 59/58, 9 Mar 1959; SA: Acc 2001/98, Matron's Records, 9 Mar 1959; SA: Acc 2001/98, Matron's Records, 14 Feb 1969; SA: SY 569/H1/15, MEX(73)14, Minute 161, 14 Dec 1973.

³⁸² J Clark, 'Nurses as managers' in *Nursing and Social Change* ed. Baly (3rd edition: London, 1995), p. 278.

³⁸³ SA: SY 333/H16/14, Minute 2i, 18 Jan 1954.

³⁸⁴ SA: Acc 1994/64, Box 4, CGH(55)2, 10 Feb 1955.

unemployment in Sheffield put the hospitals again 'in keen competition with other employers', and in 1973 the hospitals reportedly found it difficult to secure builders and engineers.³⁸⁵ Conversely, in the 1963 USH Annual Report the Board of Governors observed that the hospital had managed to recruit to establishment in most staff categories 'due partly to more difficult employment conditions in industry locally and a sharp increase in Sheffield and surrounding districts of the number of unemployed.'³⁸⁶

This appears to have been short-lived. Pollard notes that, in general, Sheffield's economy and employment prospects flourished throughout the period, even though the cutlery trade was affected by competition from Germany and the Far East from the 1950s onwards. By the 1970s, unemployment rates in the city had risen to two percent but serious economic problems and job losses did not affect Sheffield until the late 1970s. While 13,800 male jobs were lost in the cutlery industry during the economic downturn between 1971 and 1977, the number of jobs for females increased by 5,700 even during these years.³⁸⁷

Women - who remained in the majority in all nursing grades during the period - were encouraged to return to or take up work in the steel industry, cutlery and distributive trades, to contribute to the revival and modernisation of these sectors after the Second World War, or at least to enter secondary employment so that others could do so.³⁸⁸

The Sheffield District Employment Committee estimated that there had been a reduction of ten thousand in the number of eighteen to twenty year old men between 1939 and 1947. Over the same period, there were reductions of 4,479 in the number of

³⁸⁵ Pollard, 'Labour', p. 277; SA: Acc 1994/64, Box 3, MC(54)2, Minute 27, 8 Dec 1954; SA: SY 333/H16/4, (1959), p15; SA: SY 291/H1/2, Minute 883, 25 Oct 1973.

³⁸⁶ SA: SY 709/H1/1; SA: SY 709/H2/1; SA: Acc 1994/64, FVI(56)3, 16 Mar 1956; SA: SY 333/H16/5, (1963), p. 15.

³⁸⁷ Pollard, 'Labour', pp. 274-276.

³⁸⁸ Anon, 'Our view: US Aid for Industry', *The Star* 7 Jan (1948), p. 1.

'boys' and similar in the number of 'girls' available for work, although the numbers of over twenty-one year olds had increased by 7,101 men and 12,781 women. The number of men actively employed in local industry had increased by 4,214, but the number of women had decreased by 994. Only half a percent of people registered for employment in the city were described as 'unemployed', compared to a national average of one and a half per cent. There was no pool of unemployed men from which to augment the workforce; women represented the only locally available source of additional employees.³⁸⁹

Immediately after the end of the Second World War, many women in Sheffield appear to have left employment but this did not prevent an overall increase in the proportion of females in the workforce during the 1950s, reflecting national post-war trends.³⁹⁰ This adds weight to the speculation of the general hospital Matrons that appeals to women to enter nursing would have to compete with the demands of other local industries, but with less to offer them. Certainly the Matron of Fir Vale complained in 1956 that, apart from the discouraging aspects of nursing work, 'Industry offers better wages and what are considered better working hours'.³⁹¹

The Matrons correctly identified that the major local industries, steel and cutlery, were able to offer better hours of work. From 6 January 1947, the Engineering and Allied Employers National Federation and the National Engineering Joint Trades Movement agreed to reduce the working week from forty-seven hours to forty-four, based on a five-day week. In addition, they agreed on the payment of overtime rates for any time worked over eight and a half hours in a day, premium overtime payments for any work done at the weekends, and enhanced national bonuses, all to apply to night as well as

³⁸⁹ 'Only 907 Unemployed in Sheffield', *The Star* p. 5.

³⁹⁰ S Dunkley, 'Women in public: women elected representatives in local government in Sheffield, 1870-1992', in *History of Sheffield – Volume II, Society*, p. 289; Anon, 'Employment Trends in Great Britain, 1950-1960', *Ministry of Labour Gazette* July (1961), pp. 281-282.

³⁹¹ SA: Acc 1994/64, Box 2, FVI(56)3, Matron's Report, 16 Mar 1956.

to day-shift workers. The principles on which they reached the agreement included 'The need to maintain and develop maximum production in the interests of the domestic consumer and export markets.' That April, a further agreement was reached that employees would work thirty-seven and a half hours over five days, with the weekend off, but be paid for a forty-four hour week.³⁹² In 1960, the working week was reduced to forty-two hours to be worked over five days – although this was longer than the average of forty-one hours and twenty-four minutes worked by women employed full-time, by 1959.³⁹³ Hours of work were clearly more favourable, at least for employees of engineering firms that belonged to the Engineering and Allied Employers National Federation and those non-members who decided to abide by the national agreements, than they were for NHS nurses during the 1940s and 1950s.

Salaries also appeared to favour recruitment to local industry. For women of eighteen years of age working in engineering – the age at which they became eligible to enter nurse training - the weekly income in 1958 was 120 shillings and sixpence - nearly £315 annually. Even with an increase in the annual training allowance for a first year Student Nurse to £273 in 1958, the new Student would have been fifteen shillings and sixpence per week worse off than her counterpart working in industry. However, qualifying as a nurse would reverse the position. Assuming that she had qualified as a Registered Nurse at the age of twenty-one, her starting salary in 1958 would have been £418 annually, giving her 160 shillings to the female engineering worker's 126 shillings and sixpence at the same age. The differential was less if the latter was remunerated according to piece-rates, but it remained.³⁹⁴

³⁹² Amalgamated Engineering Union, 'Lists of Minimum Wages in Sheffield and District', 1946-1962.

³⁹³ *Ministry of Labour Gazette*, Feb (1967), p. 112.

³⁹⁴ Amalgamated Engineering Union, 'Lists of Minimum Wages in Sheffield and District', 1946-1962; United Sheffield Hospitals, *Nurse Training* (Sheffield, 1958).

However, nursing in Sheffield does not appear to have been competing for recruits mainly with the major local industries. Information available locally, most of which relates to the previous occupation of nurses recruited to the Royal between 1948 and 1966, indicates that at most three students in a year had worked in industry before they entered nursing. The more limited information available from the General appears to confirm this. Between 30% and 40% of recruits to the Royal from 1948 until 1966 had worked in a variety of settings including offices, shops and as domestic workers. The changing patterns of pre-nursing experience reported by students recruited to the Royal during this period indicates that this was more likely to have been in areas of work or study cognate with nursing than with any other field. The records indicate that recruits to nursing in Sheffield brought with them previous experience in nursing, whether while studying on a pre-nursing course, in fever nursing, orthopaedic nursing or as a Nursing Assistant, in cognate occupations such as nursery nursing, or in shop or office work. In 1973, 63% of Students and 50.4% of Pupil Nurses training at the General reported that they had previously been 'in gainful employment' before starting their nursing course.³⁹⁵ Nor did students who left nursing before qualifying appear likely to do so for the better working hours and higher salaries of a post in industry. Nurses left to undertake further training, usually but not exclusively in midwifery, to marry, or for other reasons unrelated to employment.³⁹⁶

The absolute number of nurses employed was less significant than the number of hours they were able to contribute to the hospital. In certain respects, reductions in the number of nurses available on duty could be predicted. In order to gain the breadth of clinical experience required by the GNC where this was not available in their own training school hospital, Student Nurses were sent to a gradually increasing range of specialist clinical areas in other hospitals and later in the community. Initially, this

³⁹⁵ SA: SY 569/H1/14, NEC(73)1, 21 Mar 1973.

³⁹⁶ SA: Acc 2001/98, Royal Hospital – Nurses' Registers 12-26, *passim*.

affected only the USH hospitals, although in 1962 and again in 1969 the range of training experiences required by the GNC expanded, which meant that by 1974 all general Student Nurses in Sheffield spent between two and three months, at least once in their training period, away from their training hospital. This was in addition to time spent in education blocks and thus not available for clinical duties.³⁹⁷ As the hospitals found it difficult to increase their staff establishments, the absence of students for prolonged periods of time created significant problems for the provision of nursing care.

3.3 Demand for Nursing Care, 1948-1974

While the number of nurses employed in Sheffield's general hospitals increased, so did the number of patients requiring their attention. Comparison between two of the hospital units, the General and the Infirmary, indicates that each expanded the overall nursing staff establishment and bed complement over this period, and in each case a crude assessment of the number of beds per nurse showed an improvement between 1951 and 1970. At the General, the number of employees in all nursing grades working either full or part-time increased from 333 to 467, while the number of beds increased from 521 to 530. At the Infirmary over the same period, the number of nursing employees increased from 333 to 481, while the bed complement increased from 500 to 558. At the General, this meant that the number of nurses available for each bed increased from 0.63 to 0.88, while at the Infirmary the increase was slightly less, rising from 0.66 to 0.86.³⁹⁸ However, this represents a crude ratio, and not the number of hours available, which – in the absence of detailed information on the number of hours worked by each employee – is not computable. In addition, the rising number of beds available gives only limited information about the increased workload.

³⁹⁷ SA: SY 333/H16/1-2, 1948-60, *passim*; SA: SY 333/H16/9, Minutes F207, F225 and *passim*. See also McGhee, *Patient's Attitude to Nursing Care*.

³⁹⁸ SA: SY 569/H1, *passim*; SA: SY 333/H16/3-8, *passim*.

Between 1948 and 1974, the number of in-patients treated in the USH hospitals rose from 38,545 to 39,834, with an increase in the number of out-patient attendances from 536,532 to 685,296.³⁹⁹

Despite the relatively low number of Consultant grade medical staff in the Sheffield Region in 1948 that number was rising, with implications not only for medical recruitment and training but also for associated occupations, including nursing, radiography, and physiotherapy.⁴⁰⁰ The range of clinical specialities, and the number of medical staff of all grades associated with them, gradually increased between 1948 and 1974 at the Infirmary, the Royal and the General.⁴⁰¹ Greater levels of specialisation and therapeutic innovation were associated with the opening of new wards and departments, and with increases in the number of nursing staff required. During early 1952 at the General alone new professorial gynaecology and cardiology units opened, increasing the requirement for full time clinical staff by sixteen, including three Sisters, three Staff Nurses, seven Student Nurses, two Ward Orderlies, and a trainee Electrocardiograph Technician, as well as three part-time Cleaners.

The development of intensive care, renal and other high dependency units separate from the general medical and surgical ward units during the 1960s further increased the number of nurses required. Between 1969 and 1971, the NGH opened a new suite of four theatres, a nine-bed renal dialysis unit, an orthopaedic ward and day surgical ward with twelve beds apiece, and a four-bed coronary care unit. In all, these increased the ideal nursing establishment by at least forty-seven. Moreover, the

³⁹⁹ SA: SY 333/H16/8, Final Report of the Board of Governors, 1974, p. 13.

⁴⁰⁰ Ministry of Health, *Consultant Services; Webster Health Service - Volume II*, p. 17.

⁴⁰¹ SA: SY 333/H16/3-8; SA: SY 569/H1 *passim*.

difficulty in matching nursing time available to that required was exacerbated by the gradual replacement of 'Nightingale' wards with partitioned wards.⁴⁰²

Important though changes in the medical staff and therapeutics were, other factors amplified the amount of nursing time required. Between 1948 and 1974, following a trend accelerated by the reduction in the number of hospital beds available with the outbreak of war in 1939, patient turnover steadily increased. The average length of stay fell, so that the proportion of technical nursing as well as of basic care required by each patient increased.⁴⁰³ Beyond this, hospital staff perceived that: 'There has been a gradual change over the past years and the public and patients alike now look for a higher standard of attention in hospital than was previously accepted.'⁴⁰⁴

The pressure to increase the turnover of patients on the acute hospital wards was associated with a decrease in tolerance of older and chronically ill people with complex health and social care needs on these wards, although there was a concomitant increase in interest in improving their care in the former Poor Law hospital at Fir Vale.⁴⁰⁵ The nursing needs of older patients with chronic diseases, formerly regarded as requiring routine, technically undemanding care, were reassessed from the mid-1950s onwards by nurses and their colleagues working at Fir Vale. Opportunities for active therapeutic intervention and rehabilitation expanded, and these required the complementary application of increasingly skilled nursing. The ageing of the population prompted other – sometimes revealing – changes. Patients had been expected to contribute to the work of Fir Vale, but '[i]n future it would be necessary to engage domestic staff for work on the Mental Observation and Mental Defective wards

⁴⁰² SA: Acc 2001/98, Matron's Records, 13 Apr 1959; SA: SY 333/H3/31, Minute 64/136, 14 Dec 1964.

⁴⁰³ Medical Officer of Health Report, Sheffield, 1930-1937; SA: SY 569/H1/14, MC(73)1, Nurse Staffing Report, Jan 1973.

⁴⁰⁴ SA: Acc 1994/64, Box 4, NEH(55)3, Minute 18, 16 Mar 1955.

⁴⁰⁵ SA: SY 333/H1/35, 8 Feb 1966.

as many of the patients who had been doing the domestic work for many years were fast becoming too aged to continue.⁴⁰⁶

Meanwhile, reductions in all nurses' hours of work and changes in nurse training had reduced the amount of nursing time available and the number of recruits had not kept pace with increased demand. Contemporary accounts indicate that, in the view of nursing and administrative staff, the root of the problem was that the number of ill people requiring higher standards of nursing care had increased in the Region.

3.4 Managing The Availability Of Nursing Time In Sheffield, 1948-1974

Although nurse recruitment appeared simply to involve appointing enough of the 'right sort' of person, those possessing clinical ability and a sound knowledge base and displaying qualities of loyalty, cooperation, helpfulness, and reliability, the hospitals had to use a combination of approaches to improve their chances of matching nursing time available to nursing care requirements.⁴⁰⁷ Terms and conditions of employment were largely beyond the control of nurses working in the hospitals, as the Nursing and Midwifery Whitley Council negotiated these on a national basis. Nonetheless, opportunities for promotion, part-time work, post-basic education, improvements in staff residences and nursery facilities were among the incentives offered to prospective employees. Strategies also included attempts to increase recruitment of traditional nursing recruits – young, female school-leavers – but others, including men, mature women, and overseas recruits were also sought.

Senior nurses also endeavoured to make use the nurses they already employed to better effect. For example, Student Nurses were moved to areas which were poorly staffed, and made up a major part of the nursing workforce at night. On some evening and

⁴⁰⁶ SA: Acc 1994/64, Box 1, FVI(52)10, Minute 137, 14 Nov 1952.

⁴⁰⁷ SA: Acc 2001/98, Royal Hospital - Nurses' Register 12 to 26, 1944 to 1966, *passim*.

weekend shifts, students were effectively in charge of the ward or department where they were working. An alternative approach to increasing the supply of nurses was to reduce demands on them. Such strategies included, for example, the permanent or temporary closure of beds in the hospital, or the redefinition of roles and responsibilities for specific tasks. Between 1948 and 1974, the boundaries between nursing and non-nursing work and the allocation of duties within and outside the nursing grades were approaches taken to reducing the number of nursing hours required.

The Report of the *Lancet Commission* in 1932 and the Interim Report of the Inter-Departmental Committee in 1939 had suggested that successful nurse recruitment and retention depended largely on improving terms and conditions of service, including pay, for all grades, and enhancing training and career development opportunities for registered nurses.⁴⁰⁸ In April 1943, Sheffield City Council and the Royal Sheffield Infirmary and Hospital's Court of Management agreed to adopt the Rushcliffe Committee's recommendations for a national scale of salaries, terms and conditions of service for nurses. This, and the 1948 Whitley Council structure, limited the scope for hospital authorities to offer financial incentives to prospective employees, or to retain existing staff.

From 1948, Whitley Councils made salaries, terms and conditions of service for nurses and midwives subject to national agreement, negotiated between employers' and employees' representatives. Hospital authorities retained limited inducements to recruitment and retention, including residential accommodation, although the operation of limits on the revenue available to hospitals constrained their actions. Nonetheless, they manipulated those inducements that were under their control in order to guide

⁴⁰⁸ *Lancet Commission*; Wood: *Majority Report*; DHSS, *Pay and Related Conditions of Service of Nurses and Midwives*; SA: SY 333/H6/14, 28 Jan 1948; 'BK', 'Comments on the nursing shortage', *Nursing Times* (1956), pp. 813-814; Baly, *Nursing and Social Change*, p. 211.

recruits to work where they were required. For example, the Infirmary began to promote Registered Nurses to the post of Junior Sister or Charge Nurse in 1950, increasing the number of such posts from three to ten in 1951.⁴⁰⁹ This was a grade between that of Staff Nurse, to which nurses were appointed on successful completion of student training, and that of Sister or Charge Nurse, and it was considered to offer nurses an opportunity to develop their career within the hospital as the alternative was for them to leave in order to pursue promotion elsewhere.

Promotion attracted a higher salary, although it also imposed higher charges for emoluments, to the extent that in May 1958 the Sheffield Region of HMC Group Secretaries noted that many nurses only received a small part of the increase in salary when promoted. They agreed that, when promoted, nurses should receive a salary increase of at least thirty-five pounds sterling per annum as long as this did not exceed the maximum permitted under the salary scale for the new post.⁴¹⁰

Nurses became increasingly dissatisfied with their pay awards during the 1950s, dissatisfaction that led to a national pay campaign in the early 1960s. The Matron and Sisters of the Infirmary agreed to support the nurses' pay claim fully 'by bringing our dissatisfaction to the notice of the local MPs, the Press and General Public'. Nationally, protests included a rally of 7000 nurses at the Royal Albert Hall on 29 May 1962, which was attended by seventy-two nurses 'of all ranks and taken from most of the hospitals in the Sheffield groups'.⁴¹¹

Enoch Powell was able to resist nurses' pay claims in the early 1960s as increasing numbers of overseas recruits off-set the shortage of recruits available from the UK and Eire, but it appears that this was no longer possible for his successors at the DHSS by

⁴⁰⁹ SA: SY 333/H6/68, 1950; SA: SY 333/H6/69, 1951.

⁴¹⁰ SA: SY 291/H1/1, Minute 696, 20 May 1958.

⁴¹¹ SA: SY Acc 2001/98, Meetings with Sisters, Minute 557, 5 Feb 1962; SA: SY 333/H6/80, pp. 11-12, 15.

the end of the decade.⁴¹² In 1969, the RCN launched the 'Raise the Roof' campaign for better pay and conditions. The Infirmary's nurses were asked to support this, although the Matron and Sisters agreed that nothing should be done to antagonise the public on 28th January 1970, so they would neither march nor carry banners or wear uniform to the public meeting to be held that day.⁴¹³ In sum, external pressures and professional socialisation constrained the operation of pay as an incentive to the recruitment and retention of nursing staff.

Although this represented the implementation of national rather than local policy, there was leeway for hospital authorities to delay the implementation of changes in working hours, which did not exist for salary and wage increases. When the NHS was established in 1948, nurses in Sheffield's general hospitals worked between fifty and fifty-six hours each week; the hours worked by the Infirmary's students had been reduced to 110 per fortnight in 1939. Nurses working at the Infirmary in June 1948 had two and a half hours off-duty each working day, with two hours for meal breaks. When on day duty they would have found it necessary to be in or near the hospital for as many as thirteen hours each working day. They were allowed one day off each week, and a half day off on alternate Sundays. Night nurses worked a fifty-four hour week, with six nights off in a calendar month and one hour off for rest and one hour for meals each night.⁴¹⁴

The changing relationship between the hospital and its nursing staff was associated with the reduction in the working hours of nursing staff, and the introduction of new patterns of attendance at work. Local implementation of nationally agreed hours and other terms and conditions of service could be delayed for several reasons. These included the hospital's nursing and ancillary staff numbers, their workload and

⁴¹² Balfour, *Incomes Policy*, p. 227-228; Webster, *Health Service - Volume II*, p. 173.

⁴¹³ SA: SY Acc 2001/98, Meetings with Sisters, Minute 1020, 13 Jan 1970.

⁴¹⁴ TNA: PRO DT 33/456.

whether the nursing work could be managed within the nursing hours available after a reduction or the introduction of new shifts. A corollary of this was that securing the support of the medical staff was central to successful implementation.

In 1951, a one hundred and two hour fortnight was introduced at the General, but this was only possible because the number of beds in the hospital was reduced by one hundred and thirty-six. This was effected through the twin expedients of closing one ward and increasing the space between beds in others, at the suggestion of the Matron with the support of the lay administrators. This 'too drastic' measure initially led to a dispute of several months' duration between the hospital and the Nursing Committee of the RHB, in which the Sheffield Local Medical Committee and the local news media ultimately became involved. The HMC's decision prevailed. The support that the hospital's medical staff gave to the decisions taken by the Matron and lay administrators in 1951 appears to have been crucial.⁴¹⁵ Nursing hours were again reduced, to ninety-six per fortnight in October 1952, and this did not provoke such resistance but, on that occasion, it was not overtly linked to reductions in the level of service that the hospital could give to the community. A sequel to this was that the GNC Inspector's report on the fourth visit to the hospital, in December 1954, noted that the reduction of the bed complement had provided 'better facilities for carrying out nursing procedures'.⁴¹⁶

In 1955, Miss Janson reported that it was 'impossible' to introduce the shift system at the General, in view of the limited numbers of staff available to cover the nursing work. At this time, she informed the House Committee that the majority of nurses worked three split shifts one week, and four the next.⁴¹⁷ Reduction in the hours

⁴¹⁵ SA: SY 569/H1/4, 12 Feb to 23 July 1951, *passim*.

⁴¹⁶ SA: SY Acc 1994/64, 'Extract from the Report of the General Nursing Council on the fourth visit to the City General Hospital', 4 Dec 1954.

⁴¹⁷ SA: Acc 1994/64, CGH(55)6, Matron's Report, 14 June 1955.

worked by nurses made a necessary contribution to changing the relationship between employee and hospital, but was not of itself sufficient as the nurses' working day could still last for many hours interspersed with brief periods 'off duty'. As her first duty was to the hospital, the nurse's time off could not be taken for granted but was circumscribed by the requirements of the institution. The very term 'off-duty' carried the implication that the nurse's time 'belonged' to the hospital. Research published in 1956 indicated that nurses' reasons for dissatisfaction with their employment included 'the wearying day' from half-past seven or eight in the morning to nine o'clock at night and the eleven or twelve hours on night duty; uncertain free time; overwork, too much cleaning and lack of essential equipment; and the 'vastly superior air of trained staff.'⁴¹⁸ The reduction in the total number of hours worked was less important to changing hospital nurses' working lives and situation with their employers than the gradual demise of the split shift system over a decade from the late 1950s.⁴¹⁹

The Infirmary began the process of implementation in 1958, but split shifts were still worked in some areas up to four years later.⁴²⁰ The introduction of a new shift system enabled the nurse to finish her working day within eight hours, as the exuberant poem that appeared in the Infirmary's League of Trained Nurses' magazine in 1959 indicates:

'Whatever would Miss Florence think
Of working two till ten
The clear-cut hours of a factory lass
And plenty of time for men.'⁴²¹

At the General, split shifts were still in operation until at least 1968. The hospitals' records indicate that the delay was in part occasioned by problems in covering the

⁴¹⁸ 'Staff Nurses – Nursing Research Report' [editorial], *Nursing Times* 30 Nov (1956), p. 1217.

⁴¹⁹ SA: Acc 2001/98, Matron's Records, 8 Sept 1958 and 24 Nov 1958; SA: SY 333/H3/30, Minute 61/55, 13 Mar 1961 and 8 May 1961; SA: SY 569/H1/8, Nur(67)8, 15 Nov 1967; SA: SY 569/H1/9, Nur(68)5, Minute 16, 19 June 1968.

⁴²⁰ SA: SY 333/H3/30, 13 Mar 1961.

⁴²¹ SA: SY 333/H6/77, P A Jones, 'The New Era'.

work to be done, in part by reluctance to discard shift patterns that were preferred by some members of staff.⁴²²

In 1958, a further reduction of nurses' working hours to forty-four a week was agreed. Although this was to be implemented for all NHS nurses by 1961 the Infirmary implemented the change over a period of five months in 1958. The lengthy implementation period was attributed to the associated change in the organisation of nursing care. After seven weeks, the Matron reported that the patients were receiving 'the nursing care required', and that 'The Consultants concerned have been very co-operative and agreed for the patients who are normally on twice daily temperature charts to have temperatures taken once only in 24 hours'.⁴²³ Although part of the USH group, the Royal was not able fully to introduce the shorter working week until 1959, and hours worked by night staff remained unchanged until December that year. Once again, the cooperation of the medical staff was sought.⁴²⁴ In July 1964 the Infirmary was able to reduce nurses' hours to forty-two per week. In the same month nursing staff at its sister unit, the Royal, were still 'seeking' this change.⁴²⁵ By 1970, all hospitals in the USH and the HMC groups had reduced nurses' duty hours to forty hours, with two full days off each week.⁴²⁶

Reducing the number of hours worked by nurses caused problems for the hospitals and did not address the needs of nurses with families. While the employment of nurses on part-time contracts was done cautiously at first, this was one solution to the lack of sufficient whole-time staff. The USH and HMC hospitals employed part-time staff throughout the period, although without great fervour. The Infirmary had been

⁴²² SA: SY 569/H1/8, Nur(67)8, 15 Nov 1967; SA: SY 569/H1/9, Nur(68)5, Minute 16, 19 June 1968.

⁴²³ SA: SY Acc 2001/98, Matron's Reports, 14 July to 8 Dec 1958, *passim*.

⁴²⁴ SA: SY 333/H1/33, 13 Jan to 13 Oct 1959, *passim*.

⁴²⁵ SA: SY Acc 2001/98, Matron's Reports, 13 Jul 1964; SA: SY 333/H3/31, 14 Jul 1964.

⁴²⁶ DHSS, *Pay and Related Conditions of Service of Nurses and Midwives*; SA: SY 333/H6/52-96, *passim*.

unenthusiastic about employing married female nurses, but had been forced to do so during World War Two in the absence of a realistic alternative. 'It was agreed that in normal circumstances it was undesirable to retain the services of nurses who are married, but present wartime conditions make it necessary to retain the services of as many as possible.'⁴²⁷

However reluctant initially, by 1970 hospital authorities recognised that part-time staff were an essential part of the workforce. The General and the Infirmary had reported frequent shortages of nursing staff in their operating theatres during the 1960s. The General had sought to address this problem through the employment and training of operating department assistants as substitutes for scarce nurses, while the Infirmary had developed a postgraduate theatre nursing course in an attempt to attract trained nursing staff. However, the problems of staffing the operating theatres persisted at the General, as the Management Committee attempted to reduce the hospital's surgical waiting list and the number of patients increased accordingly. They established a Working Party to examine how the department might best be staffed, which concluded that 'The prospects of expanding or even maintaining existing nursing and other services depend upon wider and greater use of part-time staff.'⁴²⁸

The proportion of nursing staff, excluding learners, employed on a part-time basis increased from 31.6% to 58.1% at the General and from 21.9% to 59.2% at the Infirmary, between 1951 and 1971. At the Infirmary, changes in the absolute and relative contribution of part-time staff are difficult to estimate, because the number of hours they worked was not included in the staff returns until June 1968. In national statistics, part-time members of nursing staff were often crudely counted as equivalent

⁴²⁷ SA: SY 333/H14/2, Minute 3356, 27 May 1940; SA: SY Acc 1994/64, FVI(55)8, Matron's Report, 16 Sept 1955.

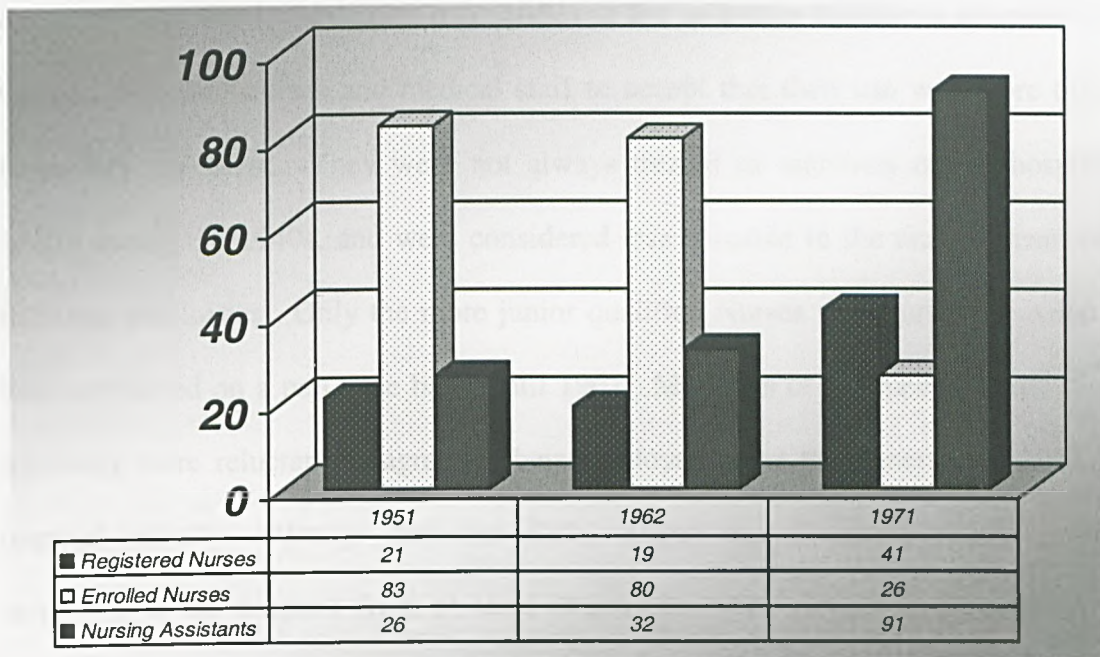
⁴²⁸ SA: SY 569/H1/11, MC(70)5, 'Report of the Working Party to Examine the Methods of Staffing the Operating Theatres at NGH', 13 Apr 1970.

to half a full-time nurse, regardless of the actual number of hours they worked. At the Infirmary, which did not employ Sisters on a part-time basis until 1968, the proportion working less than full-time was 36.1% in 1971, compared to 34.1% at the General. Conversely, with the exception of the General towards the end of the period, which allowed a very limited number of Pupil Nurses to study part-time, the hospitals employed learners only on a full-time basis.

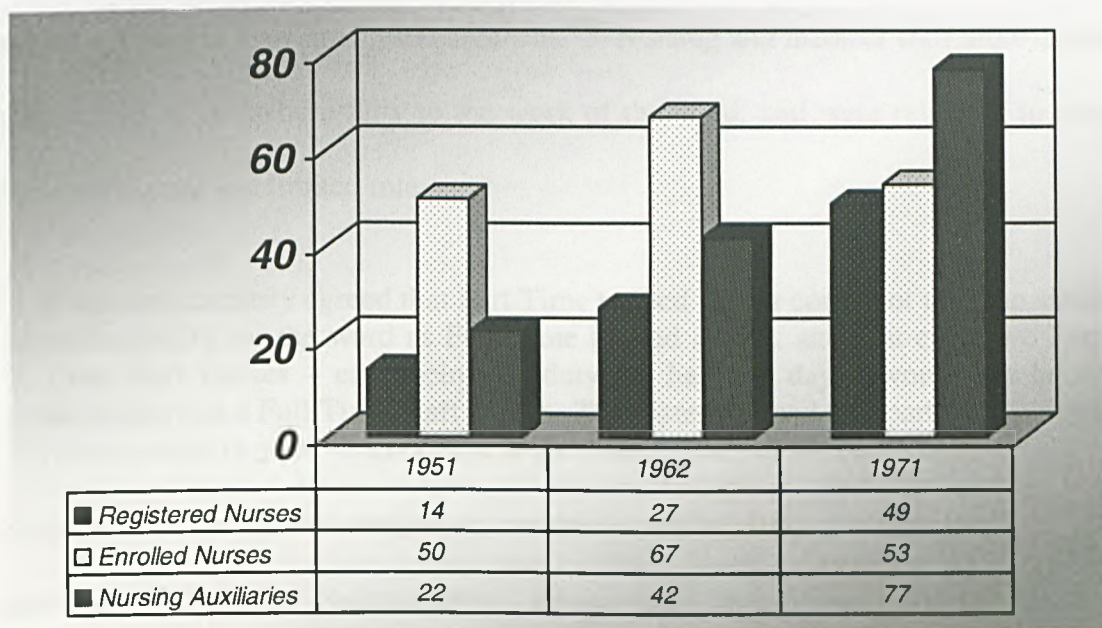
The remuneration of part-time work meant that the net pay of a nurse working maximum part-time hours was only a little less than that received by her full-time colleague in 1961. So that Hospital Secretaries in Sheffield Region felt that although 'specific personal causes' contributed most to the increasing tendency of full-time nurses to transfer to part-time employment, financial incentives played an important role.⁴²⁹

Sheffield's hospitals also attempted to boost the hours of nursing time available by taking a more flexible approach to employment conditions. The employment of part-time nurses was an expedient driven by local necessity. For example, in Gloucestershire and Wiltshire during the mid-1940s the employment of part-time nursing staff was initially introduced to overcome staff shortages in infirmaries caring for people with chronic illness. *The Lancet* suggested that the employment of part-time nurses could be used in other regions and in other types of hospital to solve the recruitment problems, and might even allow qualified staff more time to teach students. The General employed part-time staff of all nursing grades throughout the period, from at least 1951, and in general their presence was unremarkable, in that there is no record of discussions over the principle of employing nursing staff on a part-time basis.

⁴²⁹ SA: SY 291/H1/1, 6 Dec 1961.



3.3 Percentage of Registered Nurses, Enrolled Nurses and Nursing Assistants employed on a part-time basis at The General, 1951, 1962, 1971.⁴³⁰



3.4 Percentage of Registered Nurses, Enrolled Nurses and Nursing Auxiliaries employed on a part-time basis at the Infirmary, 1951, 1962, 1971.⁴³¹

⁴³⁰ SA: SY 569/H1, *passim*; SA: SY 333/H16/3-8, *passim*.

⁴³¹ SA: Acc 2001/98, Matron's Records, *passim*.

Recorded attitudes towards part-time nurses at the Infirmary indicate a reluctance on the part of senior nurses and medical staff to accept that their use was more than a temporary expedient. They were not always treated as members of the hospital's 'staff' during the 1940s, and were considered less valuable to the nursing team than full-time employees. Only the more junior qualified Nurses and Nursing Auxiliaries were employed on a part-time basis until 1967. Members of the medical staff of the Infirmary were reluctant to agree to their employment on the general wards of the hospital initially, although part-time SRN, SEAN and Nursing Assistants were employed at the hospital from at least December 1950. In 1954, the Infirmary's medical staff accepted that part-time staff should be engaged on the wards during the extant nursing crisis, which had only been partly alleviated by closure of both ophthalmic wards for an indefinite period for alterations and the temporary closure of wards for annual cleaning. Nonetheless, they suggested that part-time nurses should not be counted in the wards' establishment.⁴³² Nursing and medical staff alike doubted their ability to contribute fully to the work of the ward, and were reluctant to accept them other than in a limited role.

It was unanimously agreed that Part Time trained nurses could not take the same responsibility for the ward as Full Time trained nurses, and that even two Part Time Staff Nurses – each being on duty for half the day – would not be as satisfactory as a Full Time Staff Nurse. The Sisters agreed that part time trained Nurses might be used to advantage in the bedside care of the patients.⁴³³

Scepticism about their contribution persisted until at least the late 1960s.⁴³⁴ The Infirmary's Domestic Subcommittee agreed that Junior Ward Sisters might be

⁴³² SA: SY 333/H6/14, 20 Sept 1954, 30 Sept 1954 [Extraordinary Meeting].

⁴³³ SA Acc2001/98, Meetings with Sisters, 10 Apr 1956.

⁴³⁴ *The Lancet*, 8 Mar 1947, 'Part-time nursing and its future', p. 294 and 'Part-time nursing – conference at Cheltenham', pp. 300-302; Dan Mason Nursing Research Committee, *Marriage and Nursing*.

employed on a part-time basis only in June 1967; part-time Sisters are listed on the hospital's staff from June 1968.⁴³⁵

Part-time employment on contracts that allowed for flexibility in the hours worked by individual nurses, the provision of subsidised childcare, and refresher courses for trained nurses – and midwives - who wished to return to hospital work, allowed the hospitals to increase the number of nurses available, although the number of hours contributed was not reported until June 1968. From then, the number of whole time equivalent (WTE) staff was included in staffing returns along with the crude numbers of full- and part-time employed staff. These measures are also indicative of changes in the relationship between nurses as employees and the hospital, which recognised the necessity of accommodating the lives nurses lived outside the walls of the hospital in order to allow the hospital to secure sufficient nursing time.⁴³⁶

Between 1948 and 1974, the role of the general hospitals in Sheffield's USH and the HMC groups gradually changed from one akin to that of a 'total institution', with effective control over much of the nursing staff and students' lives, to that of a partner in a more conventional employer-employee relationship.⁴³⁷ For example, until the early 1950s it was expected that from the start of their employment as students until they left nursing, either to marry or for other employment, nurses would live in the hospital nurses' home.⁴³⁸ Many hospitals, particularly those in rural areas, struggled to provide sufficient accommodation, and the expansion in the numbers of nurses

⁴³⁵ SA SY333/H6/14, 7 May 1956, Minute 6a); SA Acc2001/98, Matron's Records, 13 Feb 1958, *passim*; SA SY333/H3/31, 12 June 1967, Minute 67.

⁴³⁶ Bruley, *Women*, p. 120; McGhee, *Patient's Attitude to Nursing Care*; SA SY333/H6/88.

⁴³⁷ E Goffman, *Asylums: Essays on the social situation of mental patients and other inmates*, (London, 1961, 1968), p. 17.

⁴³⁸ SA: SY 333/H17/1, Minute SN132, 13 Apr 1971; SA: SY 569/H1 and SA: Acc 1994/64, *passim*.

employed by the NHS from 1948 coupled with restrictions on capital expenditure, made it impossible for some to uphold this expectation of their employees.⁴³⁹

Even the USH, which retained independent sources of income after July 1948, found it difficult to expand and improve upon its stock of nursing residences sufficiently to meet the increased demand attendant on expansion in staff numbers – actual and anticipated. Capital projects were subject to strict controls, which included consideration of the costs of maintenance out of future revenue allocations. In July 1950, the Ministry of Health called the USH's Chief Administrative Officer to a 'personal interview' in London, as although the Ministry had approved the expansion and modernisation of one of the USH nurses' homes, they were not satisfied that there would be sufficient funds available for its maintenance. In the School of Nursing Committee's view, the possibility of a delay threatened to undermine their continued ability to attract recruits. The Board of Governors agreed to fund the project to the tune of £4,750 out of its capital allocation.⁴⁴⁰ The first *Quinquennial Report* of the Sheffield RHB, whose rural hospital authorities faced great difficulties in providing sufficient accommodation, favoured provision of alternative accommodation away from the hospital for trained staff. This was in accord with articles published by the *Nursing Times* in 1952 and 1953 that suggested that much hospital accommodation should be replaced as 'unsuitable or inadequate'.⁴⁴¹

Deficiency in the quantity of places available for those who wished to be resident was exacerbated by poor standards in the accommodation available. Nurses' homes in Sheffield were criticised as inadequate on several occasions between 1948 and 1974. In January 1948, an inspection of nurses' homes owned by the Infirmary was conducted by two members of the medical Staff and the Matron who found that living

⁴³⁹ SA: SY 291/H1/1, *passim*.

⁴⁴⁰ SA: SY 333/H17/1, Minute SN28, 14 July 1950 and Minute SN40, 8 Sept 1950.

⁴⁴¹ SA: SY 709/H1/1.

conditions were 'extremely poor' – in the largest home, there were one hundred and eighteen beds but only twelve baths, twelve washbasins and fifteen lavatories available. All amenities were described as 'poor', and the majority of rooms were small. Larger rooms were shared by two or more Student Nurses. The inspection team noted that for qualified nurses their room was their home, yet they had little privacy especially when family or friends visited them.⁴⁴² The Royal's nurses' homes also required improvements – but lack of money initially prevented even the installation of fire alarms.⁴⁴³

The General's Nurses' Home was already sixty years old in 1948. Although the HMC made improvements to the furniture and facilities, and by 1953 the 'Yale' locks fitted to individual room doors meant that there was '...now practically no loss of personal property,' the House Committee's inspection of the General's Nurses' Home in April revealed that toilet and bathroom accommodation was inadequate and the building was in urgent need of redecoration.⁴⁴⁴ In September 1957, the Hospital Secretary noted that extant plans for redevelopment of the hospital meant that improvements to the nurses' accommodation would not commence until the 1960s and completion was unlikely before 1970.⁴⁴⁵ His plea for work to commence immediately was unsuccessful. In 1970, his successor noted that

The main Nurses' Home is urgently in need of structural alterations to bring it to 1970 standards. There are no wash-hand basins in any of the bedrooms; there is very little privacy in the bathrooms/washrooms. The cooking facilities are unacceptable by modern standards – mainly a partitioned area off a bathroom. For junior staff there is a spirit of camaraderie from living in an old-fashioned nurses' home BUT they require and expect modern facilities to be available. An improvement scheme has been too long under discussion – action is required.⁴⁴⁶

⁴⁴² SA: SY333/H6/14, Jan 1948.

⁴⁴³ SA: SY333/H1/33, Oct 1951.

⁴⁴⁴ SA: SY569/H1/6, CGH(53)4, 16 Apr 1953.

⁴⁴⁵ SA: Acc1994/64, Box 5, MC(57)9, 14 Oct 1957.

⁴⁴⁶ SA: SY569/H1/12 *Action to improve the nursing situation – follow-up of HM(70)35*

The GNC inspection report on a visit to the General in February 1973 called for the Management Committee to make improvements in the nurses' accommodation that inspectors had requested in 1962 and again in 1967.⁴⁴⁷ In sum, the conditions in which resident nursing staff lived were sub-optimal.

Despite this, student nurses' training at the USH and HMC hospitals were still expected to be resident and, during the early 1950s, most trained nurses also lived in the nurses' home. When in 1951 the Matron of the Infirmary asked the House Committee for permission to become non-resident, the Medical Staff Committee 'regretted the break with tradition' but her request was granted.⁴⁴⁸ In April 1952, the HMC's Executive Committee advised that all nurses under twenty-one years of age should be resident during training. After reaching the age of majority, they could be non-resident as long as they lived with either their parents or someone acting *in loco parentis*.⁴⁴⁹ A memorandum prepared by two members of the Sheffield Region of the National Association of HMC Group Secretaries in late 1954 included the observation that '...nearly all Matrons prefer resident nursing staff to non-resident and those who do engage non-resident staff or permit residents to become non-resident do not do so from choice.' The writers of the memorandum commented that the Matrons' motivation was their belief that having a resident nursing staff produced an '*esprit de corps*'. The view of the authors of the memorandum was that this had as its obverse the tendency to produce a 'narrowness of outlook' among the nursing staff.⁴⁵⁰

The policy issued in 1952 was challenged in June 1954 as increasing numbers of Student Nurses asked for permission to be non-resident. Although the Management Committee did not rescind it, they compromised so that even second year students

⁴⁴⁷ SA: SY569/H1/14 – NAC(1973)4. Summary of Recommendations of the GNC, Feb 1973.

⁴⁴⁸ SA: SY 333/H6/14, 10 Apr 1951, pp. 83-84.

⁴⁴⁹ SA: SY 569/H1/5, Exec(52)4, Minute 155, 28 Apr 1952.

⁴⁵⁰ SA: SY 709/H1/1; Anon, 'A place of one's own', *Nursing Times* 1 Nov (1952); Anon, 'Free to live out', *Nursing Times* 15 Aug (1953); SA: SY 291/H1/1, Minute 339, 14 Dec (1954).

might thenceforth 'live out' with the Matron's permission. By 1958, many hospitals in the Sheffield Region permitted second and third year students to become non-resident, with parental consent, although the HMC hospitals still normally required students to be resident until the final year of training.⁴⁵¹

Student Nurses' training allowances were low and limited alternative accommodation was available during the 1950s but in 1960, the Matron of the Infirmary noted that the poor standard of the hospital's staff accommodation meant that most nurses wanted to be non-resident. In 1968, the Infirmary's League of Trained Nurses' magazine informed its readers that first year students 'are now resident' and stated that they hoped to be able to offer this service to Pupil Nurses. The USH hospitals had 'long had a problem trying to accommodate our students', but the author hoped that 'by pooling our residential resources' it would be possible to meet this need, and they had appointed a bursar with special responsibility for nursing to effect this.

In 1973, 50% of those training at the North Sheffield University HMC's hospitals were from outside Sheffield, and required residential accommodation.⁴⁵² By 1974, the balance of obligation had shifted from the student who was required to be resident to the hospital authorities that were required to provide their students with accommodation.⁴⁵³ The availability of suitable hospital accommodation was increasingly perceived to be an important factor in a hospital's success in attracting recruits whether locally or from outside the vicinity.

Non-residence for qualified nurses became the norm across England during the mid-1950s, as more qualified staff decided to live out and as more married women were

⁴⁵¹ SA: Acc 1994/64, Box 1, MC(57)9, 14 Oct 1957; SA: SY 291/H1/1, Minute 740, 23 Sept 1958; SA: Acc 1994/64, Box 1, MC(58)1, 13 Jan 1958.

⁴⁵² SA: SY 333/H3/30, Minute 64/124, 9 Nov 1964; SA: SY 333/H6/86, p. 1; SA: SY 569/H1/14, NEC(73)1, 21 Mar 1973.

⁴⁵³ SA: SY 333/H6/14, 8 Jan 1954, p. 136.

recruited either to return to nursing after establishing their families or as learners, usually to Enrolled Nurse training, or as untrained Nursing Auxiliaries. By 1956 the majority of qualified nurses were non-resident, with 54.5% of female and 79% of male qualified nurses 'living out' of the nurses' home.⁴⁵⁴ By July 1957, more members of the General nursing staff were non-resident than were resident – information that the House Committee had been 'more than a little surprised' to receive.⁴⁵⁵

While part-time work opportunities were attractive to some nurses, training programmes for qualified staff were used to recruit nurses to posts in wards and departments with the opportunity to gain the official acknowledgement of the hospital of the clinical experience gained there. This approach to recruiting and retaining staff could create problems as well as solving them. In 1958, the medical staff at the Infirmary described inexperienced theatre nurses as 'a liability'; they were qualified nurses employed ostensibly to learn the skills of operating theatre nursing, but their presence was crucial to allowing surgeons to continue performing operations.⁴⁵⁶ The role of post-basic courses in recruitment is discussed in more detail in Chapter Four.⁴⁵⁷ However, a survey of Student and Pupil Nurses at the end of their first year of training in Sheffield indicated that career prospects and security of employment were less important to female learners than working with and for people, and being able to nurse.⁴⁵⁸

In addition to improving the terms and conditions of service, and offering opportunities for promotion and career development, hospitals also acknowledged the contribution of nurses with young families through the provision of nursery and crèche

⁴⁵⁴ SA: SY 333/H6/14, 10 Apr 1951, pp. 83-84 and Minute 5, 28 Nov 1955, record discussions over the desirability of matron being allowed to be non-resident and then continuing to do so; 'Staff Nurses – Nursing Research Report' [editorial], *Nursing Times* 30 Nov (1956), p. 1217.

⁴⁵⁵ SA: Acc 1994/64, Box 5, MC(57)9, 'Report by Hospital Secretary', 14 Oct (1957).

⁴⁵⁶ SA: SY 333/H6/14, Minute 3, 2 Dec 1958.

⁴⁵⁷ See Section 4.6.

⁴⁵⁸ SA: SY 569/H1/14, NEC(73)1, 21 Mar 1973.

facilities. Crèche facilities were first offered by the Infirmary in 1970, when a daytime service was opened in the 'Recreation Room'.⁴⁵⁹ This does not appear to have continued for long as the crèche was reopened in 1972, when the *League of Trained Nurses Magazine* reported that this facility allowed 21 nurses – equivalent to 12 full-time staff - to return to work at the hospital.⁴⁶⁰ The General also opened a nursery in 1970, offering facilities to staff at this and another Sheffield hospital.⁴⁶¹

Increasing the number of nursing hours available to meet demand for care for the increasing number of patients treated remained challenging, in spite of the above efforts to improve the terms and conditions of service. Matrons actively sought recruits from among cohorts of the city's school-leavers. However this did not produce sufficient recruits. Therefore, hospitals increasingly recruited nurses from non-traditional sources. These included men, mature women – especially as SENs – and overseas recruits.

Throughout the period from 1948 until 1974, the majority of nurses working in hospitals in Sheffield were women; in 1969 only approximately seven percent of nurses in general hospitals in Britain were male. Male nurses were more likely than their female counterparts to have left school without educational qualifications, to have worked in unrelated employment before entering nursing, and to be older on entering nurse training. They were also approximately twice as likely to come from a manual working class background than their female colleagues.⁴⁶² Conversely, they were less likely to have family members in the medical and related professions than were female nurses. The immediate post-war years were an exception to this, as men who had served in the various medical corps of the armed forces were encouraged to enter

⁴⁵⁹ SA: SY 333/H6/88, p. 16.

⁴⁶⁰ SA: SY 333/H6/90; SA: Acc 2001/98, Matron's Reports, 14 Feb 1972.

⁴⁶¹ SA: SY 569/H1/11, 8 June 1970.

⁴⁶² J G Rosen and K Jones, 'The male nurse', *New Society*, 9 Mar 1972, pp. 493-494.

nursing on accelerated programmes of pre-registration training, although not all hospitals were approved as training schools for men. The Sheffield School of Nursing did not apply to the GNC for approval to train male nurses until February 1947, when the GNC granted provisional approval until 1949.⁴⁶³ During the early post-war years, the majority of male nurses recruited had previously worked as medical or sick berth attendants, or held a qualification in mental nursing and were seeking a second qualification in general nursing.⁴⁶⁴

In June 1950 the promotion of male nurses to junior Charge Nurse grade was reported as a 'new venture' at the Infirmary, while male nurses were employed at this grade at the General by 1954. By 1974 male nurses were more likely to have been promoted to senior posts than were their female colleagues with comparable levels of experience after qualifying.⁴⁶⁵ Recent research on the role of men in nursing indicates that hospitals were able to adapt to socioeconomic changes in requirements for nursing and make good use of the contribution of male nurses to the provision of care.⁴⁶⁶ However, the number of men training at the Royal, for which the most detailed biographic information is available, was very low, especially after 1950 when numbers of ex-servicemen entering nurse training fell.⁴⁶⁷

As noted in Chapter Two, the SEN qualification was presented as an opportunity for mature women – or those who wanted to undertake a more practical training programme.⁴⁶⁸ In January 1950, the School of Nursing Committee confirmed its

⁴⁶³ SA SY333/H17/1, 11 Feb 1947, Minute 140.

⁴⁶⁴ SA: Acc 2001/98, Royal Hospital Nurses' Register 12 to 15, 1944 to 1951.

⁴⁶⁵ SA SY 333/H6/68, p18; J G Rosen and K Jones, 'The male nurse', *New Society*, 9 Mar 1972, pp. 493-494.

⁴⁶⁶ B Brown, P Nolan, P Crawford 'Men in nursing: ambivalence in care, gender and masculinity' *International History of Nursing Journal* Vol 5(3), (2000), pp. 4-13.

⁴⁶⁷ SA Acc 2001/98, Royal Hospital Nurses' Register 12 to 15, 1944 to 1951.

⁴⁶⁸ Department of Health for Scotland – Standing Nursing and Midwifery Advisory Committee, *The State Enrolled Assistant Nurse in the National Health Service* (Edinburgh, 1955), p. 4, paragraph 5; M Dixon 'People at work - what nursing means to mature pupils' *The Guardian* 5 Mar 1968, p. 10;

policy that the USH hospitals should not seek approval to offer 'Assistant Nurse' training, although Fir Vale offered this route to a nursing qualification throughout the period.⁴⁶⁹ In 1955, the Executive Committee of the Infirmary's League of Trained Nurses, which included the Matron and the Principal Nurse Tutor of the hospital, discussed and rejected a proposal to admit SEANs. The League's policy was only to admit nurses who had trained at the Infirmary and the hospital did not train Enrolled Assistant Nurses until the late 1960s. Acknowledging this, the Executive Committee's rejection of the proposal went further, arguing that:

The SEAN should not be considered for entry to the National Council of Nurses, and we feel it should only be SRN on the Roll of the National Council of Nurses; even though they applied for membership through their 'Roll of Nurses' they should not be admitted to the National Council of Nurses as associate members.⁴⁷⁰

In 1969, a further approach was made as the very existence of the League was threatened by the cessation of independent recruitment of students to the two USH general hospitals. The Infirmary was already experiencing a loss of nurses who were leaving in a 'steady stream' to the new specialist oncology hospital, Weston Park, and the new teaching hospital, the Hallamshire.⁴⁷¹ 'Miss Lowarch said that now nurses were being trained for their SEN examinations at the RI it would be an advantage if these nurses could be admitted as League members.' An Extraordinary General Meeting of the League voted to admit them in November 1970, but the poll of 154 to 106 in favour indicates that a substantial minority of League members disagreed with the change.⁴⁷²

Sheffield Number One HMC *A Simple and Practical Course of Training as a State Enrolled Assistant Nurse, (Sheffield, ?1960).*

⁴⁶⁹ Sa SY333/H17/1, 6 Jan 1950, Minute SN372

⁴⁷⁰ SY, 333/H6/45, 17 Aug 1955.

⁴⁷¹ SY 333/H6/88, pp. 1, 5.

⁴⁷² SY 333/H6/46, 25 Nov 1969, Executive Committee, p. 24; SY 333/H6/88, p. 5; SY 333/H6/46, 7 Nov 1970, EGM, p. 32.

The introduction of Pupil Nurse training in 1968 hints at greater acceptance of the grade at the Infirmary. Yet there was still uncertainty over the Enrolled Nurse's place in the ward hierarchy. The GNC issued guidance in March 1968 that while Enrolled Nurses were always senior to first and second year students, it was for Matrons to determine whether an Enrolled Nurse or a third year student should be treated as most senior. The Enrolled Nurse was trained, and the student was not, but '[V]ery careful consideration should be given, however, to the placing of these two grades in the nursing team, taking into account the need for the student to learn to take responsibility.' The GNC failed to take the opportunity to clarify the position of the Enrolled Nurse, instead issuing ambiguous guidance. At the Infirmary, 'Matron told the Sisters that Enrolled Nurses were not to be placed at the bottom of ward off-duty lists, but in the appropriate position for their qualification.'⁴⁷³

In September 1973, it was suggested that increasing the number of Senior SENs employed by the acute general hospitals in the group by 9.5 would - after meeting initial costs of £996 during the first two years - save £100 each year by substituting them for SRNs when the latter retired. In 1974 it was noted that two Senior SENs were to substitute for one Ward Sister on the establishment of the Infirmary's psychiatric unit, Whitely Wood Clinic.⁴⁷⁴

Overseas recruits to nurse training were also of increasing importance to the overall workforce by the second half of the 1960s, although reservations were expressed by Matrons and their medical and administrative colleagues when the recruitment of overseas nurses and learners was first discussed in 1948.⁴⁷⁵ In October 1948, it was alleged to the Nursing Committee of Sheffield RHB that one (unnamed) hospital had

⁴⁷³ SA: Acc 2001/98, Matron's Meetings with Sisters, Minute 878, 19 Mar 1968.

⁴⁷⁴ SA: SY 333/H16/12, 24 Sept 1973 and 15 Mar 1974.

⁴⁷⁵ SA: SY333/H17/1, Minute 274, 9 Sept 1948; D Hiro, *Black British, White British*, (London, 1971, 1973)

decided to admit a maximum of eight 'colonial Student Nurses', and the RHB was asked whether it intended to fix the proportion of 'colonial' students admitted for training. They resolved to leave this to the discretion of each HMC. In January 1949 it was reported that across the Sheffield Region, there were thirty-three 'colonial' nurses employed. In an unspecified number of cases, the nurse's employment was arranged through the Colonial Office, in others independently through the hospitals, and in others via the Church Missionary Society. At the same meeting, the RHB's Nursing Committee received advance notice that the Ministry of Health was to advise HMCs that a maximum of only eight colonial nurses were to be employed in any one hospital, and that this was to be done only after consultation with the Colonial Office.⁴⁷⁶ In December 1953 Sheffield Region's HMC Group Secretaries predicted that expedients including the recruitment of nurses from 'certain European countries' would not bridge the gap between demand and supply. They concluded that 'some form of dilution of nurses will be necessary...It would appear that much of the basic nursing will ultimately have to be undertaken by nursing attendants.'⁴⁷⁷

At the end of December 1959, the number of overseas nursing and midwifery students, thirty-one, was very similar to the 1949 level. A year later, in December 1960, the number had increased to 406, of whom 255 were undertaking student training, and 64 were undertaking Pupil Nurse training. A survey requested by the Ministry of Health in December 1961 revealed that there were 247 Student Nurses in the region who had been recruited in twenty-seven different countries in the British dependencies, independent Commonwealth and the Republic of Ireland, and a further 169 students of overseas origin who had been recruited in the UK. There were also fifty-five Pupil

⁴⁷⁶ SA: Acc 1987/55, Nursing Subcommittee, 17 Jan 1949.

⁴⁷⁷ SA: SY 569/H1/6, 2nd Supplementary Report on 'Nursing and Nurse Training at City General Hospital'. 8 Apr 1953; SA: SY 291/H1/1, 'Report of the Subcommittee to Consider Economy in Manpower' [discussion of first draft], 15 Dec 1953.

Nurses who had been recruited in their home countries, and ninety-one pupils of overseas origin recruited in the UK.⁴⁷⁸

The sharp increase in the number of nurses recruited overseas is consistent with Marwick's observation that there was 'something of an upturn' in immigration during 1960, followed by an even greater increase in numbers during 1961, following the Conservative Government's announcement that they planned to introduce legislation to limit the numbers of immigrants allowed to enter the UK. Legislation in February 1962 allowed for people offering particular skills to receive greater consideration than others when seeking to enter the country, but removed the right of settlement in the UK granted under the 1948 British Nationality Act to all people of British citizenship, whether of UK, colonial or independent Commonwealth origin.

However, the number of nursing students from overseas continued to increase in spite of some incidents of racism in Sheffield and the restrictions imposed by the 1962 Immigration Act. An article published in Sheffield in mid-1961 claimed that 'racialists' were campaigning against overseas workers. Its author claimed that without overseas Doctors in particular, 'Sheffield would be in a sorry plight where life and death are concerned.'⁴⁷⁹ In December 1964, there were 704 Student and Pupil Nurses from the Commonwealth training at hospitals in the Sheffield Region, or 15% of nurses in training, of whom 238 were originally from Jamaica. Across the United Kingdom, it was estimated that from approximately 5,700 overseas nurses in 1959, the number had risen to 16,882 in the year 1966 to 1967 and 18,546 in 1970. Of these nurses, 90% were from the Commonwealth countries, and they made up 30% of nurses in training by 1970.

⁴⁷⁸ SA: Acc 1987/55, Nursing Subcommittee, 19 Feb 1962.

⁴⁷⁹ 'Sheffield's debt to overseas doctors', *Sheffield Forward*, 6:264, June 1961, p. 1

While the number of people born overseas who were training as nurses was known, the number who were employed was not, although information collected by Sheffield RHB in 1961 and a study conducted during the mid-1960s each indicated that the majority remained to work or undergo further training in the United Kingdom. Sheffield RHB Nursing Committee noted in early 1961 that while successful during nurse training, 'colonial' nurses 'rarely proceeded to more senior nursing posts after qualification'. They attributed this to reluctance on the individual's part, although they also sought further information about where the nurses went after training.⁴⁸⁰ In 1969 it was estimated that between a quarter and one third of nurses employed in Britain were from overseas, although research suggests that they faced considerable prejudice at work and outside.⁴⁸¹

The Royal and Infirmary's records indicate that a small number of nurses were recruited from continental Europe, particularly during the late 1940s and 1950s, with a larger minority from Eire. The more limited records surviving from the General indicate a small number of recruits from overseas, including various Commonwealth countries, such as Jamaica and Nigeria, and non-Commonwealth countries, including Thailand, from the 1950s onwards. When the Jamaican High Commissioner visited Sheffield in October 1974 arrangements were made for him to visit the General in response to his request to meet hospital staff of Jamaican and West Indian origin, but the majority of nurses recruited to the Sheffield hospitals appear to have come from Sheffield or the towns and counties neighbouring the city.⁴⁸²

⁴⁸⁰ SA: Acc 1987/55, SRHB Nursing Committee, 20 Feb 1961

⁴⁸¹ Oscar Gish, 'A note on aid for nurse training in Britain', *Journal of Development Studies*, Volume 5, Apr 1969, pp. 220-222; M N Kendall, 'Overseas Nurses', *New Society*, 9 Aug 1973, p. 239; SA: Acc 1987/55, SRHB, Meetings 1-19, 1948-1949; SY, 1987/57, SRHB, Nursing Committee, 15 May 1961; SA: CA523(1), *Further Education Subcommittee*, Sheffield Youth Service – West Indians in Sheffield, A Study Group Report', (Sheffield, 1965); Baxter, *The Black Nurse*; Hiro, *Black British, White British*, gives an account of a 'colour bar' that operated in a Sheffield dance hall in 1954, p. 34..

⁴⁸² SA: Acc 2001/98, Royal Hospital Nurses Registers 1901-1966/1948-1966; SA: Acc 2001/98 Royal Infirmary, Nurses' Records, 1947-1974; [private collection], *City General Hospital Register of Nurses*,

The number of trained nurses increased at Sheffield's general hospitals between 1948 and 1974 but as noted above this did not represent a significant increase in the proportion of trained staff in the nursing establishment. Moreover, the increase in numbers of trained nursing staff was not sufficient to meet the demand for nursing time. At the Infirmary, there were 'frequent periods' when untrained members of staff were left in charge of wards during the late 1940s, and particular problems in staffing the departments, especially the Accident Department, which lacked qualified nursing staff cover at night.⁴⁸³ Student Nurses were frequently used to address shortfalls in the nursing staff of each one of the general hospitals. The medical staff at the Infirmary objected to the frequent movement of nurses, in 1947 noting that this made it difficult to ensure that students received a full range of experiences in each of the clinical areas in which their training took place.⁴⁸⁴ The tenor of their objections thereafter changed, as the Infirmary experienced a prolonged period of nursing staff shortages.

Moving nurses round to deal with staff shortages was 'routine practice' at the General during the 1950s. In 1954, the Infirmary medical staff suggested that nurses should remain on a ward or department for at least three months after their appointment. They were concerned, in part, that the time involved in moving nurses from one ward or department to another was distracting the Matron from her 'normal duties'. They supported the appointment of an Assistant Matron whose role was to organise the Student Nurses' clinical experience.⁴⁸⁵ The record of their discussions indicates that

1947-1952 (RN4), 1956-1959 (RN6); SA: Acc 1987/55, Sheffield Area Health Authority (Teaching) 24 Sept 1974, 7 Oct 1974.

⁴⁸³ SA: SY 333/H3/28, Minute I.359, 19 Sept 1949; SA: SY 333/H6/14, 'Nursing Staff Problem', 4 Nov 1949.

⁴⁸⁴ TNA: PRO DT 33/456; SA: SY 333/H6/14, 8 Dec 1947.

⁴⁸⁵ SA: SY 333/H6/14, 7 Mar 1955 and 26 Apr 1955.

they were then more concerned that there should be sufficient nursing staff on duty, whether in the operating theatres, the out-patients' departments, or on the wards.⁴⁸⁶

Low numbers of qualified nursing staff in Sheffield's general hospitals, especially at night, meant that students were working at levels of responsibility beyond those that the GNC considered acceptable. The GNC noted that students training at the Infirmary at the time of their Inspection in 1957 were sent to the radiotherapy and psychiatric wards at night, even if they had not been sent there on day duty in order to gain familiarity with the nursing care required by the patients. The Inspector noted that 'It is very obvious that the Student Nurses are "used" to staff these units on night duty, and that training, and the value of the experience in these units is not considered.'⁴⁸⁷ In 1959, the Infirmary's medical staff discussed inadequacies in the care of surgical patients, intra-operatively and post-operatively, by inexperienced theatre nurses and junior students. They wrote new rules for the care of anaesthetised patients, but concern over the lack of sufficient trained and experienced nursing staff to care for very ill patients continued throughout the 1960s.⁴⁸⁸ GNC Inspectors' reports indicate that students were used to cover acute shortages of staff at the General: 'Moves sometimes have to be made for the sake of expediency, and Student Nurses are often sent for a few hours to another ward to fill temporary vacancies caused by sickness.' The amount of time spent by students on night duty exceeded the maximum allowed by the GNC in 1967 and again in 1973.⁴⁸⁹ In the latter year, the PNO of the Teaching Division at the HMC observed that

⁴⁸⁶ SA: SY 333/H6/14, 10 July 1951, 20 Sept 1954, 7 Mar 1955, 4 June 1956; SA: SY 569/H1/15, July 1948.

⁴⁸⁷ TNA: PRO DT 33/456.

⁴⁸⁸ SA: SY 333/H6/14, *passim*.

⁴⁸⁹ SA: SY 569/H1/6, 'Second Supplementary Report on Nursing and Nurse Training at City General Hospital', 8 Apr 1953; SA: SY 569/H1/8, Report on 6th Visit of the GNC, 15 Feb 1967; SA: SY 569/H1/14, NAC(1973)4, Feb 1973.

Whatever the factors contributing to wastage may be it must be realised that at the present time learners are doing three times the *minimum* night duty recommended by the GNC. Secondly, they are frequently left alone on wards at night which is contrary to GNC policy and that in some cases have to take their meals in the wards because there is no-one to relieve them. Furthermore, the number of weeks in Study Block is the minimum now allowed. It is not suggested that these are the only causes of wastage but they must be contributing.⁴⁹⁰

A corollary to the use of students to cover staff shortages was that, when recruits could not be found, particularly for specialised posts, arrangements were made to provide appropriate training for staff already employed in another capacity by the hospital. This was a strategy used by the Royal Infirmary on three occasions during the 1960s.

Despite efforts made to increase the number of nursing hours available, or to make more use of the staff available, senior nurses also found it necessary to reduce the nursing workload. Closure of beds, either on a permanent or a temporary basis – the latter for cleaning or redecoration of wards – was one way in which Matrons sought to do this.⁴⁹¹ In February 1952, staffing levels were so low at the Infirmary that the Matron requested permission to close wards completely, in turn, during the summer holidays in anticipation of being unable to provide sufficient nurses.⁴⁹² That October, the Royal's Matron asked permission to close wards for cleaning, also to ease the nursing shortage, although the House Committee rejected her proposal.⁴⁹³ The General deferred its planned February 1952 School of Nursing intake until March, and while the intake then increased from five to fourteen the number of Pupil Assistant Nurses recruited at Fir Vale the following month was not as high as anticipated.⁴⁹⁴ Matrons also negotiated with their medical and administrative colleagues for temporary

⁴⁹⁰ SA: SY 569/H1/13, 'Policies and Priorities 1972/1973 – Teaching Division', [PNO, D Brookes].

⁴⁹¹ See Section 6.3.

⁴⁹² SA: Acc 2001/98, Matron's records, 18 Feb 1952.

⁴⁹³ SA: SY 333/H14/5, H(52)217, Minute 217, 14 Oct 1952.

⁴⁹⁴ SA: SY 569/H1/5, Exec(52)2, 14 Feb 1952; Exec(52)3, 24 Mar 1952; CGH(52)3, 13 Mar 1952; FVI(52)3, 14 Mar 1952.

reductions in operating lists, in order to relieve the pressure of work on their nursing staff.

Nursing responsibilities were redefined and various tasks were reassigned to non-training and non-nursing staff from the qualified and learner nurses. The employment of the former was viewed as a means by which trained and learner nurses could be enabled to conserve their time for nursing, and for those aspects of nursing that required training. As noted above, by 1970, the proportion of non-training unqualified nursing staff had reached a similar level in both the General and Infirmary, but their presence provoked an ambivalent response. Simultaneously valued for their contribution to the expanding nursing service, but suspected of lowering the overall quality of nursing care, each hospital made efforts during the early 1970s to reduce their number in favour of trained nurses and learners.

Finally, all three general hospitals in Sheffield reduced the number of nursing hours required by redefining some work originally done by nurses and transferring it to the responsibility of non-nursing staff. Examples of this include clerical and domestic work, although responsibility for venepuncture was returned to the medical staff at the Infirmary – with some resistance from the latter.

The Infirmary experienced 'very poor results' in the Preliminary State Examinations during 1948. The School of Nursing Committee discussed this at their meeting in January 1949, but blamed the large size of the cohort and 'inadequacy of Teaching Staff' at the time. The School also lacked basic teaching equipment, and had no nursing library. An internal investigation by the Infirmary's House Committee recommended that a form of the 'block' training system, allowing students to be released from their ward duties for 'blocks' of time in order to attend classroom teaching and examination revision, could be facilitated by the appointment of ward

assistants and might lead to improvement. Staff shortages delayed implementation of the recommendation, which was to be funded using money originally intended for nursing recruitment. The Infirmary's Matron suggested that the appointment of clerical assistants on the wards could also relieve nurses of non-nursing duties, and one 15-year old ward assistant was appointed for a three-month trial period in November 1948. The Matron estimated that her appointment had saved approximately 60% of nursing time by March 1949.⁴⁹⁵ Despite this, revenue cuts imposed a delay of a further two months before the House Committee could approve the appointment of more ward assistants. In May 1949, the House Committee agreed that further appointments could be made 'in order to allow the introduction of a modified block system for nurses' training'.

Nonetheless, the Tutors produced a Plan of Training, incorporating a 'Block System', which was received and approved by the School of Nursing Committee in June 1949, immediately submitted to the Board of Governors, and received the latter's approval on 1st July 1949. In July, the Matron reported to the Infirmary's House Committee that the School of Nursing intended to introduce a 'full block system', which would mean the closure of either one large or two small wards at the hospital, regardless of their efforts to avoid this.⁴⁹⁶ The first block was to take place between 11th and 23rd July 1949. Further discussion followed, and a 'modified block system' of training was introduced on the instruction of the Board of Governors. This meant that throughout the year, twelve nurses would be absent from each of the unit hospitals' wards.⁴⁹⁷

Coincidentally, the Infirmary medical staff's written agreement to closure of wards for cleaning was secured in July 1949, though they stated that this was not because the

⁴⁹⁵ SA: SY 333/H3/27, Minute I.86, 15 Nov 1948, and Minute I.207, 21 Mar 1949.

⁴⁹⁶ SA: SY 333/H3/27, Minute I.229, 11 Apr 1949; SA: SY 333/H3/28, Minute I.248, 16 May 1949 and Minute I.301, 18 July 1949.

⁴⁹⁷ SA: SY333/H17/1, Minutes 297, 300-301, 20 Jan 1949; Minute SN326, 3 June 1949; Minute SN332, 1 July 1949; Special Meeting, 26 July 1949.

block training system had been introduced. Nevertheless, the anticipation that this might lead to further ward closures by the end of the year was a cause of great concern. Introduction of the block training system reduced the nursing hours available to the Infirmary and the Royal, but the proposal at the Infirmary to use the funds set aside for recruitment of nurses to recruit ward assistants suggests that the hospital was already experiencing difficulties in recruiting sufficient nurses. Repeated advertisements for additional qualified nurses had 'brought little or no response' by July 1949.⁴⁹⁸ The Matron's suggestion that one of the terms of the ward assistants' employment at the Infirmary should be that they would agree to consider entering nurse training once they attained the minimum age of entry is also indicative of the desire to improve recruitment.⁴⁹⁹

The existence of staff shortages at the Royal the following year is implicit in the records of the House Committee; in March 1950, the House Committee agreed to recommend the appointment of eight ward orderlies to the Establishment Committee. In September 1950, the Medical Superintendent at the General, Dr Clancy, wrote to the HMC's General Purposes Committee, stating that the nursing shortage there had led to a 'serious situation' on the medical and surgical wards, which was likely to 'deteriorate during the winter months'. He alleged that '...at some periods there were no persons in the wards to whom patients could call in an emergency', and proposed the employment of additional ward orderlies to alleviate the shortage. The Hospital Secretary reported that the Matron had already written to suggest this to him, and the HMC Chairman had agreed that the hospital would employ four ward orderlies. The General Purposes Committee confirmed his action and agreed to remove an

⁴⁹⁸ SA: SY 333/H1/33, Minute H.375, 19 July 1949.

⁴⁹⁹ SA: SY 333/H3/27, Minute I.207, 21 Mar 1949.

appointment freeze instituted in June 1950 in order to allow more such appointments.⁵⁰⁰

The General experienced a shortage of senior qualified nursing staff on night duty in December 1950, but following consultation with the RHB in February 1951 they determined on closing nearly a fifth of the hospital's beds in order to address the problem.⁵⁰¹ Despite these 'drastic' measures, the hospital's problems persisted. In March 1952, the Executive Committee approved a proposal to relax the procedure on filling casual vacancies as long as resulting levels of staff did not exceed total establishment figures. This meant that 'Staff Nurses, Student Nurses, State Enrolled Assistant Nurses, Pupil Assistant Nurses, Nursing Assistants and Ward Orderlies should be regarded as interchangeable'.⁵⁰² The adoption of this expedient suggests that there were then insufficient nurses to provide even the most basic nursing care and that the need to employ anyone in order to get the work done had become paramount. It also suggests the existence of ambivalent attitudes towards the need for qualified nurses in the provision of patient care, a recurrent theme in nursing occupational politics and in the history of the NHS.⁵⁰³

Having been employed in increasing numbers as a matter of expediency during an acute shortage of trained and student nursing staff in 1953, auxiliaries were perceived by some to have demonstrated their worth.⁵⁰⁴ In October 1955 the USH Establishment Committee decided that they should not be included on the nursing staff establishment,

⁵⁰⁰ SA: SY 569/H1/3, GP(50)8, 25 Sept 1950.

⁵⁰¹ SA: SY 569/H1/4, GP(50)11, 8 Dec 1950; MC(51)2, 12 Feb 1951; GP(51)2, 26 Feb 1951 and 28 Mar 1951; Joint Conference of HMC and Nursing Committee of the RHB, 28 May 1951; Exec(51)2, 9 July 1951; MC(51)7, 23 July 1951; Exec(51)4, 10 Dec 1951; MC(51)11.

⁵⁰² SA: SY 569/H1/5, Exec(52)3, Minute 104, 24 Mar 1952.

⁵⁰³ C Davies, *Gender and the Professional Predicament in Nursing* (Buckingham, 1995), pp. 19-42 and 133-152; Miers, *Gender Issues*, pp. 111-127; S M Reverby, 'A caring dilemma: Womanhood and nursing in historical perspective' *Nursing Research* 36(1), pp5-11; S M Reverby, *Ordered to care: the dilemma of American nursing 1850-1945* (Cambridge, 1987).

⁵⁰⁴ SA: SY 291/H1/1, 15 Dec 1953; Lee, 'Dependence on the Auxiliary', *Nursing Times*, 28 June 1968, Volume 64(26), pp. 865-866.

but nonetheless they should continue to be employed instead of Student Nurses, as required to augment the nursing numbers.⁵⁰⁵ The number of full and part-time Auxiliaries employed rose steadily until it reached a peak of 114 in June 1962. Thereafter, the numbers fell, yet the avoidance of ward closures at the Infirmary in 1966 was attributed to their presence in the hospital, as was the successful training of Student Nurses in more advanced nursing work because Auxiliaries were doing the repetitive work and allowing the students to learn specialised skills.⁵⁰⁶ This argument was used to support an increase in the number of Nursing Auxiliaries on the staff establishment, originally agreed in 1959 but exceeded in the intervening years in order to cover a shortfall in Student Nurse numbers.⁵⁰⁷

While increasing the numbers of auxiliaries provoked 'serious anxiety' that the standard of nursing care possible would be compromised, they were accepted as an essential part of the nursing team at local hospital level.⁵⁰⁸ Ward orderlies would primarily be expected to relieve nurses of non-nursing domestic duties, allowing them to devote more time to clinical nursing tasks, while the employment of auxiliary grade staff appears to have been a response to the need to increase the capacity of the nursing staff to provide direct care when faced with restrictions on recruitment. Notwithstanding this, when expenditure on nursing staff salaries increased during the 1970s, all three hospitals sought to restrict and even reduce the number of auxiliaries in order to control staffing costs.⁵⁰⁹ However, the alternative possibility of providing entirely non-nursing personnel to perform non-nursing but patient-care oriented work in order to contain the workload of qualified nurses was explored in several ways

⁵⁰⁵ SA: SY 333/H16/14, Minutes E 96/55, E 108/55, 25 Oct 1955.

⁵⁰⁶ SA: SY 333/H3/31, Minute 66/99, 10 Oct 1966.

⁵⁰⁷ SA: SY 333/H3/31, Minute 66/96, 10 Oct 1966.

⁵⁰⁸ Royal College of Nursing and National Council of Nurses of the United Kingdom, *A Reform of Nursing Education – First Report of a Special Committee on Nurse Education*, (London, 1964), pp. 6-8, paragraphs 19-20 and table; Berridge, *Health and Society in Britain*, p. 47.

⁵⁰⁹ SA: SY 333/H1/36, 10 Oct 1971 and 30 Dec 1971.

between 1948 and 1974, including the employment of Ward Orderlies, increased numbers of domestic staff, messengers and porters and from 1970, the creation of Ward Housekeeping teams.

The recruitment and retention of nurses had a profound impact on the provision of care within the hospital setting. The availability of sufficient nurses determined the capacity of a hospital to provide a clinical service. In 1955, Sheffield RHB blamed the lack of sufficient nurses as the main reason why they felt that they had to lower their ambitions to expand the Region's hospital bed numbers. Conversely, while the absence of an agreed formula for the calculation of nursing needs may have contributed to the problem, senior nurses in the hospitals became engaged in a continual process of defining the role of nurses in hospital care, a theme that is revisited in Chapter Five. This helped to facilitate change in the way in which 'nursing' was perceived by nurses themselves, at least in the scope of clinical nursing responsibilities. Preparation for those roles and responsibilities, and how this changed between 1948 and 1974, is now considered in the Chapter Four.

4. 'These very uncertain days' - Nurse Training in Sheffield, 1948 to 1974⁵¹⁰

The only way a patient outside an intensive care unit can receive nursing care by trained staff is either from a 'private' nurse or a member of a religious order (God or Mammon); otherwise he is nursed by student or untrained staffs.⁵¹¹

The GNCs, established by the 1919 Nurses' Registration Act, applied the statutory framework for the development, approval and maintenance of nurse training in the hospital-based nursing schools, and for the undergraduate degrees linked to registration in nursing offered by Universities and Polytechnics from the 1950s.⁵¹² However, many factors other than the GNC syllabus for the State Examination influenced nurse training. Not the least of these was the status of Student and Pupil Nurses as employees of the hospital in which they were training.⁵¹³ As indicated above, Student and Pupil Nurses in Sheffield provided a significant proportion of the hospital's nursing workforce during the training period, were often used to address staff shortages in specific areas of the hospital and were a source of qualified staff thereafter. Furthermore, nursing involved both 'basic' and 'technical' nursing, and the latter became increasingly specialised during the post-war period. Nurse training and education was thus not only essential to the provision of a flexible sub-section of the nursing workforce, it was crucial to ensuring that each cohort was able to develop the range of skills and knowledge required in order that the hospitals could provide the increasing quantity and complexity of health services required within the NHS.

This chapter examines the development of nurse training in the USH and the HMC hospitals between 1940 and 1974, from the initial establishment of separate training schools to the gradual amalgamation of nurse training in the city that began to take

⁵¹⁰In full: 'In these very uncertain days, when the Nursing Profession and particularly Nursing Education comes in for so much criticism and discussion...' SA SY333/H6/66, p. 1.

⁵¹¹B White, 'Personal view', *British Medical Journal* 18 Jan (1969), p. 179.

⁵¹²TNA: PRO MH 133/328, 20 Mar 1950; J MacGuire, 'The function of the "set" in hospital controlled schemes of nurse training', *British Journal of Sociology* 19 (1968), pp. 271-283.

⁵¹³Dingwall, Rafferty and Webster, *Social History*, pp. 119-121.

place from 1963 onwards. The contribution of nurse training to the ability of the hospital to provide clinical nursing care is considered through examination of the recruitment and retention of Student and Pupil Nurses, and the delivery of pre-registration and post-registration courses. Discontinuous schemes for the training of Nursing Auxiliaries are also described.

4.1 Nurse Training in Sheffield – the Sheffield School of Nursing

Under the 1922 Rules of the GNC for England and Wales, a hospital was required to provide experience in gynaecological and children's, as well as in medical and surgical, nursing. It was also expected to have 'at least one resident medical practitioner', and 100 beds with 75% occupancy in a voluntary hospital or 250 beds in a Poor Law infirmary, before it could be approved as a training school.⁵¹⁴ In Sheffield the Royal and the Infirmary were united under private legislation passed in 1938 in order to rationalise the provision of voluntary general hospital services in the city and facilitate conjoint appointments of senior medical staff in pursuit of this objective.⁵¹⁵ Despite their legal union, the range of clinical specialities practiced at the hospitals was narrow. The extent of collaboration over clinical care was limited initially and attempts to avoid duplication of effort were slow to develop.

The Junior Medical Staffs of the Royal Sheffield Infirmary and Hospital had reviewed arrangements for the training of nurses in January 1939, and their Staff Club Report recommended that the hospitals should establish a joint Training School for nurses. There was general agreement 'in principle' with the Staff Club's suggestion, but the Court of Management took no further action initially. However, at the outbreak of World War Two, the paediatric and gynaecology wards at the Infirmary were closed in order to release acute beds for use by war casualties, rendering the available

⁵¹⁴ Bendall and Raybould, *General Nursing Council*, pp. 60-61.

⁵¹⁵ Ministry of Health, *Hospital Survey: Sheffield*, p. 18.

experience in those fields of nursing care insufficient to meet GNC requirements.⁵¹⁶ Professor Ernest Finch, a surgeon at the Infirmary, reminded colleagues in January 1941 that a Complete Training School had to provide experience in medicine, surgery, gynaecology and children's diseases - and the Royal and Infirmary could no longer do so.⁵¹⁷ Members of the nursing staff were aware of and supportive of proposals to address this threat to the status of the hospitals as Complete Training Schools from early 1941, at least. The means by which the threat was to be averted was the creation of a single School of Nursing.⁵¹⁸

Although there appears to have been further discussion during 1941, it was not until 1942 that planning began in earnest. In February 1942, the Royal's Nursing Committee, which comprised members of the honorary medical staff and lay people serving on the hospital's House Committee, met to '...consider co-ordination of the nursing services of the voluntary hospitals in Sheffield'. They were mindful that Sheffield's voluntary general hospitals would probably not meet GNC criteria for recognition as a Complete Training School. In the view of the members of the Nursing Committee, it would be preferable in terms of prestige, remuneration and recruitment to the hospitals if they were to retain Complete Training School status. As individual units, the Royal and Infirmary could only achieve the status of 'Associated Training School' under extant GNC Rules, and would thus become dependent on other hospitals to allow students to meet outstanding training requirements.⁵¹⁹ The Royal Sheffield Infirmary and Hospital's plans for a new teaching hospital, to be built near to the University of Sheffield, did not include increasing the number of gynaecology and

⁵¹⁶ Ministry of Health *Hospital Survey: Sheffield*, p. 19; SA: SY 333/H1/17; SA: SY 333/H6/69, pp. 5-6.

⁵¹⁷ SA: SY 333/H14/5, Special Committees, 'Report of a Meeting of the committee Appointed to Consider the Coordination of the Nursing Services of the Voluntary Hospitals and the Establishment of a Sheffield School of Nursing', 18 Jan 1942.

⁵¹⁸ SA: SY 333/H6/59, 'Recent changes in our training school', pp. 5-7.

⁵¹⁹ SA: SY 333/H14/5, Special Committees, 'Meeting of Representatives of the Four Voluntary Hospitals on Coordination of Nursing Services', 9 Mar 1942.

child patients and were still several years from realisation at the most optimistic estimate. It was concluded that a Sheffield School of Nursing should therefore be proposed, with the collaboration of all four voluntary hospitals. This would encompass the Children's Hospital and the Jessop Hospital for Women – thus ensuring that students would be able to gain the full range of clinical experiences required by the GNC.

The final recommendation of the committee appointed by the Court of Management to consider the coordination of the nursing services of the Voluntary Hospitals was to establish the Sheffield School of Nursing. Thereafter, the Court of Management established a School of Nursing Committee, to which all four constituent hospitals sent representatives, and which their Matrons attended. The 'definitive date' for the opening of the school was to be 1st June 1944. It was originally planned to include a Preliminary Training School [PTS], General Training School [GTS] and School for Sick Children's Nurses. Nursing students from the Infirmary and the Royal were to be sent to the Children's Hospital for three months and to the Jessop Hospital for Women for a further three-month period during the second year of their training programme. Before this, the School required them to have passed both parts of the GNC's Preliminary State Examination.⁵²⁰

The NPHT was involved in the development in an advisory capacity, especially with regard to domestic arrangements for the accommodation of students, but also encouraged collaboration between Sheffield's voluntary and municipal hospitals. The Hospital Surveyors favoured such intersectoral collaboration in the establishment of Schools of Nursing. The survey team met with those proposing to establish the Sheffield School of Nursing when they visited the city in 1942 and their 1945 report

⁵²⁰ SA: SY 333/H6/69, June 1951, pp. 5-6; SA: SY 333/H17/1, 27 July 1942, 17 Jan 1944.

indicates their approval. They also advised that students from the Sheffield School of Nursing should spend some time gaining experience in the city's infectious diseases hospitals, tuberculosis sanatoria, and the Nether Edge and Fir Vale Infirmary Public Assistance Institutions.⁵²¹

In early November 1943, representatives of the four voluntary hospitals met to discuss the possibility of including the municipal hospital, the General, in the proposed PTS. While three of the partners were willing to cooperate with the General, the Jessop Hospital for Women's representative expressed concern that the size of the General's staff would have an 'unfortunate impact' on the size of the PTS. The British Hospitals Association (BHA) had recommended that the maximum number of pupils in a PTS should be between thirty and forty students. The Sheffield School of Nursing would already exceed this number, with fifty recruits planned in order to ensure that there would be sufficient students to prevent serious depletion of staff on the two general hospitals' wards when second year students were away for six months, gaining children's and gynaecological nursing experience.⁵²²

The Chairman argued at the meeting that regionalisation of hospital services was likely to lead to larger Preliminary Training Schools, but that meanwhile, the General already had a PTS, established in 1938, and would anyway only send their students to the proposed joint PTS.⁵²³ Thereafter they would return to the General for the balance of their training. The Committee agreed to recommend cooperation and referred their decision to the Sheffield Municipal and Voluntary Hospitals Advisory Committee. The General appears to have been approached with a view to its students being invited to participate in the PTS. Nothing had come of this tentative attempt at intersectoral cooperation by April 1944, although the reasons for this are not clear from the

⁵²¹ SA: SY 333/H17/1, 17 Apr 1944; Ministry of Health, *Hospital Survey: Sheffield*, pp. 10, 78, 82.

⁵²² SA: SY 333/H17/1, 3 Nov 1943.

⁵²³ Medical Officer of Health Report, *Sheffield*, 1939, p. 24.

surviving records.⁵²⁴ Annual Reports of Sheffield's municipal hospitals during the Second World War indicate that, having established its PTS in 1938 in order to address recruitment problems, they had sufficient students and either had no need to participate or did not wish to jeopardise their early success. The voluntary hospitals went ahead with the scheme alone.

The new School lacked accommodation for a PTS initially, but this was not then a GNC requirement, and the decision to establish the Sheffield School of Nursing without it was confirmed in July 1943. A centralised PTS was established in July 1947. By then it had become urgent, as the GNC warned that the provision of a PTS would be a condition of approval as a General Training School with effect from May 1947.

In April 1944, a Supervising Tutor was appointed, and an advertisement for students was placed in the national and local press, as well as in nursing and women's journals.⁵²⁵ During the first year of its existence, 89 students entered the Sheffield School of Nursing, of whom 28 left before completion of the trial period, and a further ten resigned during the first year of service. The advertisement noted that students were required to sign a contract for a training period of four years' duration. This was the normal period of training at the Royal, though not at the Infirmary, prior to its incorporation in the new School. Following consultation with the GNC, it had also been established that this was the norm for provincial nurse training schools.

By 1948, the four-year duration of training was held to be deterring potential students from applying, and it was recommended that the training period should be described as of three years' duration followed by one year's service as a Staff Nurse.⁵²⁶ This would

⁵²⁴ SA: SY 333/H17/1, 15 May 1944.

⁵²⁵ SA: SY 333/H17/1, 29 June 1944.

⁵²⁶ SA: SY 333/H17/1, Minute 234, 10 Feb 1948.

mean that the fourth year students would be re-graded as Staff Nurses, and would receive a salary on the Rushcliffe Scale of £140 per annum, as opposed to the £95 earned by fourth year students. However, the Matrons Committee reminded the School of Nursing Committee that in July 1942 it had been agreed that nurses in the fourth year of training would be released in order to train in midwifery at the Jessop Hospital or in Sick Children's Nursing at the Children's Hospital, for a maximum of six months. The training period remained four years until 1950, when it was reduced to three.⁵²⁷

Members of the medical and surgical staffs, qualified Sister Tutors, Ward and Departmental Sisters were responsible for most of the teaching in the School. Lecturers from the University of Sheffield taught anatomy and physiology.⁵²⁸ Previously the Honorary Medical staff had taught these subjects to the Student Nurses in the hospital buildings. The new arrangement lasted until August 1951, when the cost - £520.17s.6d - was questioned. The University was unwilling to reduce the fees and the USH Board of Governors asked the School of Nursing Committee to make alternative arrangements for the teaching of these subjects.⁵²⁹

In March 1945, the Governing Bodies of the constituent hospitals agreed that the City's Education Committee, and a representative of the Headmistresses' Association 'or other appropriate body' should be invited to send representatives to the School of Nursing Committee. The 'appropriate body' whose representative served on the Committee was the National Union of Teachers, as the largest representative body of teachers in the city. The Matrons' Committee, comprising the Matrons of the four constituent hospitals and the Supervising Tutor, was charged with responsibility for the

⁵²⁷ SA: Acc 2001/98, Meetings with Sisters, 5 March 1950.

⁵²⁸ SA: SY 333/H17/1, 27 June 1945.

⁵²⁹ SA: SY 333/H16/9, Minute F266, 26 Sept 1949; Minute F748, 28 May 1951; Minute F758e, 27 June 1951; Minute F835, 27 Aug 1951.

day-to-day operation of the School, selection of Student Nurses, supervision of domestic arrangements in the PTS, and advising the School of Nursing Committee.

In 1950, a new constitution was approved for the School of Nursing, and the committees that had previously managed it were reconstituted in May to form a new School of Nursing Committee that included representatives from the Sheffield Head Teachers Association and the University of Sheffield, as well as a former assistant to Sheffield's Director of Education.⁵³⁰ The reconstituted School of Nursing Committee continued to meet until 1952, when as a result of reorganisation of the USH administrative committees, its functions were subsumed within those of the newly formed Nursing Services Committee. The four Matrons and the Principal of the School of Nursing were to be 'in attendance' at this Committee.⁵³¹

The local press claimed that the establishment of the Sheffield School of Nursing was radical and innovative.⁵³² In certain respects this was the case – it predated the recommendations of the Hospital Surveyors in 1945 and of the Working Party Report in 1947 that nurse training should be reorganised around schools based on groups of hospitals. The creation of a School of Nursing that was not situated in a hospital building was controversial. It highlighted tensions between the roles of education and clinical practice and ambivalence amongst nurses over the separation of the two spheres. The *League of Trained Nurses'* magazine referred to statements by unspecified 'others' in Britain that separation of a school of nursing from the hospital would 'produce theoretical nurses' at the expense of 'practical bedside nursing'.⁵³³

⁵³⁰ SA: SY 333/H17/1, Minute SN413, 14 Apr 1950; SA: SY 333/H16/9, Minute A350, 16 Jan 1950; Minute A365, 20 Feb 1950; Minutes A393(50) and A394(50), 20 Mar 1950.

⁵³¹ SA: SY 333/H16/9, Minute A808, 19 Nov 1951; Minute A831, 17 Dec 1951; Minute A20, 18 Feb 1952.

⁵³² SA: SY 333/H1/47, Joan Shillitto, 'Girls who staff our Hospitals', *Sheffield Star* 25 Oct 1948.

⁵³³ SA: SY 333/H6/69, 'Report on the School of Nursing', pp. 5-6.

As late as 1954, it was suggested by the medical staff of the Infirmary that the centralisation of the School and its removal from the hospital had exacerbated the difficulties that Sheffield experienced in recruiting students. These difficulties were not shared by other teaching hospitals in Leeds, Liverpool, Manchester and Newcastle.⁵³⁴ GNC inspectors voiced criticisms in both 1957 and 1965 of the lack of awareness on the part of Ward Sisters of the requirements of the GNC syllabus for students' clinical learning on the ward, apparently in spite of efforts on the part of the tutors to inform them.⁵³⁵ While the Sheffield School of Nursing incorporated novel features, the records of its creation and the absence of substantial evidence that the School's creators made more than tentative efforts to involve the city's other hospitals indicates that it was a pragmatic response to the threat to the voluntary hospitals' approval to train nurses, rather than a bold experiment in nurse education.

4.2 Nurse Training in Sheffield – The Nurse Training School at the General

The General had offered a three-year training programme since at least 1906, when it was the Sheffield Union Hospital. Students training there in 1906 all appear to have been 26 years of age or more. Although no details were kept of what they did prior to commencing nurse training, they had come to the hospital from several parts of Britain, and later found work as far away as the United States of America and South Africa.⁵³⁶ The hospital's size and the range of medical work conducted at the General meant that it was recognised as a Complete Training School by the GNC.⁵³⁷

⁵³⁴ SA: SY 333/H6/14, 8 Jan 1954, p. 136.

⁵³⁵ TNA: PRO DT 33/456, 9 Oct 1957 and 12 May 1965.

⁵³⁶ Miss Jobling's personal effects [private collection]; Fir Vale Hospital 22 Sept 1881– [typewritten copy of a report in the *Sheffield and Rotherham Independent* of 23 Sept 1881]; T J Caulton, 'The Sheffield Workhouse near Kelham Island' in *Aspects of Sheffield 1. Discovering Local History*, ed. M Jones (Barnsley, 1997); Yorkshire [West Riding] Sheet CCLXXXVIII. 16. Surveyed in 1890, Revised and Resurveyed in 1902, (Southampton, 1905); Yorkshire [West Riding] Sheet CCLXXXVIII. 16, Resurveyed 1890, revised 1934-1935 (Southampton, 1937)

⁵³⁷ Bendall and Raybould, *General Nursing Council*, pp. 60-61.

However, while the hospital could offer the range of clinical experiences required to meet the GNC's criteria, its approval as a Training School was questioned in 1950 and 1967. The poor physical environment and lack of modern equipment rendered working conditions in many clinical areas at the hospital inadequate, and this was exacerbated by the lack of sufficient qualified tutorial and clinical staff to teach and supervise students. GNC Inspectors in 1950 and again in 1967 gave the hospital only 'provisional approval' as a nurse training school. In 1950 the condition of the built environment gave most concern, while in 1967 deficiencies in the practical experience and classroom instruction of trainees were blamed. In spite of these concerns, the GNC continued to approve the hospital as a training school, and even 'provisional approval' meant that nurse training could continue while recommended improvements were awaiting implementation.⁵³⁸

GNC inspectors' reports were sometimes greeted with hostility, on the grounds that they made '...incursions into the wide fields of hospital structure, design and furnishing'.⁵³⁹ In July 1953, the HMC suggested that evidence from the Association of HMCs to the Guillebaud enquiry should include criticism of the GNC, as the inclusion of reference to necessary capital works in their recommendations meant that they had 'become a serious embarrassment financially and administratively, to Management Committees'.⁵⁴⁰ Concern that the GNC exceeded the bounds of their responsibilities was again expressed in 1954 and 1959.⁵⁴¹ Yet the records of the HMC indicate that

⁵³⁸ SA: SY 569/H1/6, CGH(53)4, Minute 49, 16 Apr 1953; SA: SY 569/H1/9, GNC Inspectors' Reports: City General Hospital, Fir Vale Infirmary, Nether Edge Hospital.

⁵³⁹ Memorandum to Association of HMCs with suggestions for inclusion in evidence to Guillebaud Committee, SA: SY569/H1/6, Sept 1953.

⁵⁴⁰ SA: SY 569/H1/6, 'Memorandum to the Association of HMCs', July 1953.

⁵⁴¹ SA: SY 291/H1/1, 15 Nov 1954, and 1 July 1959.

when the GNC made recommendations, they took action to implement each of them, identifying actions taken or explaining why they could not be met, as appropriate.⁵⁴²

Although members of a single HMC, three hospital units - The General, Nether Edge Hospital and Fir Vale - did not form a single nurse training school until the late 1960s. Fir Vale and Nether Edge Hospital trained Pupil (Assistant) Nurses, and the General trained only Student Nurses until 1967. The RHB Nursing Committee raised the possibility of amalgamating the three Training Schools in 1950, but it was not discussed by the HMC until 1954, when a national shortage of trained nurse tutors prompted the Ministry of Health to issue circular HMC(54)75 on the 'Function, Status and Training of Nurse Tutors'. The HMC asked the Matron, Hospital Secretary and Medical Superintendent of each unit hospital to consider the potential implications of implementing recommendations for the recruitment and training of nurses, which referred *inter alia* to establishment of Schools of Nursing covering groups of hospitals.

The reports expressed several reservations about the formation of a group School of Nursing. The General's Matron and Medical Superintendent objected to the proposal to remove responsibility for the allocation of learners to the wards from the Matron and transfer it to the nurse tutors.

The suggestion of these as a responsibility of the Nurse Tutor is fresh and possibly practical but Dr Clancy and Matron think that the application of this might cause conflict between the Matron and the Nurse Tutor, as Matron is the overall head and might not agree with a delegated responsibility. Matron has, of course, first interest in patients. A Nurse Tutor's first interest is in the training of the Nurse.⁵⁴³

They also observed that the GNC was not in favour of pupils and students sharing ward placement experiences, and they would therefore have to segregate the wards

⁵⁴²SA: SY 333/H16/10, Minute GP39, 29 Mar 1971; SA: SY 569/H1, *passim*; SA: Acc 1994/64, Box 4, MC(55)2, 7 Feb 1955.

⁵⁴³ SA: Acc 1994/64, Box 4, CGH(54)1, 'Report on the 'Function, Status and Training of Nurse Tutors (Circular HM(54)75)' 9 Dec 1954.

used in training if a group training school were to be established. The Nether Edge Hospital report raised fewest objections, but noted that learners would have to travel further to move between classroom and clinical area, and it was objected that this would increase attrition; those who did not leave would lose training time. The Fir Vale report suggested that pupils required particular skills on the part of tutors that those who trained students did not possess, and that '...only the most competent tuition will make the best of the available material and prevent intolerable 'wastage'.' The General and Fir Vale units were in any case perceived to be large enough to provide the range of clinical experience necessary to their own trainees, and able to make appropriate arrangements to secure exchanges of students with other hospitals where necessary to achieve a suitable breadth of clinical practice. The circular recommended the institution of three-month secondments of Ward Sisters to the School of Nursing, and similar periods of training away from the wards to prepare them for their teaching role. This was welcomed, and it was even suggested that Ward Sisters should receive financial recognition on attainment of the additional skills, though this was not implemented. However, their loss from the wards during this time would cause difficulties for the hospitals. The Fir Vale *ad hoc* committee was alone in questioning the assumption that a shortage of tutors existed – they contended that those who were available were inappropriately distributed.⁵⁴⁴

Notwithstanding these objections, during the following two decades the separate schools gradually became more closely aligned. Initially, separation of Student and Pupil Nurses into different ward areas was eroded by changes in Pupil Nurse training which essentially acknowledged the shifting boundaries between acute and chronic care, and that requirements for skilled hospital nursing could not be met by relying solely on the recruitment of SRNs to the acute wards. During the 1950s, Fir Vale's

⁵⁴⁴ SA: Acc 1994/64, Box 4, NEH(54)11, 8 Dec 1954; SA: Acc 1994/64, Box 4, CGH(54)12, 9 Dec 1954; SA: SY FVI(54)11, 10 Dec 1954.

Matrons argued the need for improved nursing staff establishments at the hospital by challenging the automatic assumption that 'geriatric' care was unquestionably equivalent to 'chronic' care, contending that their patients required increasingly complex nursing that involved acute as well as rehabilitative care skills, and these were not those required by traditional - custodial - models of care. Not only were more nurses required, but also more of those employed should be trained and skilled.⁵⁴⁵

From the mid-1960s, developments in the management of nurses at local and national level facilitated further changes. First, the anticipated amalgamation of the City General Hospital and Fir Vale Infirmary to create the Northern General Hospital in 1967 led the Management Committee to request approval from the GNC for the formal integration of nurse training on the site, which was given in 1966. The GNC Inspection report for Nether Edge Hospital in 1967 indicates that the Matron and the Chairman of that unit's House Committee were reluctant for their hospital to become part of the group, as this would involve the 'withdrawal of approval as a recruiting hospital' from Nether Edge Hospital. However, from 1971, the implementation of the Salmon reforms of senior nursing management completed the process of integration through the creation of a Teaching Division that encompassed the school at Nether Edge Hospital as well as that at the General.⁵⁴⁶

Contemporary with these developments in the administrative and nursing management structures of the HMC was a gradual shift in emphasis in the GNC requirements for nurse training, which is evident both in the inspectors' reports following visits to the HMC hospitals in 1967, and in the revised syllabus issued in 1969. Initially, Pupil

⁵⁴⁵ SA: Acc 1994/64, Box 4, Exec(55)1, Minute 35, 24 Jan 1955; SA: Acc 1994/64, Box 4, FVI(55)2, Minute 17, 11 Feb 1955; SA: Acc 1994/64, Box 4, FVI(55)3, Minute 26, 18 Mar 55; SA: Acc 1994/64, Box 4, Fin(55)4, 'Special meeting on the Nursing Situation at Fir Vale', 27 Apr 1955.

⁵⁴⁶ SA: SY 569/H1/8, GNC Reports on Sixth Visits: City General Hospital, Fir Vale Infirmary, Nether Edge Hospital, Feb 1967; SA: SY 569/H1/10, NEC(69)1, 19 Mar 1969; SA: SY 569/H1/13, NAC(72)2, 'Teaching Division Report, 1971-1972'.

Nurses moved from the long-stay wards to gain experience of acute medical and surgical nursing care, but from 1969 Student Nurses' clinical training included either ward experience in the care of older people or community nursing, where they would also meet predominantly older people.⁵⁴⁷

4.3 The Gradual Amalgamation of Nurse Training in Sheffield, 1963-1974

It has been noted that an attempt was made during the development of the Sheffield School of Nursing to forge a link between the General and Sheffield School of Nursing. During the 1950s and 1960s, separate Schools of Nursing existed at the General and USH, although there were examples of cooperation between them. For example, from January 1964, when the GNC syllabus for Student Nurse training expanded to require experience of ophthalmic, ear nose and throat, orthopaedic and dermatology nursing, which could not be achieved at the General, students from the General's Training School were sent to USH wards.⁵⁴⁸ It appears that these arrangements were made without reference to the GNC. The Inspector's report on the Inspection of the General in February 1967 notes that the secondment was 'noticed during a visit to the Royal Hospital' in 1965, when it was first approved and its continuation was upheld at the 1967 visit to the General.⁵⁴⁹ The USH could not offer its learners experience in the care of older people, which the GNC required for Pupil Nurses and, from 1969, required for Student Nurses. When the Sheffield School of Nursing began to offer Pupil Nurse training, they arranged with the HMC that the learners should visit the HMC hospitals' wards for experience in the care of older people.

⁵⁴⁷ SA: SY 333/H6/90 1972.

⁵⁴⁸ Bendall and Raybould, *General Nursing Council*, pp. 190-192.

⁵⁴⁹ Records of GNC Inspectors' visits indicate that the arrangement was noticed during the visit to the Royal Infirmary, which took place on the same day. See TNA: PRO DT 333/465 , 7 Apr 1965; SA: SY 569/H1/8, GNC Report on Sixth Visit, 15 Feb 1967.

The reorganisation of senior nursing management after acceptance of the Salmon Report of 1966 was the precursor to amalgamation of the several hospital schools of nursing in Sheffield. In reality, the creation of the Sheffield School of Nursing in 1944 had not brought the unit hospitals' nursing staffs together for more than classroom tuition. The Royal, the Infirmary and Children's Hospital each recruited their own nurses, and it was not until the implementation of the Salmon reforms that the Sheffield School of Nursing acquired responsibility for recruitment, training and allocation of students to the different hospitals.⁵⁵⁰

In November 1971, confidential proposals for an 'Education Centre for Sheffield' were presented to the USH General Purposes Committee. Drafted by the most senior nurse in the Sheffield School of Nursing, Miss Hunt, this anticipated that the education of nurses from pre-nursing to the post-registration stage, alongside midwives, social workers, physiotherapists, radiographers and orthoptists, would take place on one site, the whole to be supported by a hospital careers recruitment and advisory service. The publication of the Committee on Nursing's (Briggs Committee) report, the creation of the '1974 Area Health Boards' under the reorganisation of the NHS, and the Seebohm Report on Community Services, would all have implications for this new institution. She noted that closer links between hospital and community were already being established, as 'All learners are to have experience in Community Care, thus the nurses in training are already crossing the boundaries of HMCs and Board of Governors.'⁵⁵¹ The General Purposes Committee supported the proposal, and recommended its adoption as policy by the Board of Governors, although they would have to await the creation of the new Area as approval in principle was required from them before implementation could proceed. Although all non-medical health care and social work

⁵⁵⁰ SA: SY 333/H6/88; SA: SY 569/H1/13, NAC(72)2, 'Teaching Division Report, 1971-1972'.

⁵⁵¹ SA: SY 333/H16/10, V Hunt, PNO (Teaching), USH, 'Education Centre for Sheffield' [marked 'in confidence'], 11 Nov 1971.

students would have been involved in the School that Miss Hunt suggested, the General's records do not contain reference to this entity.

However, this proposal for a multi-disciplinary pre-registration education centre did not survive the reorganisation of the NHS. On 21 March 1973, the NAC of the HMC noted that the Nursing Working Party of the Sheffield Area Joint Liaison Committee 'envisaged' the creation of an Area Nurse Training School – or Education Centre. The model eventually approved in 1973 was for this more limited model, as already agreed for Nottingham, Leicester, Grimsby, and Rotherham. The Sheffield Hospital Careers Committee wrote to the North Sheffield University HMC in May 1973 that the new School would be able to 'make the best use of the clinical facilities which existed in all the City hospitals' and 'would be able to withstand any changes in administration under the Regionalisation of the NHS'. Amalgamation followed NHS reform and the new training arrangements commenced in 1975.⁵⁵²

4.4 Recruiting and Retaining Student and Pupil Nurses

Lorentzon has noted that, during the early years of the twentieth century, most recruits to nursing were between 23 and 27 years of age, with 23 considered by the *Nursing Times* to be ideal. The modal age at recruitment fell to between 18 and 22 during the inter-war years, following the GNC's establishment of 21 years of age as the minimum for entry to the Register.⁵⁵³ School leaving age was set at 14 by the 1918 'Fisher' Education Act and raised only to 15 by the 1944 'Butler' Education Act, so that there were between three and four years during which potential recruits who had completed

⁵⁵² SA: SY 333/H16/10, Minute GP165, 29 Nov 1971; SA: SY 333/H16/11, Minute GP135, 30 Oct 1972; SA: SY 333/H16/12, Minute GP66, 21 May 1973; SA: SY 569/H1/13, NAC(72)2, 'Teaching Division Report, 1971-1972'; SA: SY 569/H1/14 NAC(73)2, Minute 16, 21 Mar 1973; SA: SY 569/H1/14 MC(73)5, Minute 19, 14 May 1973; SA: SY 333/H6/93.

⁵⁵³ M Lorentzon, 'Nurse Education at the London Homeopathic Hospital 1903-1947: preparation for professional specialists or marginalised Cinderellas?', *International History of Nursing Journal* 5:2, (2000), pp. 20-27.

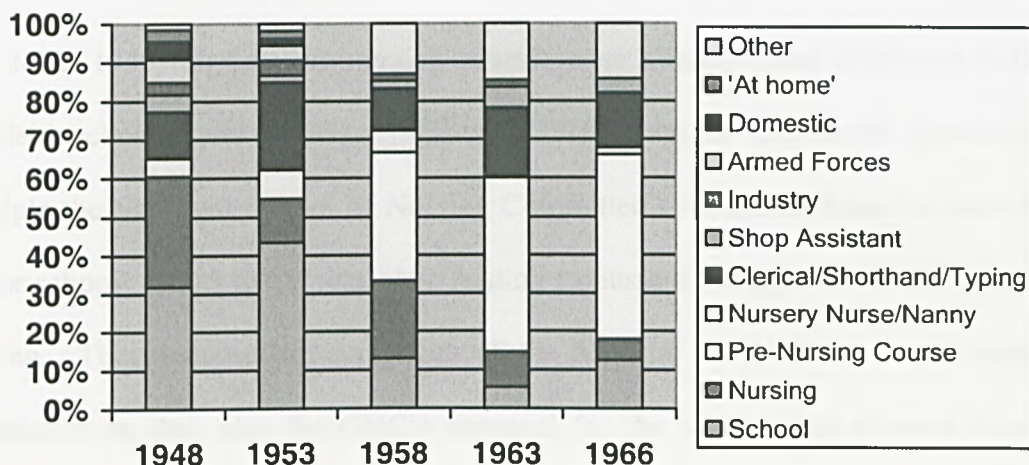
their general education might find alternative employment before commencing nurse training.

Reports of Matrons to hospital House Committees, and in the *League of Trained Nurses'* magazine, noted that various attempts were made to familiarise schoolchildren with hospital life, in order to attract them into nursing. Schoolchildren were invited to visit the various hospital departments for one or two days at a time, or volunteer through community projects to spend time with patients, particularly those who were in hospital for long periods, talking with them and helping them with letter writing. Senior nurses from the hospitals also went out of the hospital to schools to talk to schoolchildren. The Sheffield hospitals established a Careers Committee, which the various hospitals' Matrons attended, to consider recruitment strategies.⁵⁵⁴

In July 1941, a confidential outline of proposals for secondary education after the Second World War was circulated as the 'Green Book'. This set out plans for raising the school leaving age to 16 but requiring 16 to 18 year olds who had left school and entered employment to attend 'Day Continuation Schools' and proposed that attendance would form part of the individual's normal working week. Continuation Schools were originally modelled on German Trade Continuation Schools and were first introduced by the 1918 Education Act in order to allow young people to continue with their education on a part-time basis, but were lost to economies in government spending on education during 1921 and 1922, before they had become firmly established. The Day Continuation Schools proposed in the 1941 paper would have constituted a new approach to adult continuing education and discussion of the facilities occupied nearly half of the 'Green Book'. The curriculum was to have vocational as well as spiritual, physical and social dimensions. The 1944 Education

⁵⁵⁴ SA: SY 333/H16/4, 1958; SA: SY 333/H6/83, p. 1.

Act did not enact all proposals of the Green Book – the school leaving age was raised only to 15, not 16, for example and the proposals for the continuation of education were attenuated – but it gave local education authorities powers to provide classes in



4.1 Table of prior occupations declared by students of the Royal Hospital Sheffield, 1948, 1953, 1958, 1963 and 1966.⁵⁵⁵

'appropriate' subjects. Cooperation between Sheffield Local Education Authority and the Schools of Nursing in the city appears to have developed in the context of this policy framework for the expansion of further education provision.⁵⁵⁶

The Yorkshire Council for Further Education met in Leeds on 12 June 1944 to discuss Pre-Training for Nursing and Pre-Nursing courses and certainly invited the Sheffield School of Nursing to send a representative. Representatives resolved to welcome courses established in mainstream educational facilities for girls intending to enter nursing. They approved in principle the Yorkshire Council for Further Education's recommendations that additional full-time courses and schools to prepare girls for nursing and similar occupations should be established and that there should be closer

⁵⁵⁵ SA: Acc 2001/98, Royal Hospital Nurses Register 1948-1966, *passim*.

⁵⁵⁶ Ministry of Reconstruction – Adult Education Committee, *Final Report*, Cmd 321 (London, 1919), Paragraph 189, pp. 105-106; M Sanderson, *Educational Opportunity and Social Change in England* (London, 1987); PHJH Gosden and PR Sharp, *The Development of an Education Service – The West Riding 1889-1974* (Oxford, 1978); Timmins, *Five Giants*, pp. 77-78; SA: SY 709/H1/1, p. 82..

cooperation between hospitals, local authorities, the GNC and others in implementation of these programmes.⁵⁵⁷ These decisions clearly identified nursing as an occupation for females, and that courses preparing prospective nurses would be directed towards girls.⁵⁵⁸

In October 1945 full-time pre-nursing courses were already being offered in 'a few' Sheffield schools, and in May 1952 the USH Board of Governors approved in principle the Sheffield School of Nursing Committee's recommendation to provide a 'junior school' for 15 to 18 year olds, leading to nurse training at the USH School of Nursing. They secured the agreement of the Ministry of Health to an increase in expenditure on this, also the GNC's approval for the scheme that allowed it to be categorised as a pre-nursing scheme, as well as the agreement of the city's Director of Education to the establishment of part-time programmes at technical schools to provide the students with general education. Agreement was reached on the pre-nursing scheme and the joint venture between the Sheffield School of Nursing and the city's Education Department began in September 1952.⁵⁵⁹

Originally, Pre-Nursing programmes were approved by the GNC to prepare students to take Part One of the Preliminary State Examination before they entered the School of Nursing programme. Programmes accepted students from the age of 15, and provided them with four days of education and one day of 'visits' to the hospital and 'kindred institutions and public works' during the first year. During the second, they had three days of education and two hospital days, and in the third and final year, two days of education and three days of hospital duties including attendance on Saturday mornings. During the first two years, the pre-nursing students were entitled to school holidays,

⁵⁵⁷ SA: SY 333/H17/1, 29 June 1944

⁵⁵⁸ J G Rosen and K Jones, 'The male nurse'.

⁵⁵⁹ SA: SY 333/H16/1, Minute 91(52), 5 May 1952.

but in the final year, their annual leave entitlement was as for Student Nurses, 28 days.⁵⁶⁰

Extant records indicate that by 1958 a growing number of students recruited to the Royal were entering through the Pre-nursing programme. The overall proportion of students entering training at the Royal either directly from school or following some nursing experience fell as the proportion of those undertaking the pre-nursing programme increased. It appears that the programme provided an alternative to these sources of recruits, rather than an additional route. The General Hospital also ran a pre-nursing 'cadet' programme for girls too young to enter nurse training. This commenced in 1939, although the hospital consulted the RHB and the Local Education Authority on its redevelopment between 1948 and 1961. In 1953, approximately one third of students entering the hospital's School of Nursing had been pre-nursing students, but by June 1960, the proportion had risen to 89.5%. The cadets at the General received one day of general education each week, with one and a half hours of lectures in the hospital, and undertook a rota of duties in the hospital's departments lasting 31 hours each week.⁵⁶¹

From September 1966, the Pre-Nursing School was centralised to recruit students for all Sheffield's hospitals. In the academic year 1966 to 1967 the Centre had a total of 115 pre-nursing students and nursing cadets pursuing courses of 'school standard', leading to qualifications of up to General Certificate of Education (GCE), Ordinary Level, standard, and student numbers were expected to increase to 135. The duration of the programme was reduced to two years when the school leaving age increased to

⁵⁶⁰ United Sheffield Hospitals, *Pre-Nursing Education Scheme*; SA: SY 333/H16/4, 1955.

⁵⁶¹ SA: SY 569/H1/2, Staff and Establishment Subcommittee, 16 Sept 1949; SA: SY 569/H1/6, CGH(53)6, Minute 6, 11 June 1953; SA: Acc 1987/55, SRHB Nursing Committee, 20 Mar 1961.

sixteen years of age in 1967, and the pattern of attendance in school and hospital was adjusted to allow for this.⁵⁶²

Pre-nursing programmes did not eliminate attrition. Of those Sheffield School of Nursing students who undertook the clinical aspect of their nurse training at the Royal and started their training in 1948, only 48.5% completed the course. The completion rate for those who started in 1953 was 69.81% but thereafter, although the pre-nursing programme was established, the wastage rate was persistently between 37% and slightly over 38%. Of 100 who commenced training between 1961 and 1962 at the Infirmary, 28 students left – seven each to marry, because of ill health, because they were unsuitable, or because they did not like nursing.⁵⁶³ This compares favourably with attrition rates for Student Nurse training at the General of 45% in 1964 and 48% in 1965, improving to 29% in 1966. The rate in 1972 was 49% overall, with 50% of students leaving during the first year of training.⁵⁶⁴

However, research conducted in Manchester RHB hospitals and published in 1961 indicated that cadet schemes, involving a balance of further education and hospital experience, varied widely in their expectations of the cadets and in the amount of practical support they received from senior nurses, but successful schemes had a beneficial effect on attrition rates.⁵⁶⁵ Senior nurses and hospital administrators in Sheffield considered that the city's programmes contributed usefully to reducing wastage from nurse training programmes. In May 1952, the Matron of the General sought permission through the House Committee to increase the numbers of students recruited through the pre-nursing programme, as more than 50% of students recruited

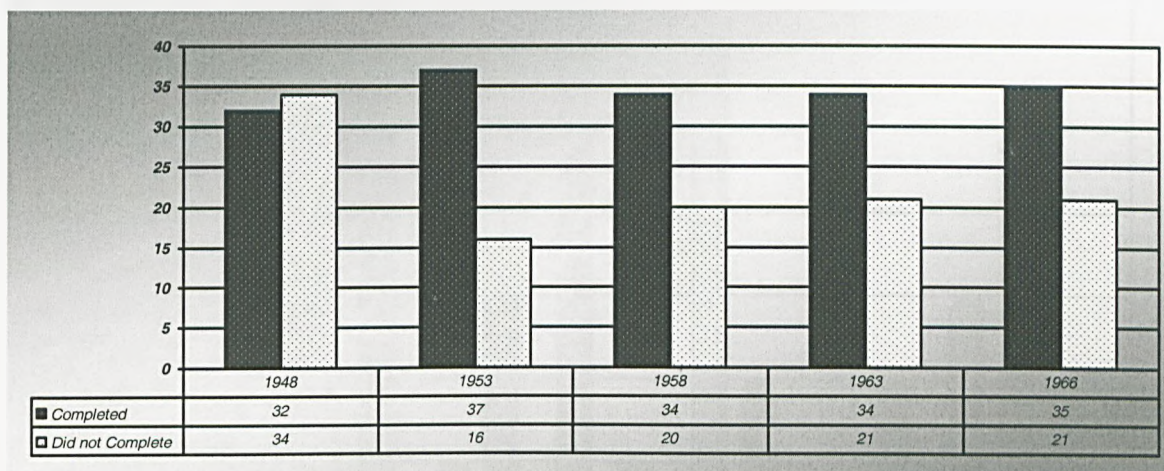
⁵⁶² SA: SY 333/H6/84; SA: CA 523(1-2); Sheffield Hospitals Careers Committee, *Pre-Nursing Course for All the Sheffield Hospitals* (Sheffield, c.1966/67).

⁵⁶³ SA SY333/H3/31, 9 Nov 1964, Minute 64/124.

⁵⁶⁴ SA SY569/H1/8, NUR(67)8, 15 Nov 1967, Minute 37; SA SY569/H1/13, NEC(72)1, 22 Mar 1972, Minute 20; SA SY569/H1/13 NAC(72)2, Teaching Division Report 1971-1972; SA SY569/H1/13, May 1972, Policies and Priorities 1972/73, Teaching Division.

⁵⁶⁵ V Chambers, 'Cadet Schemes, recruitment and wastage', *Nursing Times*, 20 Jan 1961.

directly left the training programme before completing their studies, while only 12 of 71 recruited from the pre-nursing programme had done so.⁵⁶⁶ This positive outcome was sustained. In September 1968, Sheffield's Student Nurse attrition rate was one in four, compared to a national average of one in three.⁵⁶⁷



4.2 Numbers of students completing and not completing nurse training at Royal Hospital Sheffield, 1948-1966.⁵⁶⁸

Nurses who left the hospital were expected to inform the Matron's office of the reason for their resignation. The reasons recorded by the Matron's office should be treated with caution, as even a faithful record of what was said by the student on departure reflects only what she was willing to disclose. One difference between the reasons given for discontinuation before and after the establishment of the pre-nursing programme associated with the Sheffield School of Nursing is that the number of those who left because they had failed an examination or found the course difficult halved. Other reasons appear to have been less subject to change, with a small number of students in each of the years leaving because they were homesick or disliked nursing.

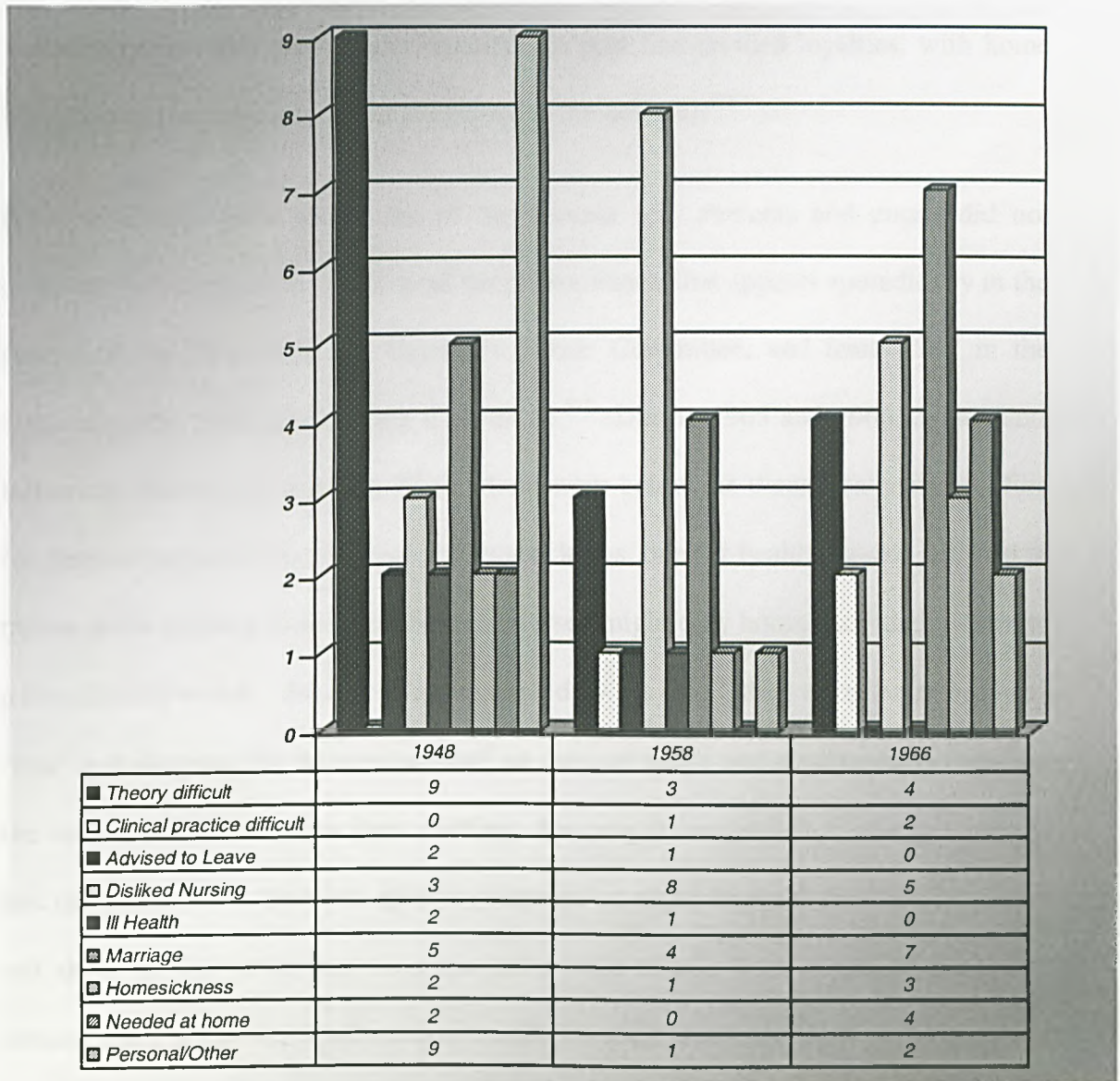
Marriage was also a common reason for leaving. Marriage had ceased to be a bar to continuing nurse training during the Second World War, although it was accepted as

⁵⁶⁶ SA: SY569/H1/5, CGH(52)5, 15 May 1952, Minute 96, and CGH952)10, 13 Nov 1952, Minute 191.

⁵⁶⁷ B Hickman, 'Prenursing experiment', *The Guardian*, 10 Sept 1968.

⁵⁶⁸ SA: Acc 2001/98, Royal Hospital Nursing Records, 1948-1966, *passim*.

legitimate grounds for the student leaving the hospital, and while she might have 'a moral and legal obligation to honour her contract', hospital authorities in Sheffield were prepared to recommend that no 'positive action' be taken against such students.



4.3 Reasons for non-completion of training: students from Royal Hospital Sheffield Unit, 1948, 1958, and 1966.⁵⁶⁹

There was, though, no legal basis for them to impose a financial penalty on the former student.⁵⁷⁰ This position was changing by the second half of the 1960s – the nursing staff records indicate that those who wished to leave when they married had to give the additional reason of pregnancy in order to convince the hospital that they should be

⁵⁶⁹ SA: Acc 2001/98, Royal Hospital Nurses Register 1901-1966/1948-1966, *passim*.

⁵⁷⁰ See, for example, SA: SY 333/H17/1,

allowed to break their contract, when marriage alone had sufficed before. Whether this is indicative of changes in behaviour on the part of Student Nurses, or of changes in what they were prepared to tell the Matron's office is not clear from available evidence. Conversely, in the view of the senior nurses who wrote reports on the students, nurses who married but remained in post had divided loyalties, with home life reducing their interest in and allegiance to the hospital.⁵⁷¹

It is possible to elicit some idea of the reasons why students and pupils did not complete their training at the General from information that appears sporadically in the reports of the Matron to the General's House Committee, and from 1967 in the minutes of the General's Nursing Committee.⁵⁷² During 1965 and 1966, 39 students left in the first year of training, 27 of whom were below the theoretical standard, five for personal reasons, four because of homesickness, one for health reasons and two to pursue nurse training elsewhere. Student Nurses' night duty hours exceeded – often to a considerable extent - the limits recommended by the GNC, they were 'borrowed' and 'lent' to make good the numbers of staff on duty on wards and departments other than the one on which they were then working, they might also be left in charge of wards and departments.⁵⁷³ The time spent by learners on night duty, the fact that they were left alone on the wards and 'in some cases have to take their meals on the wards because there is no-one to relieve them', added to their problems.⁵⁷⁴

The GNC's Inspectors repeatedly criticised the misuse of learners to staff wards unsupervised, especially at night, and to undertake responsibility for which they were not adequately prepared. Matrons acknowledged that the amount of night duty learners had to do was detrimental to the learners and to the hospitals' efforts to retain

⁵⁷¹ SA: Acc 2001/98, Royal Hospital Nursing Records, 1948-1966, *passim*.

⁵⁷² SA: SY 569/H1/8, NUR(67)8, Minute 37, 15 Nov 1967.

⁵⁷³ SA: SY 569/H1/8, GNC Report on Sixth Visit, 15 Feb 1967;

⁵⁷⁴ SA: SY 569/H1/13, NEC(72)1, Minute 20, 22 Mar 1972; SA: SY 569/H1/13, 'Policies and Priorities 1972/73, Teaching Division', May 1972.

their nurses.⁵⁷⁵ Efforts were made to increase the number of trained staff on duty at night, or at least to recruit untrained staff so that learners would not be entirely alone on night duty.

Providing supervision by trained staff is not always possible and this is a matter of concern. All Staff Nurses and Enrolled Nurses in the Northern General, General Wing are required, as part of their contract of employment, to take their turn on night duty each year. It is more than a matter of concern to the senior nurses that sometimes acute wards have only unskilled staff on duty, i.e. Nursing Auxiliaries without either trained nurses or learners. Senior Student Nurses are occasionally in charge of wards for an afternoon on day duty but are always supervised by the nearest ward. It is part of their training in management to experience supervised responsibility.⁵⁷⁶

While this was probably a factor in student attrition, the fact that time given for study blocks was the minimum allowed by the GNC was also cited as a possible reason for attrition, although the PNO for the HMC's Teaching Division acknowledged that those leaving did not always give a full explanation of their motivation for so doing.⁵⁷⁷

Learners formed the only section of the hospital nursing staff to work exclusively on a full-time basis, and were the most flexible section. They could leave – as many did – if unhappy with the vagaries of clinical experience, including the expectation that they would undertake months of night duty, much of it managing the needs of a ward of sick people single-handed. There is little information in the records to indicate what the learners themselves thought about their experiences during most of the 25 years between 1948 and 1974, with the exception of a survey conducted by the Sheffield Hospital Careers Committee during the early 1970s.⁵⁷⁸

⁵⁷⁵ SA: SY 569/H1/5,CGH(52), Minute 5.96d, 15 May 1952; SA: Acc 1994/64, Box 4,CGH(55)4,Matron's report, 14 Apr 1955; SA: SY 569/H1/11,NAC(70), Minute 1.63, 18 Mar 1970; SA: SY 569/H1/13, NAC(72), Minute 5.29, 15 Nov 1972.

⁵⁷⁶ SA: SY 569/H1/11, Nursing Advisory Subcommittee 'First Report on the Consideration of the Secretary of State's Letter and Pink Circular HM(70)35 on "Action to Improve the Nursing Situation"'.
⁵⁷⁷ SA: SY 569/H1/13 – Policies and Priorities 1972/1973 – Teaching Division.

⁵⁷⁷ SA: SY 569/H1/13 – Policies and Priorities 1972/1973 – Teaching Division.

⁵⁷⁸ SA: SY 569/H1/14, NEC(73)1, 21 Mar 1973, Sheffield Hospital Careers Committee, 'Report on Factors Influencing Choice of Nursing as a Career'.

The description of student experiences at the NGH during the early 1970s indicates the existence and even tolerance of deviation from national policy at local level. This was in spite of the close control over training programmes that was apparently exercised by the GNC through the requirement that all training schools and the programmes they offered should be approved and that they be subject to regular GNC inspections. Limitations imposed by the built environment, by lack of money and insufficient numbers of appropriately trained staff, and above all by the continuing necessity to provide a service to patients, repeatedly perverted attempts to improve the lot of the students.

4.5 Pre-Registration Nurse Training

In 1939, the syllabus of subjects to be studied for the Final State Examination included local applications – hot and cold; counter-irritations by poultices, mustard leaves, blisters, cupping, and leeches, none of which was an expected part of the nurse's repertoire after 1952.⁵⁷⁹ The syllabus of subjects for the General Certificate of Nursing was revised on three occasions between 1948 and 1974: in 1952, 1962 and 1969. Until 1962, the State Examination comprised a Preliminary and a Final stage. The former was further divided into two papers, of which Part One could be entered while the candidate was still in full-time general or pre-nursing education. The Preliminary State Examination was retained in the 1952 syllabus, although the list of subjects to be covered was amended, but from 1962 it was replaced with an Intermediate Examination. The 1952 syllabus introduced bacteriology and asepsis as new subjects and required students to be familiar with not only the social aspects of disease, but with sociopolitical dimensions of health including citizenship and the place of the hospital in the health services. The range of subjects to be studied was

⁵⁷⁹ TNA: PRO DT 38/5.

also revised in 1962 and 1969.⁵⁸⁰ The predominant emphasis of the syllabi of 1952, 1962 and 1969 was, nonetheless, hospital-based acute nursing, albeit that the study of psychological and social aspects of disease was included and that the health of the community was also included.⁵⁸¹

In addition to the subjects to be studied in the classroom, the GNC specified the minimum period to be spent on their teaching, the minimum age of entry to nurse training, and the range of clinical experiences and length of time to be spent in specialist wards and on night duty. Students' training requirements and the hospitals' requirements for their labour in providing a service led to tension, which was manifest in resentment of the impact of requirements for nurse training on the clinical work of the hospital. It was also apparent in the criticisms made of the GNC Inspectors by Hospital Secretaries in the Sheffield region, and was given vent in the suggestion made by medical staff of the Infirmary that the School of Nursing should rearrange its lectures for the convenience of the wards and to give priority to enabling students to work.⁵⁸²

The GNC tolerated very gradual implementation of new syllabi – indeed, their 1952 syllabus did not have to be fully implemented until January 1959. Conversely, an inspection of the Infirmary and the Royal in 1957 noted that students should no longer be checking and sorting dirty linen and doing domestic work – knowledge of the execution of which was examined under part two of the Preliminary State Examination under the 1939, but not the 1952, syllabus. At her visit in 1965, the GNC Inspector noted that Ward Sisters in the USH units were unaware of the provisions of the 1962 syllabus, and the Inspector who visited the General in 1967 recommended that 'a scheme of training for the 1962 syllabus should be prepared'. This was done by 1968,

⁵⁸⁰ TNA: PRO DT 38.

⁵⁸¹ TNA: PRO DT 38/5-7, 12-13, 16-19.

⁵⁸² SA: SY 333/H6/14, 6 May 1952, pp. 99-100; SA: SY 291/H1/1, 1 July 1959.

when a further GNC visit took place in view of concerns raised the previous year. Such delays were still evident by the end of the period of this study, when the annual report of the Teaching Division of North Sheffield University HMC indicated that the School was still in the process of implementing the 1969 Syllabus.⁵⁸³

In each decade between 1948 and 1974, changes in the training of nurses reduced the amount of time that they were available to work on the hospitals' wards. The introduction of the block training system, which replaced individual lectures fitted around ward duties with dedicated periods for study in the School of Nursing, was effected during the 1950s. During the 1940s for USH students, and for all students during the 1960s, the incorporation of blocks of experience in aspects of nursing not available in the employing unit raised concerns over the staffing of wards and departments.

The introduction of the 'block training' system was seen positively as facilitating longer placements for students in particular areas of practice, which was favoured both by the GNC and by medical staff, who preferred to have a stable group of nursing staff. However, the development of a more settled approach to clinical experience was dependent on other factors, including the planning of experience over the duration of the three-year course, and the appreciation of the perspectives of school and wards each on the part of the other. The appointment of a senior nurse to coordinate nurse training at the General was made in 1967. Until then, the allocation of students to wards had been primarily determined by the staffing needs of the individual wards and departments, and this was evident in the continuation of a system of study days, rather than study blocks, in this school of nursing.⁵⁸⁴ From 1948 until 1959, students training

⁵⁸³ TNA: PRO DT 33/456; SA: SY 569/H1/8, GNC Report on Sixth Visit, Feb 1967; SA: SY 569/H1/9, GNC Report on visits to the Northern General and Nether Edge Hospitals, 1968; SA: SY 569/H1/13, 'Teaching Division Report 1971-1972'.

⁵⁸⁴ SA: SY 569/H1/8, GNC Report on Sixth Visit: City General Hospital, 15 Feb 1967.

at the Royal and the Infirmary spent between two weeks and over three months in each clinical area, although the need to plan for circulation to the Jessop and Children's Hospitals, as well as to the school blocks implied a degree of overall coordination. In spite of these changes, nurses' learning was secondary to meeting the hospitals' need for nursing staff.⁵⁸⁵

4.6 Post-registration Nurse Training

The newly qualified nurse is up-to-date in theoretical knowledge but lacks practical experience. All too frequently subsequent months and years provide her with a wealth of experience, but a minimum opportunity to keep her knowledge of modern treatments and methods ungarished [sic].⁵⁸⁶

Post-registration nurse training programmes in England date back to the 1920s. Allen and Jolley note that courses were established first in tuberculosis, orthopaedic and disability nursing.⁵⁸⁷ Programmes of training were available to relatively few nurses in this limited range of fields.⁵⁸⁸ After July 5th 1948, Sheffield RHB identified early that it had responsibility for the provision of post-certificate study courses, and established this as one of the duties of the Nursing Committee it established in October 1948. However, these were courses of short duration that covered very specific aspects of nursing work, rather than specialist clinical courses addressing the skills needed by a nurse employed in a particular role.⁵⁸⁹

In 1956, delegates to a World Health Organisation (WHO) conference on post-basic nursing education in Europe concluded that it was necessary to ensure that nurses had access to opportunities for further professional education beyond the basic

⁵⁸⁵ A Lapping 'Society at work - training our nurses' *New Society* 26 Oct (1967), p. 589

⁵⁸⁶ D Blair, 'Medico-Nursing Societies', *Nursing Mirror* 24 Apr (1948), pp. ii-iv.

⁵⁸⁷ P Allan and M Jolley, ed. *Nursing, Midwifery and Health Visiting Since 1900* (London, 1982), p. 71.

⁵⁸⁸ Blair, 'Medico-Nursing Societies'; SA: SY 333/H3/29,I.57/168, 246.

⁵⁸⁹ SA: SY 709/H1/1, p. 80.

qualification that allowed them to practice. It was another decade before the Ministry of Health's SNAC reviewed the provision of post-basic education in the NHS.⁵⁹⁰

In order to understand the lengthy delay between the agreement at the WHO conference and action to address variations in the provision of post-registration education in England and Wales, it is necessary to appreciate the dual role that specialist clinical courses played for hospitals. Post-registration, often referred to as postgraduate, education enabled nurses working or intending to work in specialist areas of practice to receive specific preparation in the skills and knowledge required to work proficiently in that field. In October 1950, for example, the USH Board of Governors appointed an *ad hoc* committee to consider postgraduate ophthalmic nursing training at the Royal. The House Committee had recommended that the hospital should provide the nurse with a certificate after 12 months' training, which she could then produce when applying for future employment, and meanwhile the hospital 'would be assured of a continuous flow of nurses trained in ophthalmic nursing of which there is, at present a shortage.'⁵⁹¹

Conversely, a small number of programmes were established under the ægis of national organisations such as the Ophthalmic Nursing Board, with nationally prescribed curricula. The GNC had approved the provision of 'postgraduate' ophthalmic nursing training at the Infirmary, the Royal and the Children's Hospital in 1948. The Royal continued to offer post-basic courses in this speciality throughout the period to 1974, offering qualifications for SENs and SRNs from 1972.⁵⁹² It was a statutory requirement that the prospective midwife should undergo an approved programme of training. Until 1970, however, most post-registration training available

⁵⁹⁰ Allan and Jolley, *Nursing, midwifery and health visiting*, pp. 71-72

⁵⁹¹ SA: SY 333/H16/1, Meeting of an *ad hoc* Committee appointed by the Board of Governors to consider introduction of postgraduate nurse training and issue of proficiency certificates, 19 Oct 1950.

⁵⁹² TNA: PRO DT 33/456, GNC Inspector's Report, Royal Hospital, 9 June 1948.

to nurses was offered outside the purview of the GNCs or other national bodies. It was also possible to obtain a post in a branch of nursing other than general hospital nursing without possessing the relevant qualification, and to become a Nurse Tutor or Matron without directly relevant training.

Clinical courses were developed during each decade from the 1950s onwards and most were developed by individual hospitals. For example, in Sheffield, the two general hospital units within the USH generated courses quite independently of each other. In 1956, a six month postgraduate course in neurosurgical nursing to include 'lectures, practical ward work and theatre experience' was proposed by the Infirmary's House Committee. The proposal to develop the neurosurgical nursing course at the Infirmary in 1956 does not appear to have been discussed with the Royal.⁵⁹³ While only the Infirmary could provide the necessary experience, it remains remarkable that the plans were not noted at what was its partner general hospital unit in the Sheffield School of Nursing.

In 1958 the Infirmary established new one year courses in theatre nursing and in ward and department work. The motivation for developing the latter was specifically to aid recruitment. The Matron argued to the House Committee that 'As the present Postgraduate Courses running at the Royal Infirmary have gone a long way to solving the staffing difficulties, I would now like to extend these courses to cover a Staff Nurses' Postgraduate Course in Ward and Departmental work.'⁵⁹⁴ The increasing numbers of patients, specialisation of medicine, and concomitant requirements for skilled nurses to work in areas including operating theatres, and development of general and specialist intensive care units, renal and neurosurgery units during the 1960s, contributed to the development of associated training programmes by hospitals. High dependency care

⁵⁹³ SA: SY 333/H3/28, Minute I.56/406, 10 Dec 1956.

⁵⁹⁴ SA: Acc 2001/98, Matron's Records, 10 Mar 1958.

in areas such as operating theatres, intensive care and renal dialysis required the development of nurses' observational skills in monitoring patients' responses to treatment, their confidence in acting upon changes in the patients' condition in the absence of their medical colleagues, and proficiency in the use of expensive technology – ventilators, dialysis machines and monitoring equipment. These areas were often ones to which hospital authorities found it difficult to recruit.

In 1965, the Infirmary's Matron proposed development of a radiotherapy and cancer course; and a revised, six-month theatre course was introduced.⁵⁹⁵ In late 1966, the General's Nursing Committee proposed establishment of an Intensive Care Nursing course for SRNs, the syllabus to be prepared by the Matron; the Consultant medical staff approved of this and recommended that the course should be free for those attending, although the records refer to the payment of lecture fees by the HMC.

The Royal offered a specialist clinical course in renal nursing from 1966. The General offered an obstetric nursing course that was open to staff employed by the local authority as well as to hospital staff, although their employers were expected to second them to the programme and pay their salaries while they studied. By September 1970, the General offered four non-statutory courses. These courses included intensive care nursing, theatre nursing, and geriatric nursing, each of which lasted six months, and an eight week course in thoracic nursing for SENs.⁵⁹⁶ An intensive care nursing course commenced at the Infirmary in 1972, encompassing experience in the general intensive and coronary care units and lectures from the medical staff. The following year, Sheffield RHB approved funding of post-basic general intensive care nursing courses.

⁵⁹⁵ SA: SY 333/H3/28, 10 Dec 1956; SA: SY 333/H3/28, I.56/406, 10 Dec 1956; SA: SY 333/H3/29, I.57/86-87, 11 Feb 1957; SA: SY 333/H3/31, 11 Nov 1964; SA: SY 333/H6/76; SA: SY333/H6/83.

⁵⁹⁶ SA: SY 569/H1/10, NAC(69)5, 22 Oct 1969; SA: SY569/H1/11, NEC(70)2, Minute 6, 23 Sept 1970.

Also in 1973, the JBCNS approved a proposal by the Infirmary to offer a course for SRNs and Senior SENs in sexually transmitted diseases.⁵⁹⁷

The records of Sheffield's hospitals indicate that staff shortages were one reason for the development of courses in diverse areas of hospital nursing care from the 1950s onwards. While undertaking a course, the nurse made a relatively skilled contribution to the daily work of the nursing team. Nursing staff could be recruited to post-registration courses with the promise of a certificate confirming that they had gained experience of working in a particular area of nursing, as long as they stayed in post for the requisite time of up to one year. The quality of the courses varied, some offering a certificate that simply verified the nurse's experience gained on-the-job, while others signified the nurse's attendance at lectures and demonstrations and ability to demonstrate her or his newly acquired knowledge and skills.

For the hospitals, post-registration courses thus facilitated the delivery of clinical services, as well as enhancing the skills of nursing staff. Having observed that courses were of uneven quality, not always addressing the theoretical basis for practice alongside clinical experience, the SNAC suggested in 1966 that a body should be created to establish and monitor national standards. The Joint Board for Clinical Nursing Studies (JBCNS) was formed in 1970 for three years initially, to develop national standards and syllabuses as an organisation distinct from the GNC for England and Wales.⁵⁹⁸ The JBCNS was reconstituted for a second term commencing on the first of April 1973. From then, its terms of reference were extended to include

⁵⁹⁷ SA: SY 569/H1/8, NUR(66)9, Minute 49, 14 Dec 1966; SA: SY 333/H6/90, p. 3; SA: Acc 1987/55, Nursing Committee, 21 May 1973.

⁵⁹⁸ SA: SY 333/H16/74, p. 13; Jolley, Darling and Lee, 'General Nursing'.

courses related to community nursing services, although not health visiting or district nursing qualifications.⁵⁹⁹

Funding for post-registration nurse training was limited, particularly in the early years of the NHS. In 1951, the Ministry of Health advised that the maximum sum of money to be granted in any year in respect of the attendance by all members of a hospital's non-medical staff at conferences, study days, and related activities was to be fixed at £500. They also approved the payment of fees for nurses attending teaching courses out of Exchequer funds. Prior to this, such courses could only be funded out of 'free money' – that which was to cover all non-essential items of expenditure. Clinical courses developed in-house would cost the salaries of the nurses attending them, but these would be registered and experienced nurses able to contribute to patient care. Lectures and demonstrations, if offered, could be given by the hospital's own medical staff. Costs could be minimised by avoiding even this call on the hospital's resources.

Individual nurses were expected to bear additional costs. Attendance at study days, conferences and housekeeping courses did not incur a penalty in loss of salary, but midwifery training did. The nurse who became a pupil midwife received a training allowance instead of a salary, because midwifery was a separate profession and the course was a pre-registration rather than a postgraduate one. In July 1951, the Board of Governors of the USH agreed to award scholarships to nurses from the Royal Infirmary or Children's Hospital wishing to undertake post-basic midwifery training, subject to the approval of the Commissioners for the Inland Revenue. The HMC was not in a position to do this, as it lacked the financial reserves that the USH possessed.

A survey of HMC expenditure on study leave carried out by Sheffield RHB's Nursing Committee during 1961 identified that the HMC was among eleven of the region's

⁵⁹⁹ SA: Acc2001/98, Nursing Committee, 21 May 1973.

twenty-nine HMCs that only funded compulsory midwifery refresher courses, although the Ministry of Health by then permitted expenditure on five other approved programmes. Between 1960 and 1961, only one HMC in the region used funds other than public funding to support non-midwives undertaking study courses, and the Nursing Committee urged HMCs to recognise the need for post-basic education of Staff Nurses by providing in-service training.⁶⁰⁰

The NHS was not the sole source of funding for nurses wishing to train in other fields or to attend conferences and study days. In 1933, one of the founding aims of the League of Trained Nurses at the Infirmary had been to raise funds in order 'to help forward the young nurse to post-graduate work which otherwise she could not undertake'. In the first year of its existence, the League became affiliated to both the National Council of Nurses and the ICN, to whose Congress they sent delegates regularly thereafter.⁶⁰¹ The League's annual magazine provided a medium through which adherence to this principle could be advertised in the form of reports about the courses that were developed at the Infirmary and from those who had benefited from the League's support in pursuing further education. The League also gave practical support to members who wished to attend international and national conferences of nurses, and continued to do so during the 1950s and 1960s.

Nurses working at the Infirmary received support to undertake postgraduate training. The hospital granted study leave and paid course fees and salaries to those who attended courses run by external organisations, such as management courses run by the

⁶⁰⁰ SA: Acc 1987/57, Sheffield RHB Nursing Committee, 19 June 1961, 16 Oct 1961, 18 Dec 1961.

⁶⁰¹ SA: SY 333/H6/52; SA: SY 333/H6/54.

RCN and King Edward's Hospital Fund, nurse tutor courses and others that introduced Ward Sisters to the principles of teaching students in the clinical setting.⁶⁰²

In addition, study days for Sisters, night schools for trained nurses, back-to-nursing courses, and study tours are referred to in the records of the USH and the HMC, as well as in the Magazine of the League of Trained Nurses; these might be offered in-house or elsewhere. References to qualified nurses of all grades attending professional updates, usually directly applicable to the role in which they were employed, are to be found in the records of all the general hospitals; these usually involved study away from the employing hospital. 'This is obviously the most important need of the trained staff; they must enjoy the type of work they are doing, and wish to keep up to date with other aspects of nursing and advances in medicine.'⁶⁰³ Exchanges of nurses between Sheffield and other hospitals and temporary attachments of students from various countries, often arranged in order for nurses to gain experience in a field of care that was being introduced in their employing hospital, also took place.⁶⁰⁴ Nonetheless, access to study days, lectures and training courses was limited by the need to provide nursing care.

4.7 Training of Nursing Auxiliaries

In addition to the pre-registration and post-registration training of nurses, some consideration was also given to the training requirements of ancillary members of the nursing staff establishment. Nursing Auxiliaries and Nursing Assistants – the latter distinct from Assistant Nurses – were untrained, non-training members of the hospital staff, usually counted as part of the nursing establishment. Their increasing contribution to the nursing care of the patients, not only in Sheffield but also

⁶⁰² SA: SY 333/H6/71; SA: SY 333/H16/9, Minute A524, 20 Aug 1950, and Minute A775, 21 Aug 1951; SA: SY 333/H6/86, pp. 11-12.

⁶⁰³ SA: SY 333/H3/31, 11 July 1966.

⁶⁰⁴ SA: SY 333/H3/28, Minute I.54/56, 8 Mar 1954; SA: SY 333/H16/12, 30 Apr 1973.

throughout the English NHS, led to intermittent concern that they should receive some preparation for their role. Courses for Nursing Auxiliaries were offered on an irregular basis in Sheffield from 1953, when Fir Vale offered a six week course of lectures for Nursing Assistants starting on the 24th of August. The reason for this development is not recorded but it coincided with the introduction of block training for Pupil Assistant Nurses at the hospital, and the submission of a report by the Physiotherapy Department, established in January 1953. The latter called for better cooperation with, and knowledge on the part of, the hospital's nursing staff in order to ensure that their work with the patients could be fully effective. Four years later, the Infirmary also proposed to introduce training for Nursing Auxiliaries. These courses do not appear to have been sustained, although the reason for their discontinuation is not clear from the available records.⁶⁰⁵

The growth in the numbers of Nursing Auxiliaries by the early 1970s and the greater complexity of hospital work contributed to renewed recognition that they should receive specific preparation for their role. Senior nurses and administrators at the General also feared that when the Hallamshire Hospital eventually opened it would lead to an 'exodus of staff', unless they were able to improve the stability and working conditions for all grades at the NGH. One proposal was to provide in-service training with block release from ward duties for Nursing Auxiliaries, and a course for housewives was introduced in January 1970. In May 1971 the NAC noted that the eight-week course for Nursing Auxiliaries recruited to work in the Geriatric Division alone had attracted over 100 applications and that three courses would be held during that year in total.

⁶⁰⁵ SA: Acc 1994/64, Box 1, FVI(53)8, 18 Sept 1953; SA: Acc2001/98, Meetings with Sisters, Minute 352, 2 Dec 1957.

In July 1971, a four-week in-service training programme for Nursing Auxiliaries in the General Nursing Division was introduced under the management of an SEN who took responsibility for their training and ward supervision. The NAC agreed that the course for General Division auxiliaries would thereafter run on a monthly basis, and that both this and the Geriatric Division course would continue to run the following year.⁶⁰⁶ The number of Nursing Auxiliaries leaving their employment at the General fell from 100 of 200 in post in 1971 to 34 of 189 employed in 1972. Between 1971 and January 1972 induction schemes including the demonstration of 'basic nursing methods' were introduced at the USH, with a part-time Staff Nurse providing continuing support to the auxiliaries working at the Infirmary and Royal.⁶⁰⁷

In Section 4.1, it was suggested that the creation of the Sheffield School of Nursing was attributable ultimately to the threat that the potential loss of nurse training school status offered to the voluntary hospitals' ability to attract sufficient recruits. However, subsequent sections highlight the close relationship between recruitment imperatives and nurse training at all levels – from the short programmes developed to introduce Nursing Auxiliaries to basic nursing skills to the development of post-registration clinical courses. While there was clearly a desire to ensure that the training needs and experiences of pre-registration learners, in particular, were fulfilled, the absolute imperative to staff the wards and departments repeatedly undermined this intention. This finding is not unexpected – the impossibility of assuring a positive educational experience and professional preparation for learner nurses has been acknowledged and analysed since at least the *Working Party* reported in 1947. However, the examination of the implications of this in one city provides a useful case study. Most poignant is the evidence that those who were operationally responsible for the use of learners as

⁶⁰⁶ SA: SY 569/H1/9, NUR(68)7, 24 Oct 1968; SA: SY 569/H1/11, NAC(70)1, 18 Mar 1970; SA: SY 569/H1/12, NAC(71)4.15, 19 May 1971; SA: SY 569/H1/13, NAC(72)1, Minute 85, 19 Jan 1972; SA: SY 569/H1/13, NAC(72)2, 'General Nursing Division Report', 6 May 1971-31 Jan 1972.

⁶⁰⁷ SA: SY 333/H6/39; SA: SY 333/H16/11, 27 Nov 1972.

'pairs of hands' in the clinical areas, particularly essential to the operation of the hospital at night and at weekends, were also aware of the pressure on those learners, but appear to have been unable or unwilling to challenge the situation effectively. The following Chapter examines the work that the various grades of nursing staff did, and explores the factors that contributed to continuity and change in their roles and responsibilities.

5. 'You cannot mechanise nursing' - Nursing Work in Sheffield's General Hospitals, 1948-1974.⁶⁰⁸

Those of you who are out of touch with Hospitals will be wondering just what changes nationalisation has brought to the Royal Infirmary. Well, as yet there are no apparent changes in the ordinary day-to-day running of wards and departments.⁶⁰⁹

In June 1948 Miss Warren, then Matron of the Infirmary, encouraged her colleagues in the League of Trained Nurses to deal with the inevitable 'growing pains' of the NHS thus: 'Let us keep in the forefront of our thoughts that our service is to humanity and strive always to maintain the great traditions of our Profession.' The very basis of nursing seemed to her to be threatened by the nationalisation of hospitals, the recommendations of the *Working Party on the Recruitment and Training of Nurses*, and the fact that nursing was being subjected to 'criticism and discussion'.⁶¹⁰ Yet a year later, her worst fears appeared not to have been realised. The essence of hospital nursing endured throughout the first quarter-century of the NHS's existence. However, by 1974, some aspects of the work done by nurses in 1948 had been removed altogether or transferred to others' spheres of responsibility and 'technical' aspects of nursing had changed considerably.⁶¹¹

The nationalisation of hospitals in the NHS contributed to both change and continuity in the context of nursing work, with innovation and specialisation in clinical care taking place in increasingly obsolescent buildings. Furthermore, while the number of patients treated and the range of therapeutic interventions available increased demand

⁶⁰⁸ Fir Vale Infirmary, Sheffield Number One HMC, *A Simple and Practical Course of Training as a State Enrolled Assistant Nurse* (Sheffield, c1954/1955).

⁶⁰⁹ SA: SY 333/H6/27, 1949, p. 1.

⁶¹⁰ SA: SY 333/H6/26, 1948, p. 1.

⁶¹¹ See TNA: PRO DT 38/4-18 for syllabi and associated guidelines issued by the GNC for England and Wales between 1939 and 1973; and, for example, SA SY569/H1/12, NAC(71)2,4 Aug 1971, Minute 83 on redefinition of 'nursing' and 'housekeeping' roles and responsibilities; and SA SY569/H1/15, MEX(73)14,14 Dec 1973, Minute 161, on medical and nursing responsibilities.

for care the number of staff in all professional groups never seemed to keep pace.⁶¹² As a corollary, reiterative discussions about what nurses should do - as opposed to what they actually did - took place in the hospitals and elsewhere in the NHS, in the professional nursing and medical press and in the general media. Attempts were made to define the boundaries between what 'nursing' was and what it was not; between 'basic' and 'technical nursing'; between what should be done by trained nurses and by learners and what untrained auxiliaries and assistants could do.⁶¹³ Nurses and their medical and administrative colleagues in the several Sheffield hospitals gave active consideration to national reports addressing the nature and organisation of nursing work and nurse training, as well as to the reports of the General Nursing Council's inspectors, seeking to incorporate aspects of their recommendations into nursing practice locally.⁶¹⁴

The purpose of this chapter is to explore the work of nurses in Sheffield's general hospitals, and the factors contributing to continuity and change in their nursing practice. The first part of the chapter is divided into sections on the content of general hospital nursing work in Sheffield and the changing contexts within which this was done. The second part of the chapter addresses the redefinition of boundaries around nursing work and in nurses' relationships with their non-nursing colleagues and patients between 1948 and 1974.

⁶¹² Department of Health and Social Security (Chair: M L Farrer) *Relieving Nurses of Non-Nursing Duties in General and Maternity Hospitals – A report by the Sub-Committee of the Standing Nursing Advisory Committee* (London, 1968).

⁶¹³ Nuffield Provincial Hospitals Trust, *The Work of Nurses in Hospital Wards – Report of a Job-Analysis* (London, 1953); Ministry of Health/CHSC, *In-Patient's Day*; Robb, *Sans everything*; National Board for Prices and Incomes, *Cmd 3585 Pay of Nurses and Midwives in the National Health Service – Report Number 60*, (London, 1968); Department of Health and Social Security (Chair: M L Farrer) *Relieving Nurses of Non-Nursing Duties in General and Maternity Hospitals – A report by the Sub-Committee of the Standing Nursing Advisory Committee* (London, 1968); *Working Party – Majority Report*; Bradshaw, *Nurse Apprentice*.

⁶¹⁴ SA: SY 333/H17/1, Minute 197, 30 Sep 1947, and Minute 233, 10 Feb 1948; SA: SY 333/H3/28, Domestic Subcommittee, 4 Mar 1954; SA: Acc 2001/98, Meetings with Sisters, Apr 1954; SA: SY 333/H16/14, 23 Apr 1954; SA: SY 333/H3/30, 8 May 1961; SA: SY 333/H1/33, 9 May 1961; SA :Acc 2001/98, Meetings with Sisters, 25 July 1961; SA: Acc 2001/98, Meetings with Sisters, Minute 850, 17 July 1967; SA: SY 569/H1/8, MC(67)7, Minute 58, 7 July 1967; SA: SY 569/H1/9, NUR(68)5, Minute 16, 19 June 1968; SA: Acc 2001/98, Meetings with Sisters, 13 Aug 1968.

5.1 The Content of Nursing Work

You cannot mechanise nursing. Although there is an increasing number of clever gadgets designed to relieve nurses of heavy manual labour, nursing still remains a manual but highly personal process.⁶¹⁵

A key question is to consider what nurses in general hospitals did when they 'nursed', and the extent to which this was the same in 1974 as it had been in 1948. Secular and cyclical influences of national and local origin during the early years of the NHS affected general hospital nursing practice in Sheffield. Developments in scientific medicine and clinical sciences affected the practice of clinical, or bedside, medicine and in turn produced changes in the work that nurses did.

The knowledge base that informed nursing practice also developed. For example, between 1938 and 1969, advice on the management of post-operative nausea and vomiting changed to reflect greater understanding of the pathophysiology of this common side-effect of anaesthesia. Textbooks written immediately before the Second World War recommended nursing interventions including the administration of sips of water and bicarbonate of soda. The rationale for the latter depended upon the author – it was either administered as a gastric sedative and so to relieve vomiting or in order to dissolve mucus and induce vomiting in order to rid the stomach of residual anaesthetic agents. For post-operative vomiting, Bulman also recommended half a wineglassful of either soda water or champagne as a gastric sedative, whereas Pearce noted that '...a dose of brandy or champagne, [which] also temporarily stimulates the circulation and improves the sense of general wellbeing', although not in the immediate post-operative period.⁶¹⁶ Hector, writing in 1962, described vomiting in the immediate post-operative period simply as the 'traditional accompaniment of anaesthetic' - persistent vomiting sometimes being due to 'nervous tension and anxiety', though more commonly

⁶¹⁵ Fir Vale Infirmary, Sheffield Number One HMC, *A Simple and Practical Course*.

⁶¹⁶ E Pearce, *A General Textbook of Nursing*, pp. 674, 73: *A Comprehensive Guide* (London, 1938: Second edition); M Bulman, *Surgery for Nurses and Surgical Nursing* (London, 1941), pp. 150-151.

attributable to 'some abdominal complication'.⁶¹⁷ By 1965, sodium bicarbonate, previously recommended by nursing and medical authors alike, had been found to cause fatal alkalosis in some patients and was explicitly described as unsafe. Oral hygiene and anti-emetics had become the interventions of choice, although the author of one textbook on surgical nursing that was recommended to students at the Sheffield School of Nursing during the 1960s suggested that 'one of the most effective, if old-fashioned, remedies is alcohol: it is tolerated best as sherry (60 ml.), if there is no contra-indication.'⁶¹⁸

The records of Matrons' meetings with the Sisters of the Infirmary in Sheffield show that the day began before the night nurses completed their shift, with the 'routine work' of bed making, and blanket baths. The latter were given to all patients on bed-rest, though the proportion of patients in this category changed with the acceptance of early mobilisation following surgery as the ideal. By the mid-1960s, the early mobilisation of patients had been established practice for ten years. Most post-operative patients nursed in the USH units might receive a blanket bath on the day after surgery, but were expected to wash themselves the following day and to walk to the bathroom for their wash within as short a time as their condition and Consultant allowed. Patients who had suffered a myocardial infarction were kept on strict bed-rest for nine days, however, and only allowed to sit out of bed for two brief periods on their tenth day in hospital. Usually the work of bed-bathing continued throughout the morning, but after the hospitals had accepted the general principles of the 1961 report on *The Pattern of the In-Patient's Day*, patients' waking time was officially delayed

⁶¹⁷ W Hector *Modern Nursing: Theory and Practice* Second Edition (London, 1962), pp. 230-231; D F Ellison Nash *The Principles and Practice of Surgical Nursing* (London, 1965: 3rd Edition), p. 411.

⁶¹⁸ Ellison Nash, *Surgery for Nurses*, p. 411; Ellison Nash, *The Principles and Practice of Surgery for Nurses and Allied Professions* (London, 1969: 4th Edition), p. 411; W Hector *Modern Nursing: Theory and Practice* (London, 1968: 4th Edition), pp. 235-236.

until 6.45 in the morning at the Royal and 7 a.m. at the Infirmary.⁶¹⁹ Thenceforth, night nurses were no longer expected to start washing bedfast patients in the early morning.

Junior nurses – first year students – performed the daily observations of patients' temperature, pulse and respirations in the morning and reported these to the nurse-in-charge at half past seven in the morning. She in turn allocated the morning's work to the nurses, and this was fitted around visits from members of the medical staff and senior nurses and patients' treatments on and off the ward. Treatments on the ward might include the changing of wound dressings, while those taking place off the ward would include surgical operations or visits to the X-Ray Department, for example.

A hierarchy of work existed in the wards, with junior nurses being allowed to carry out simple urine tests and keep patients' lockers tidy, more senior nurses being expected to carry out the 'more complicated and accurate tests'.⁶²⁰ Part of the role of the qualified nurse was to teach the learners, although reports including those of the NPHT in 1953, the GNC Inspectors reports on their visits to Sheffield, and minutes of meetings held in Sheffield's hospitals alike indicate that this was often neglected. An indication of this was the reminder to Staff Nurses in 1950 that they should show the students how to dress wounds, and allow the students to practice this skill under supervision.⁶²¹ Between 1948 and 1974, the surviving records indicate that Student Nurses were denied opportunities for learning specific skills, including the administration of medicines and doing dressings, because of the intensity of the workload. Paradoxically, they were expected to assume responsibilities beyond those they would

⁶¹⁹ E L Farquharson, 'Early ambulation: with special reference to herniorrhaphy as an outpatient procedure', *Lancet* ii:269 (1955), pp. 517-519; Spritzer, 'A Matron retires', p. 44; SA: Acc 2001/98, Meetings with Sisters, *passim*; R Maddocks, USH student nurse 1969-1972, personal notes.

⁶²⁰ SA: Acc 2001/98, Meetings with Sisters, 9 June 1952; NPHT, *Work of Nurses*; TNA: PRO DT 33/456.

⁶²¹ TNA: PRO DT33/456; SA Acc 2001/98, Meetings with Sisters. 8 Aug 1950 and Minute 98, 7 Apr 1952,.

ideally be expected to bear – in working alone on wards at night, or in caring unsupervised for patients recovering from general anaesthesia.⁶²²

Nursing work, as reports by the NPHT in 1953 and, separately, by McGhee and the Ministry of Health eight years later observed, thus comprised a number of tasks, many involving sheer, time-consuming, hard physical labour.⁶²³ The Nuffield study described nursing work as comprising two main types - 'basic' and 'technical' nursing tasks. Basic nursing care included all those aspects of nursing that were required by any sick person, and seventy-one per cent of nursing fell into this category. Examples included meeting patients' hygiene needs, giving of enemata, and regular pressure area treatments to prevent patients from developing pressure sores. Some of the work that nurses did throughout the period between 1948 and 1974 included technical tasks, including the administration of prescribed medications, management of blood transfusions and intravenous infusions, preparation of patients for surgery and care of anaesthetised patients post-operatively. In the view of one Consultant surgeon, the development of technical nursing skills in specialist units such as intensive care units represented 'one of the major nursing advances in recent years.'⁶²⁴

The Nuffield Report made various recommendations to reduce the amount of unnecessary nursing work done. These included the installation of piped oxygen and suction to individual beds, which was not controversial, in spite of carrying a cost to hospitals' budgets. Other suggestions, such as stopping the routine observation and recording of patients' vital signs every four hours whether indicated or not by the individual's condition, and introducing a system of 'case assignment' which would allow the nurse to assume responsibility for all aspects of the nursing care of individual

⁶²² TNA: DT 33/456; SA SY569/H1 *passim*; SA Acc2001/98, Meetings with Sisters, 8 Aug 1950; SA: SY 333/H16/14, Feb, Mar and Apr 1959.

⁶²³ Nuffield Provincial Hospitals Trust, *Work of Nurses*; McGhee *Patient's Attitude to Nursing Care*; Ministry of Health/CHSC, *In-Patient's Day*.

⁶²⁴ SA: SY 333/H6/82, p. 12.

patients, and equipment, were more controversial. They questioned clinical practices and implied that safe routine, controlled by the Sister or her deputy, should give way to a situation in which individual nurses should make decisions about a patient's condition. They also required a reconsideration of the timing of nursing work. The introduction of case assignment would mean a review of the relationship between nurse and patient. This would move nursing away from the disjointed and discontinuous interpersonal interactions that took place when every aspect of care was carried out by a different nurse, but in a way that could be scheduled, to one in which the nurse should attend to all the individual patient's requirements.

Everyday nursing practice and practical knowledge was augmented by reference to a parallel oral tradition passed on in the wards and departments. This could not be entirely at variance with the teaching of the nurse training school, the textbooks and the procedure manuals, as students were assessed on their clinical knowledge and practice as a requirement of the GNC examination process. However, it is apparent in the departures from agreed procedures reported in the hospital records, and observed by GNC Inspectors, that nurses did not always follow prescribed procedures. In 1969, for example, the Matron reminded the Infirmary's Sisters that inhalers should be filled with hot water in the sterilising room and carried to the patient's bedside on a tray, two at a time, where the medication should be added. The nurses were instead putting all the inhalers onto a trolley with a jug of hot water and taking them round the ward.⁶²⁵

GNC Inspectors' reports and the records of the Matron's meetings with Sisters at the Infirmary refer to ignorance of the various GNC syllabuses on the part of Ward Sisters and Charge Nurses. They also allude to lack of contact between the schools and the wards, and to inconsistency in students' application to clinical practice of what they had been taught in the school. Such reports reveal that contradictions between theory

⁶²⁵ SA: Acc 2001/98, Meetings with Sisters, 11 Feb 1969; another example was over the type of blankets used to make up admission beds, SA: Acc 2001/98, Meetings with Sisters, 3 Feb 1958.

and practice frequently moved beyond tolerable limits. The 1967 inspection at the General revealed such a gap between GNC recommendations and practice in the clinical areas that the Training School received approval for only one year, and a further inspection was conducted in 1968.⁶²⁶ At the USH hospitals, the procedure meetings, in abeyance because of a shortage of tutors, were reintroduced in 1968, following recommendations by the GNC.⁶²⁷ At the General, the lack of contact between education and practice persisted. In 1971, the annual report of the Principle Nursing Officer of the NGH Teaching Division observed that 'Closer contact within the Nurses Education Centre and in the clinical areas of the hospitals will do much to smooth the differences and create understanding and appreciation of the other's role.'⁶²⁸

In 1971, the RCN described nursing as essentially 'a simple craft', while acknowledging also that the increasing complexity of medical treatments demanded greater specialisation of nursing skills.⁶²⁹ In addition, the increasing intensity of workload and insufficiency of nursing hours contributed to change in the ways in which nursing was delivered, when and how nursing care was given and by whom it was given.⁶³⁰

5.2 The Context of Nursing Work

The 'basic nursing' work done by general hospital nurses was physically arduous, and the built environments in which they worked could exacerbate the difficulties inherent

⁶²⁶SA: Acc 2001/98, Meetings with Sisters, Minute 113, 9 June 1952; SA: Acc 1994/64, Exec(55)8, Minute 250, 16 Sept 1955; SA: SY 569/H1/8, Report on GNC Sixth Visit, City General Hospital, 15 Feb 1967; SA: SY 569/H1/8, Report on GNC Seventh Visit, Fir Vale Infirmary, 17 Feb 1967; SA: SY 569/H1/9, Report on GNC Visits to the Northern General and Nether Edge Hospitals, 26 July 1968; SA: Acc 2001/98, Meetings with Sisters, Minute 756, 1 Feb 1966; TNA: PRO DT 33/456, 1957 and 1965 Reports.

⁶²⁷SA: Acc 2001/98, Meetings with Sisters, Nov 1968.

⁶²⁸SA: SY 569/H1/13, Teaching Division Report, 1971-1972.

⁶²⁹Royal College of Nursing, *Rcn Evidence to the Committee on Nursing* (London, 1971), pp. 23, 17, and 69, *passim*.

⁶³⁰SA: Acc 2001/98, Matron's Records, Nov 1970.

in laborious tasks. The *Hospital Surveys* made it clear that hospitals would benefit from redevelopment, the replacement of inadequate accommodation, the relocation of inappropriately situated facilities, and the rationalisation of services that were duplicated in some parts of the country and absent in others.⁶³¹ However, the inadequacies of hospital stock adversely affected nurses' ability to deliver technically competent and appropriate standards of nursing care as well as making 'basic' nursing more difficult.

The development of hospital services before 1948 had been imbalanced, and hospitals were unevenly distributed, located in old, erratically modernised and inappropriate buildings. Hospitals had never been built to an expensive budget, whether originating in the workhouse system, nineteenth century public health provision, or the voluntary hospital movement. This appeared unlikely to change within the NHS, in spite of the promise held out by the Central Office of Information's advance publicity cartoon-film, which showed well-appointed new hospitals and health centres mushrooming in an orderly fashion across the country.⁶³² Although some buildings had been replaced during the 1930s, and money was available for smaller scale refurbishment of premises in all Sheffield hospitals during the 1940s, 1950s and 1960s, this was not sufficient to address all problems inherent in working in buildings that in most cases dated back at least sixty years.⁶³³ In addition to the age of the buildings, some had never been intended to meet the requirements of nursing acutely ill people, with the implication that they were unsuitable settings in which to provide basic nursing care, let alone in which to implement therapeutic innovations.

⁶³¹ Ministry of Health, *Sheffield and East Midlands*; Nuffield Provincial Hospitals Trust, *The Domesday Book of the Hospital Services* (London, 1945).

⁶³² COI, *Health*.

⁶³³ Sheffield City Libraries, *Sheffield Hospitals*.

A meeting held at the General in October 1948 noted the Matron's recommendation of a number of measures that could be taken to increase the likelihood of recruitment and retention of nursing staff, as she believed that the hospital's physical environment was affecting this adversely. 'In this connection it was pointed out that the buildings which were at present being used for the accommodation of acute sick cases had been designed and built for chronic sick cases as far back as 1878, and that the Nurses' Home was sixty years old.'⁶³⁴ Similar concerns were raised at the Infirmary, where modernisation of the wards was planned to improve the sluices, bathrooms, kitchens, Sisters' offices, and would include the 'removal of open fires where possible'. The Royal was described by the GNC Inspector in 1949 as being 'surrounded by bomb-damaged buildings', and essential repair work was awaited at Nether Edge Hospital, which had sustained bomb damage during World War Two.⁶³⁵

All three acute general hospitals in Sheffield provided inadequate facilities for basic personal hygiene, both in the hospital wards and in the nurses' homes. Bathroom and lavatory facilities for patients were insufficient. In older wards, the only wash-hand basin was located in the sluice where the nurses cleaned and stored the bedpans. On the older wards at the General, sluice facilities for the emptying of bedpans and cleaning of mackintoshes - sheets of rubberised material used to protect bed mattresses from contamination with body fluids and excreta - were located in the same place as the patients' lavatory. On the thoracic wards at the General, sterilisers for instruments and bowls used in clinical care were located in the patients' bathrooms.⁶³⁶

The nursing areas at Fir Vale were also deficient, particularly in the provision of amenities for patients' hygiene. A meeting held to discuss the adverse effect that this contributed towards the hospital's nurse recruitment effort described:

⁶³⁴ SA: SY 569/H1/1, 22 Oct 1948.

⁶³⁵ TNA: PRO DT/456; SA SY333/H16/14, 8 Feb 1949.

⁶³⁶ SA: Acc 1994/64 Extract GNC Report on the Fourth Visit, 6 Dec 1954.

[a] small sluice opening off nearly every separate ward. It contains a patients' lavatory, bedpan washer, sink, small wash-hand basin and a wooden rack for bedpans. This wash-hand basin is the only place where a patient can wash and, in doing so, blocks access to the sink and bedpan washer for the nurses. There is no draining board attached to the sink where nurses can place wash basins, vomit bowls or wash mackintoshes. Bedpans are stored on a wooden rack in the entrance corridor. If a bed-pan is needed for a patient, the nurse has to heat it under the tap in the sink, dry it and then take it to the patient. All these inconveniences are a great consumer of nurse hours.⁶³⁷

Mackintoshes required careful handling. Authors of contemporary nursing textbooks recommended a variety of approaches to removing any soiling before thoroughly cleaning, rinsing and drying. Evelyn Pearce, giving thorough instructions for cleaning mackintoshes, estimated that simply soaping the ward's mackintoshes as part of the five-stage process that should be done 'at least fortnightly' could take half an hour. After washing, the mackintoshes had to be dried without folding, as creasing of the rubberised coating would render them useless. Finally, they were stored flat or on special rollers, no part of the surface of one touching that of any other.⁶³⁸ Mackintoshes were in use on some acute nursing wards in Sheffield into the 1960s.

Inadequate sanitary facilities also impeded good practice by nurses and other clinical staff when engaged in clinical work. The hand-washing facilities at the Infirmary and Royal appear to have been considered adequate in 1948 - GNC Inspection reports do not identify a lack of appropriate hand-washing and disinfection facilities at the Royal or the Infirmary, the facilities at the latter being singled out for praise by their Inspector.⁶³⁹ However, the standards demanded by the GNC changed thereafter. At the General in 1954, the GNC Inspector noted that not all wards were equipped with appropriate hand-washing facilities for use by nurses. In several clinical areas, the basins were equipped with screw taps. This meant that the user had to touch the tap

⁶³⁷ SA: Acc 1994/64, Box 4, 'Special Meeting to discuss the nursing situation at Fir Vale Infirmary', 25 Apr 1955.

⁶³⁸ M W Bulman, *Surgery and Surgical Nursing* (London, 1941), p. 137; E Pearce, *A General Textbook of Nursing* (London, 1949: 10th Edition), pp. 85-86; W Hector, *Modern Nursing - Theory and Practice* (London, 1962: 2nd Edition), p. 19.

⁶³⁹ TNA: DT 33/456,465

that had been contaminated when the tap was turned on in order to turn it off after use. The GNC requested that hand-operated (wrist action) taps should be replaced with elbow taps.⁶⁴⁰ The Management Committee considered this, and other, recommendations in June 1955, and proposed to replace the taps at the General.

The GNC recommended the fitting of elbow taps at the Royal, following the hospital's 1957 inspection, and repeated this recommendation in 1965.⁶⁴¹ The Infirmary's hand-washing facilities were criticised in 1966, although on that occasion by the hospital's medical staff.⁶⁴² Amongst the recommendations made by the GNC, replacing the taps was one of the easier to address as it did not involve structural alterations, but in May 1967, this work had still to be completed at the Royal. The hospital's House Committee agreed that month that the GNC's recommendation that screw taps should be replaced with elbow taps should be implemented by the end of the year, on the grounds that 'Elbow taps provide a more adequate method of hand-washing prior to Sterile Procedures on wards. Furthermore, any undue delay in implementing this proposal may invoke unfavourable comment from the GNC.'⁶⁴³ Nonetheless, with limited funds and other calls on their resources, records of the Royal's House Committee indicate that this work had not been completed by August 1970.⁶⁴⁴

There was little compulsion on hospital authorities to follow this specific recommendation by the GNC. The HMC could only improve the sanitary facilities in its hospitals within the limitations of the old buildings that housed their hospitals. Much had to wait until major reconstruction could take place, and the GNC Inspector

⁶⁴⁰ SA: Acc 1994/64, Extract from the GNC Report on the Fourth Visit, 6 Dec 1954; SA: SY 333/H1/33, 14 Jan 1958; SA: SY 333/H6/14, 4 Jan 1966; SA: SY 333/H1/35, 22 May 1967.

⁶⁴¹ SA: SY 333/H1/33, 14 Jan 1958.

⁶⁴² SA: SY 333/H6/14, 4 Jan 1966 – a letter to the Committee from a member of the medical staff drew the Committee members' attention to the poor hand-washing facilities on the wards, and suggested that these posed a 'grave danger of infection.'

⁶⁴³ SA: SY 333/H1/35, 22 May 1967.

⁶⁴⁴ SA: SY 333/H1/36, 8 Aug 1970.

acknowledged this following her visit in December 1954.⁶⁴⁵ Moreover, the SNAC's Subcommittee on Nursing Technique had issued guidance in 1952 on the prevention of cross-infection, as part of a series of *Memoranda*, which contradicted the GNC advice.⁶⁴⁶ Webster notes that the SNAC was 'consistently active' in producing guidance *Memoranda*, but its work was censured by other Advisory Committees at the Ministry of Health and by other nurses in the country.⁶⁴⁷ An article published by the *Nursing Times* in 1952 criticised their recommendations on hand-washing. The author observed that 'A great deal of importance seems to be placed on the use of chlorine disinfectants for the nurse's hands, whereas many authorities believe that plentiful use of soap and water and the provision of elbow taps to all wash basins are more important.'⁶⁴⁸

Irrespective of the SNAC's lack of influence, the Ministry of Health's official guidance on hospital buildings and equipment did not concur with that of the 'many authorities'. In 1962, their *Hospital Equipment Notes* for 'Ward Units' and for the 'Training School for Nurses' recommended that either elbow or wrist action taps could be installed in clean utility areas and treatment rooms on hospital wards and in demonstration areas in Training Schools. *Hospital Equipment Notes* were 'designed to help hospital authorities and those engaged with them in the task of equipping new hospital units' in the context of 'overall project planning.' The *Equipment Notes* stated that 'In preparing the lists [of equipment]...the requirements should be examined in

⁶⁴⁵ SA: Acc 1994/64, Box 4, Extract from the Report of the GNC's Fourth Visit to the City General Hospital, 4 Dec 1954; SA: Acc 1994/64, Box 4, FVI(55)4, 27 Apr 1955; SA: Acc 1994/64, Box 4, MC(55)6, 16 June 1955.

⁶⁴⁶ TNA: PRO MH 133/332, 1949-1952.

⁶⁴⁷ Webster, *Health Service – Volume I*, pp. 247-248.

⁶⁴⁸ M.H. 'Procedural Memoranda – A Review', *Nursing Times* 2 Feb (1952), pp. 108-109.

consultation with the head of the department or the main user likely to be concerned.'

649

Yet the Ministry of Health assumed that Doctors, Architects and Engineers were the three groups that should be involved in the planning of hospital building programmes and omitted others, including 'nurses, administrators and quantity surveyors'.⁶⁵⁰ Indeed, when guidance on *Hospital Design* was issued in 1964, 'sanitary appliances and fittings in relation to functional requirements' in hospitals were to be studied and recommendations made by an Inter-Board Architectural Study Group, but no reference was made to the involvement of clinicians.⁶⁵¹ The guidance on the selection of taps for use in clinical areas was only revised in 1968, when the DHSS noted that cleanliness and proper ward technique were essential to the prevention of cross-infection, and recommended that 'lever-type taps...will be required for staff hand-basins in patient areas and ancillary rooms where aseptic practices make this necessary.'⁶⁵²

In 1950, the facilities available for nursing patients at the General were criticised in the GNC Inspector's report, which gave the hospital only provisional approval to provide training pending improvements. While the improvements required by the GNC were achieved by 1954, most developments in the hospital were an attempt to ameliorate existing buildings – sanitary and ancillary annexes were added to the original workhouse buildings, new equipment was provided, and new facilities were created by adapting old ward accommodation, with the exception of the new theatre block opened in 1968.

⁶⁴⁹ Ministry of Health, *Hospital Equipment Note – 1 Equipping a Hospital Building* (London, 1962), p. 1.

⁶⁵⁰ Ministry of Health, *Hospital Building Note – 1 Buildings for the Hospital Service* (London, 1961), p. 1; Ministry of Health, *Hospital Plan*, Paragraph 46, p. 13; R Moss, *Hospital Design and the National Health Service; an Assessment of the Main Methods Used to Give Guidance on Planning and Design and the Procedures to be Followed* (London, 1973).

⁶⁵¹ Ministry of Health, *Hospital Design Note – 1 Dimensional Coordination and Industrialised Building* (London, 1964), Paragraph 68.

⁶⁵² Department of Health and Social Security, *Hospital Building Note 4 – Ward Units* (London, 1968), pp. 3, 16.

The hospitals' committee minutes indicate that they were willing to implement the GNC Inspectors' recommendation within the limits of their budgets.⁶⁵³ In November 1954, the General's Hospital Secretary expressed the view that the GNC 'kept hospitals up-to-date and progressing with modern ideas.' Hospital secretaries in the Region appear not to have agreed. The records of the meeting at which Stansfield expressed his positive opinion note 'This view was not generally shared'. One of those attending noted that the GNC, in his experience, failed to make note of improvements, only finding faults. The consensus was that the GNC's recommendations on structural modifications represented unwarranted straying into areas with which they should not be concerned, indicating a lack of insight into the financial and resource limitations under which the hospital authorities operated.⁶⁵⁴

During the 1950s the majority of the General's ward blocks, which were on two floors, were without lifts, so that when a chimney on an upper floor ward collapsed in the middle of the night of the first of March 1956, the nurses, two policemen and a Doctor had to carry the patients downstairs to safety.⁶⁵⁵ In order to accommodate all people requiring hospital admission, extra beds were regularly installed in the middle of the General's wards, and day patients used beds assigned to in-patients, who were obliged to sit out of them.⁶⁵⁶

The hospital authorities were, though, keen to improve the services they offered. Fir Vale was also improved during the 1950s, although the impact of these developments was limited. The wards of the hospital were described in 1965 as having 'Inadequate bed spacings and insufficient sanitary facilities [that] produced working conditions

⁶⁵³ For example: SA: SY 569/H1/14 NAC[1973]4, Feb 1973.

⁶⁵⁴ SA: SY 291/H1/1, 15 Nov 1954.

⁶⁵⁵ SA: Acc 1994/64, Box 2, CGH(56)3, 'Matron's Report', 15 Mar 1956.

⁶⁵⁶ SA: SY 569/H1/9, GNC Report on the Sixth Visit, Feb 1967; SA SY 569/H1/11, Nursing Advisory Sub-Committee, 'First Report on the consideration of the Secretary of State's Letter and Pink Circular HM(70)35 on "Action to Improve the Nursing Situation" '.

which were most unhelpful to the recruitment and retention of nursing staff'.⁶⁵⁷ A report presented in 1950 by the Hospital Secretary of the General on staff accommodation outlined ambitious proposals for the hospital to become a regional specialist centre. Yet by 1955 when Sheffield RHB published its *Hospital Planning Proposals*, it was apparent that replacing old hospital buildings with new facilities was a very long-term goal. They observed that 'even without another war' the economic and financial situation in the United Kingdom would 'not permit much expenditure upon hospitals and allied services.' As a consequence, the building of new hospitals was likely to be delayed indefinitely, although the General was identified as in need of 'complete alteration and reconstruction', the 'radical remodelling' of existing wards and provision of new departments 'of every kind'. This was accorded the highest priority – when money became available to realise the aspirations.⁶⁵⁸ While the GNC inspection of 1967 described the wards at the General as 'bright and pleasant', it also acknowledged that only structural alterations would allow the provision of 'really adequate' patient facilities and sanitary annexes, lifts between the wards on the two-storey blocks and improvements in the nurses' accommodation.⁶⁵⁹

The General was designated to become a District General Hospital within the general provisions of the 1962 *Hospital Plan*, and it was anticipated that the hospital should undergo redevelopment and expansion over at least the following ten years. Plans published in 1970 for modernisation of the hospital site included an Accident and Emergency department, orthopaedic fracture clinics, new wards, nurse and midwifery education centre and postgraduate medical education centre, and a new hospital library, although the *Hospital Plan* had anticipated that the new clinical areas would be started between 1966-67 and 1970-71. The plans were discussed in April 1971 and

⁶⁵⁷ SA: SY 569/H1/7 FVI(65)8, 17 Sept 1965.

⁶⁵⁸ SA: SY 709/H2/1, *Hospital Planning Proposals of the Sheffield Regional Hospital Board* (Sheffield, 1955); SA SY 569/H1/3, MC(50)8 – 'Hospital Secretary's Report', 11 Sept 1950.

⁶⁵⁹ SA: SY 569/H1/8. Report on GNC sixth visit, Feb 1967.

were to take between fifteen and twenty years to implement, over five phases starting in 1972, which would lead to the almost complete rebuilding of the hospital at a cost of £15.5 million.⁶⁶⁰

Hughes has noted that no hospital, whether a charitable foundation or municipal one, was built in any but the most economical way. Nevertheless, the USH hospitals' wards appear to have been more pleasant, and in the case of the Infirmary at least, more adaptable than those of the General. The GNC reports for the Royal's old wards describe them as 'good', with central fireplaces, central heating, fixed hand basins and sanitary and ancillary annexes on each ward. However, as was the practice at the General, day patients were given the beds of those in-patients who could get up, and extra beds 'permanently in the middle of the ward' made nursing difficult. The Royal had an Annexe in the south-west of the city that was described as yet more crowded, and nursing conditions there were considered by the GNC Inspector to be concomitantly worse than those at the main hospital.⁶⁶¹

Between 1949 and 1957, the Infirmary's wards were modernised, including the installation of bed cubicles in the private ward block and bed curtains in other wards. Initially the hospital's medical staff expressed reservations about the installation of bed curtains, because they might increase the risk of cross-infection by harbouring pathogens that could be dispersed when the curtains were opened and shut. In 1953, though, they decided that the risk of increased cross-infection was 'of no real importance' and agreed that cubicle curtains should be installed. They objected when dark curtains were purchased in 1964, that these would interfere with the medical examination of patients by cutting down the amount of natural light available to the Doctor. Sisters' offices were provided in those wards that had not previously had them

⁶⁶⁰ Ministry of Health, *Hospital Plan*, pp. 59-61; SA: SY 569/H1/11, 'NGH Redevelopment Report'; SA: SY 569/H1/12, MC(71)4, 19 Apr 1971.

⁶⁶¹ TNA: PRO DT33/456.

– allowing relatives privacy during discussions with the staff, and ‘erring probationers’ to be disciplined away from the main ward.⁶⁶²

For the Infirmary and the Royal, apart from financial considerations, additional constraints on modernisation came from the anticipated construction of the new Teaching Hospital and the opening of the Weston Park Hospital, although their existence did not undermine the expectation that the older hospitals would continue to develop until the end of the twentieth century. Nonetheless, in 1970 a ward block at the Infirmary had to be closed, because it was unsafe, and patients evacuated - some to other wards of the hospital, some to the General, though these were nursed by Infirmary nurses. Yet, modern ward blocks with single rooms presented nurses with management difficulties when staff numbers were limited, and many of the nurses were junior and inexperienced. ‘It is quite impossible for the Nursing Staff adequately to supervise these patients in a ward of this type [neurosurgery] unless there is a very large increase in the number of nursing staff, both on day and night duty.’⁶⁶³

The availability of nurses and the physical environment were two aspects of the context in which nursing care was delivered; a third was provided by the medical work being done in the hospitals. In 1954, the records for the General list clinical specialities at the hospital including dermatology, cardiology, gynaecology, medicine, surgery, orthopaedics and psychiatry. References to services for old people at Fir Vale and the General, and services for people with rheumatoid arthritis at Nether Edge Hospital, indicate that these were developing as areas of specialist practice within the HMC.⁶⁶⁴ Annual Reports of the USH Board of Governors for the early 1960s list

⁶⁶² SA: SY 333/H3/27, *passim*. 1949-1953; TNA: PRO DT33/456; SA: SY 333/H6/14, 10 Mar 1953; SA: SY 333/H6/14, 7 Apr 1964.

⁶⁶³ SA: Acc 2001/98, ‘Matron’s Records’, Apr 1959; SA: SY 333/H6/88, pp. 1-2.

⁶⁶⁴ SA: Acc 1994/64, CGH(54)5, ‘Report of the Hospital Secretary’, 13 May 1954; International Conference of Gerontology, *Sheffield Pre-Conference* (Sheffield, 15 July 1957). Services for people

twenty-nine specialist areas of practice with Consultants in post – twenty of them clinical specialisms, seven diagnostic specialisms with preventive medicine and medical teaching providing the balance, and these had expanded since 1948, and continued to do so.

In one of the last articles published before she left the role of Chief Nurse at the Ministry of Health, Elizabeth Cockayne wrote in 1958 that 'The development of medical science goes on apace, bringing new theories on nursing care and adding to the skilled techniques necessary.'⁶⁶⁵ Nationally, new therapeutic developments included expansion in the range and quantity of antibiotics available and a reduction in their unit price, development in the number and quality of cardio-active drugs, and new surgical techniques - particularly in orthopaedic, cardiothoracic, neurological, ophthalmic and renal transplant surgery.⁶⁶⁶ In Sheffield, developments included research - conducted at the USH - into conditions including bronchitis, hydrocephalus, paralysis, carcinoma of the bladder, and rheumatoid arthritis; symptoms such as respiratory insufficiency; diagnostic procedures including renograms, tissue lipid analysis, the use of radioisotopes, and biochemistry; and treatments including hyperbaric oxygen therapy and therapeutic interventions in rheumatoid arthritis. All three general hospitals opened intensive care units between 1964 and 1968. Other developments included renal transplantation at the Royal, and the expansion of physiotherapy and occupational therapy services in all units from the 1950s onwards.⁶⁶⁷

with rheumatoid arthritis involved collaboration between the HMC hospital, which provided clinical facilities, and the USH, which funded research into the condition and its management.

⁶⁶⁵ E Cockayne, 'Ten years of nursing in the National Health Service' *Nursing Times* 4 July (1958), pp. 762-763

⁶⁶⁶ Rivett, *Cradle to Grave*, pp. 53-79, 134-161, 209-237..

⁶⁶⁷ SA: SY 333/H6/82, p. 1; SA SY 333/H6/87, p. 1.

The introduction of the NHS facilitated medical research, but a combination of therapeutic innovation and an expanding cadre of relatively autonomous specialists and Consultants tended to undermine the capacity of hospitals to manage the associated costs of incremental change in the delivery of hospital-based clinical services.⁶⁶⁸ The chief pharmacist at the General noted in 1957 that

...it is now obvious to me that certain routine therapies have changed in the past two or three years...Routine hypertensive therapy. As recently as five years ago therapy in this field was restricted to diet and sedatives, whereas now we issue large quantities of Tablets and Injections for this condition, and it is one field of therapy that shows a spate of new drugs.⁶⁶⁹

The increase in the bill for drugs and dressings used at the General and in the USH hospitals seems to have been unexpected. Faced with limited revenue allocations to deal with these and increases in other costs, the HMC and the USH Board of Governors established committees charged with responsibility for scrutinising the use of clinical materials, including drugs, equipment, bandages and dressings and the expenditure incurred thereby. The GNC advised that students should be taught economy in the use of hospital supplies.⁶⁷⁰ Overspent in 1966 by £9000, the Infirmary asked the Sisters to identify ways of economising – although they had little power to effect change.

The combination of the continual need to economise, the increasing acuity of inpatient care and shortage of nursing hours available created difficulties for the nursing staff. Limits on the implementation of new technologies included the availability of appropriate buildings and staff. Yet these problems also contributed to a willingness to consider the implementation of alternatives to ward-based sterilisation of instruments and preparation of wound dressings by nurses, to the replacement of mackintoshes

⁶⁶⁸ Weatherall, 'The NHS and medical research', p. 164; Rivett, *Cradle to Grave*, *passim*; Harrison, *Shifting the Frontier*, p. 46.

⁶⁶⁹ SA: Acc 1994/64 Box 5, CGH(57)10, 'Chief Pharmacist's Report', 17 Oct 1957.

⁶⁷⁰ TNA: PRO DT 33/456; SA: SY 569/H1 and SY 333/H16, *passim*

with plastic mattress covers, and to new approaches to the organisation of the working day. Increasingly, nurses were involved in deciding the direction and content of change, although it would be unwise to overstate the extent of this.

5.3 Nursing Work and Non-nursing Work – Redefining the Boundaries

All nursing work had to be conducted according to the formal rules of the GNC and the procedure manuals, and the informal rules of the clinical areas. The latter were shaped by time as much as by the physical environment and social relationships of the workplace. The reduction in hours worked by nurses and changes in shift patterns and off-duty time had specific effects on the nature of clinical work done by nurses. Changes encompassed restructuring of the hospital day, alteration of the hours worked by nurses and the nature of work done at different times during the day. The Nuffield Report made suggestions for reducing unnecessary nursing work and these were largely welcomed in discussions by the various House Committees in Sheffield, for example. The identification of certain 'menial' tasks as being appropriate for delegation to other grades of staff was viewed more equivocally. The redefinition and re-allocation of domestic work offered the chance to reduce the burden on nursing staff, and maybe remove a barrier to recruitment of students that had been identified in reports from 1932 onwards. The obverse of this was that the definition of what constitutes 'nursing' was – and remains - contested, the boundaries around nursing work were permeable, and some nurses resisted the redefinition of tasks that put them beyond the scope of nursing practice.

Nurses of Ward Sister and Charge Nurse grade and above were increasingly involved in proposing solutions to the shortage of nursing time. In September 1966, the Matron's meeting with Ward Sisters at the Infirmary included informing the Sisters about modern teaching on the prevention and treatment of pressure sores. The records

indicate that this was prompted by the increasing incidence of pressure sores amongst the hospital's patients. The Sisters complained that not only were more patients being admitted with pressure sores but the situation was becoming worse because there were too few nurses to provide the care necessary to prevent and treat them. Rather than accepting this complaint, the Matron told them that there were 'more staff than ever before, and this was not the problem'. Those present at the meeting established a voluntary committee to review the use of nursing time, and identify how they might remove unnecessary work from nurses.⁶⁷¹

Nursing Auxiliaries were employed to carry out basic nursing duties. They were not employed to carry out technical tasks, such as the administration of medication or the dressing of wounds. The records of the meetings held between the Matron and the Sisters at the Infirmary indicate that on at least three occasions, it was necessary to issue Ward Sisters and Charge Nurses with a reminder of the limits of the auxiliaries' competence.⁶⁷² It is likely that Nursing Auxiliaries were allowed to work beyond what was expected of them because this was practically necessary to get the work done, especially when they were recruited in substitution for scarce learner nurses. Student Nurses found that they might be expected both to tolerate less teaching of technical nursing skills, and effectively to be in charge of a ward of patients on night duty or in the afternoon at the weekend because there were insufficient qualified nurses to supervise them.

Until the late 1950s, at least, nurses sorted foul linen before they could send it to the laundry, although the GNC deprecated this misuse especially of learners' time.⁶⁷³ Apart from the unpleasant nature of the work, it was time-consuming and the space

⁶⁷¹ SA: Acc 2001/98, Meetings with Sisters, 19 Sep 1966.

⁶⁷² SA: Acc 2001/98, Meetings with Sisters, 6 June 1955, 1 Apr 1957, and Minute 539, 5 Feb 1962.

⁶⁷³ TNA: PRO DT 33/456, Royal Hospital, Recommendation 14, 1957.

available was limited.⁶⁷⁴ The Matron of the Infirmary complained that the nurses lacked the tools they required to do their job, including sufficient quantities of bed-linen, and suggested amongst other improvements that a centralised linen store and the provision of disposable plastic draw-sheets would mean that nurses would not have to spend hours washing and drying mackintoshes on the wards without proper facilities.⁶⁷⁵ The shortage of bed-linen was again reported in late 1967, when 'The Sisters confirmed that there was always a general shortage of linen on the wards, particularly operation gowns and bed-sheets, and this shortage was very acute at weekends.'⁶⁷⁶ In 1968, the Royal was estimated to be in need of an additional £4,800-worth of bed-linen, according to recommendations for reducing the pressure of nursing work.⁶⁷⁷

A subcommittee of the Royal's Medical Staff Committee, advised by the Matron, administrators and other 'appropriate members of staff' convened in 1968 and identified that nurses were doing much of the ward domestic work when orderlies were absent for any reason. This involved nurses in cleaning the hospital's theatres, changing the Doctors' white coats, running errands, and searching for scarce items to borrow from other wards and departments. None of these involved the direct care of patients, though the blurred boundaries around what actually comprised nursing work always made it difficult to argue that they were certainly outside the responsibility of the nursing staff. If an operating theatre were blood-splattered and filthy following a surgical operation, the safety of the next patient on the operating list made cleaning the

⁶⁷⁴ SA: Acc 2001/98. Matron's Records, 12 Sept 1960.

⁶⁷⁵ SA: SY 333/H3/31 *The Needs of the Nursing Staff of the Infirmary* 11 July 1966

⁶⁷⁶ SA: Acc 2001/98, Meetings with Sisters, Minute 865, 8 Nov 1967.

⁶⁷⁷ SA: SY 333/H1/36, 9 July 1968.

environment a task for the nurse to undertake, in the absence of domestic staff to do it.⁶⁷⁸

The recommended action to address the shortage of nurses that had prompted their report included the appointment of additional ward orderlies, clerical, and reception staff and a full-time cleaner for the Casualty Department.⁶⁷⁹ Student Nurses, especially those in the first year of training, were apparently more likely to be required to do these tasks, although the supervision of domestic tasks was considered part of the nursing role throughout the hierarchy. A qualification in 'Housekeeping' was often listed amongst those possessed by nurses seeking senior nursing posts during the 1950s and early 1960s. One newspaper article claimed that

Women with presumably enormous experience of looking after the sick work up to the top and turn out to be a sort of hotel manager as well...[while]...'At the ward floor level the situation is far worse, and the amount of time students spend doing what a char could do better in the name of training is notorious.⁶⁸⁰

The article was published in 1970, but the concerns it raised had been highlighted on several occasions beforehand. Correspondence from the GNC to all hospitals in 1967 advised that Student Nurses should not be carrying out menial duties that could be done by ward orderlies.

At the Infirmary, discussion of the 1968 Prices and Incomes Board (PIB) Report identified that necessary work was being done by the wrong grade of staff. However, nurses were criticised by the hospital's Chief Administrative Officer for doing things out of ritual and routine. This prompted the Matron, who had that April found it necessary to remind them that routine four-hourly measurements of patients' temperature, pulse and respiratory rates had been discontinued for four years, to ask

⁶⁷⁸ SA: SY333/H1/36, 9 July 1968.

⁶⁷⁹ SA: SY333/H1/36, 9 July 1968.

⁶⁸⁰ TNA: DT 33/456; SA SY 569/H1/ *passim*; A Shearer 'A lady with a lamp or a char?' *Guardian* 13 Jan (1970), p. 9.

the Sisters to consider their own ward and department practices 'so that we are not open to criticism.'⁶⁸¹

Among measures taken to remove non-nursing duties from nurses were the introduction of ward and casualty department clerks, this being done earliest at the Infirmary, and the employment of housekeepers on the wards at Nether Edge Hospital, which was part of the Geriatric Nursing Division of the HMC that also included wards at The General. It was estimated that the employment of a ward assistant on one of the Infirmary's wards in 1949 had saved 60% of a nurse's time, and 'a considerable amount of the Sister's'. The House Committee agreed thereafter to extend their appointment to other wards, providing the ward had an office. Their appointment was also seen as a way of improving recruitment, as they would be between fifteen and eighteen years of age and they would be expected to enter nurse training.⁶⁸² However, employing new grades and greater numbers of ancillary staff was not sufficient to reduce the amount of work nurses did. Additional changes were required, which involved revising the demands placed on nurses by the working practices of their medical colleagues.⁶⁸³

Saving nursing time was also a factor in changes in the nature of records made of the nursing care given to individual patients.⁶⁸⁴ This change was made gradually at the Infirmary and the Royal, and involved the replacement of a single document for the recording of information about all patients with individual records for each patient.

The present Report Book for patients is entered chronologically as each patient is treated, and can only be used by one person at a time. More than one entry per

⁶⁸¹ SA: Acc2001/98, Meetings with Sisters, 9 Apr 1968, 9 July 1968 and 13 Aug 1968.

⁶⁸² SA: SY 333/H3/27, 21 Feb and 2 Mar 1949.

⁶⁸³ SA: Acc 2001/98, Meetings with Sisters, 12 Feb 1957; SA: Acc 2001/98, Matron's Records, 14 Mar 1960 and 12 Dec 1960; SA: SY 569/H1/12, 'Action to improve the nursing situation - Ward Housekeeping Service'; SA SY 569/H1/12, 'Action to improve the nursing situation - follow-up of HM(70)35'.

⁶⁸⁴ SA: Acc 2001/98, Matron's Records, 6 Sept 1958.

patient may need to be consulted, in different parts of the book, depending on when the entries had been made.⁶⁸⁵

The advantages claimed for the 'Kardex' system were that the daily report sheets, drug sheets and Nursing Orders could be filed in the patients' notes and their previous history and response to treatment 'quickly observed', whereas the present system led to 'delays and indecision...inefficiency and time-wasting' to the detriment of patient interests and poor use of nursing time.⁶⁸⁶

The Infirmary completed the introduction of the Kardex system for nursing and for drug records before the Royal. Interestingly, the Infirmary's Matron approached the medical staff for consideration of the change of reporting system before proposing it to the Board. Infirmary patients' records stayed on the ward to which they had been admitted, even if they transferred to another ward, but from September 1964, the transfer of notes with the patients was introduced – although their details had still to be entered into the 'TPR book' of the sending and receiving wards – and from February 1969, their Kardex was also transferred.⁶⁸⁷ The move to the Kardex system changed the focus of nursing from the completion of a series of tasks for a group of patients to the care of individual people. It also carried the possibility that individual nurses could ultimately be held to account for their actions.

Finally, another, though less frequently noted, issue was the presence of older people with chronic health problems in wards for acutely ill patients. These people were believed to belong in long-stay hospital wards, but there are indications that there were

⁶⁸⁵ SA SY 333/H1/36, 9 July 1968.

⁶⁸⁶ SA SY333/H1/36, 9 July 1968.

⁶⁸⁷ SA Acc 2001/98, Meetings with Sisters, Minute 198 c and f, 5 Apr 1954; SA SY 333/H6/14, 6 May 1958; SA Acc 2001/98, Matron's Records, 10 Nov 1958; SA Acc 2001/98, Meetings with Sisters, 21 Mar 1960; SA SY 333/H3/30, 13 Mar 1961; SA Acc 2001/98, Matron's Records, 13 Mar 1961; SA Acc 2001/98, Meetings with Sisters, 3 Oct 1961; SA Acc 2001/98, Matron's Records, 9 Oct 1961; SA Acc 2001/98, Meetings with Sisters, 15 Sept 1964; SA SY 333/H1/36, 9 July 1968; SA Acc 2001/98, 11 Feb 1969.

insufficient beds in this category available throughout the NHS.⁶⁸⁸ In 1955, a report on bed occupancy at the Royal highlighted concern that quality of care was in jeopardy if nurses were unable to attend to patients' needs because accurate calculation of nursing establishments was hampered when the long-term presence of chronically sick people appeared to reduce the turnover of patients in a ward.⁶⁸⁹ This suggests that the calculation of nursing establishments, no less than that of patient bed requirements, was based on activity levels rather than on objective measurement of need. The problem was a recurrent one, exacerbated by the closure of beds at the Fir Vale Infirmary in 1968, to which the USH acute units as well as the General transferred patients.⁶⁹⁰

5.4 Changing Relationships with Medical Colleagues

Much of the work of nurses was routine and yet within the context of what could appear to be unchanging, there were a number of important changes between 1948 and 1974. Though his remarks were not corroborated either by other Consultants or members of the nursing team, one cardiothoracic surgeon wrote in the 1964 edition of the Infirmary's *League of Trained Nurses* magazine that 'Decisions governing patient treatment more frequently result from joint medical and nursing consultation than has hitherto been the custom. An adaptive and constructively critical approach is desirable in all unit nursing personnel, and free discussion of clinical problems is essential.'⁶⁹¹

This might refer only to this highly specialised area of clinical care, in which the ability to trust to individual nurses' judgement when the Consultant could not always be present, and the junior medical staff were likely to be far less knowledgeable than the registered nurse on duty, teamwork and cooperation were crucial to patient

⁶⁸⁸ Bridgen, 'Elderly people', pp. 519-520.

⁶⁸⁹ SA: SY 333/H1/33, 23 May 1955.

⁶⁹⁰ SA: SY 333/H1/35, Minute H(66)16, 8 Feb 1966.

⁶⁹¹ SA: SY 333/H6/82, D G Taylor, 'Advances in Surgery of the Heart'.

survival. It could also reflect the views of only one surgeon whose personality and approach to clinical management differed from those of his colleagues. Yet the last of the USH Board of Governors' *Annual Reports*, published in 1974, noted a change in the relationship between nurses and their colleagues in other professions in the hospital hierarchy:

As nurses at all levels have become more skilled in applying the principles of good management to their work, it has been noticeable that problems are being identified and established practice is being questioned to the benefit of the patient.⁶⁹²

Medical and nursing staff were engaged in establishing boundaries around specific aspects of clinical work during the 1950s, as well as in challenging them. As much of the work of the nurse was determined by decisions taken by medical staff concerning the management of a patient's care, discussions of pressures on nursing staff and responses to staff shortages challenged medical staff to reconsider their expectations of nurses. This included - as a short-term measure during shortages of theatre nurses - reducing the length of the operating theatre lists, not expecting nurses to attend on all ward rounds and agreeing to consider proposals for improving working practices put forward by nurses.⁶⁹³

Arguments over the exact methods to be used when following clinical procedures, such as the administration of steam inhalations, the performance of venepuncture and the administration of intramuscular injections, also took place. In all three cases, the records made by successive Matrons of the Infirmary reveal disputes continuing over sustained periods. At the Infirmary, 'Notes on Procedures' were intended to guide nurses in carrying out specific clinical interventions. Nonetheless, the medical and surgical staff made 'frequent changes' to the procedures, although they had been agreed by a committee composed of senior nurses who appear to have consulted

⁶⁹² SA: SY 333/H16/8, p. 25.

⁶⁹³ SA: SY 569(H1)12, 'Action to improve the nursing situation - follow-up of HM(70)35'.

guidance from the SNAC at the Ministry of Health and the requirements of the GNC in compiling them. When disagreement arose between the nursing and medical staff over some practical procedures, the nursing staff accommodated the wishes of the medical staff more readily than the recommendations of either the SNAC or the GNC. The Matron introduced the SNAC guidelines, emanating from the Ministry of Health, as not dictating but 'enabling some uniformity all over the country, chiefly where difficulties arose in the non-teaching groups of hospitals' – which allowed for considerable leeway in their interpretation, particularly in a teaching hospital.⁶⁹⁴

The medical staff appear to have operated a veto over the decisions of the USH Nursing Procedure Committee. Thus in October 1951, Matron informed the Infirmary's Sisters that the 'basic settings of dressing trolleys now used were considered correct' by the medical staff of the USH and she asked them to ensure that they were implemented. It is unlikely that the senior qualified nurses who had devised the trolley settings could have been ignorant of how to set up a 'basic dressing trolley'.⁶⁹⁵ That the medical and surgical staffs made changes to the Procedures notes on the special wards and departments is apparent, to the extent that the records indicate that nurses disregarded the agreed nursing procedures in deference to their medical colleagues' wishes.

The administration of steam inhalations provides an example of divergence between GNC requirements and clinical practice. Student Nurses could be examined on and would have to be conversant with, GNC guidelines as set out in the syllabus of training, but the Infirmary's ENT surgeon preferred the procedure to be carried out in a different manner to that prescribed by the GNC – and thus by the USH Nursing Procedure Committee. The surgeon insisted on his preference being followed, and this

⁶⁹⁴ SA: Acc 2001/98, Meetings with Sisters, 3 Dec 1951.

⁶⁹⁵ SA: Acc 2001/98, Meetings with Sisters, 15 Oct 1951.

was then noted as a 'special request', at variance with the GNC examination syllabus.⁶⁹⁶ In April 1955, the Infirmary's Matron found it necessary to remind all Sisters that they should 'scrutinise...[the procedures]...carefully', ensure that the nurses were familiar with them, and make sure that they were available for reference.⁶⁹⁷

The second example cited was that of venepuncture, that is the withdrawing of blood from a vein, usually for diagnostic purposes. On the wards at the Infirmary, this was done in order to facilitate the assessment of blood glucose levels. It appears that qualified members of nursing staff at the Infirmary performed this task. In January 1955, the Matron is recorded as having 'again questioned the propriety' of this, although the implied earlier challenges are not recorded. The response of the Medical Staff Committee was that the practice was regrettable but necessary, indicating a shortage of medical staff, and did not recommend stopping the practice.⁶⁹⁸ In December 1956, the Matron reminded her nursing colleagues that venepuncture did not come within the province of nursing work.⁶⁹⁹ Yet in May 1958, the medical staff noted that an additional burden had been transferred to them, as Matron had recently ordered the nursing staff to stop taking intravenous blood specimens.⁷⁰⁰

By 1973, supervision of medical undergraduates undertaking venepuncture as part of their clinical training was reported as being a routine aspect of the duties of Sisters on wards at the General.⁷⁰¹ However, at the time, neither the GNC nor the Central Midwives Board approved of nurses undertaking venepuncture. The Chief Nursing Officer of the HMC advised that if the Consultant medical staff wanted nurses to

⁶⁹⁶ SA: Acc 2001/98, Meetings with Sisters, 7 Apr 1952 and 9 Jun 1952.

⁶⁹⁷ SA: Acc 2001/98, Meetings with Sisters, 12 Apr 1955.

⁶⁹⁸ SA: SY 333/H16/14, 17 Jan 1955.

⁶⁹⁹ SA: Acc 2001/98, Meetings with Sisters, 3 Dec 1956.

⁷⁰⁰ SA: SY 333/H6/14, 6 May 1958.

⁷⁰¹ SA: SY 569/H1/14, MC(73)1, Nurse Staffing Report.

perform venepuncture, they should take personal responsibility for training them and should certify their competence, as the HMC would face legal difficulties in the event that an accident occurred while a nurse or midwife was carrying out this procedure. In December 1973, the Medical Executive Committee decided 'That a supply of forms be left on each ward and that if a particular Consultant wanted nurses to carry out this procedure he would sign a certificate for a particular nurse stating that she had proven to him her ability to carry out the venae puncture procedure.'⁷⁰² Thus, they acceded to the letter of the request, though not its spirit.

The third example given of the testing of boundaries between Doctors and Nurses' spheres of responsibility concerned the administration of intramuscular injections. The Sheffield School of Nursing taught Student Nurses that an intramuscular injection could be administered to either the buttock or the thigh muscle, and the Consultants of the Royal preferred their patients to receive any intramuscular medication into the former. The medical staff of the Infirmary were 'of the unanimous opinion' that only the outer aspect of the thigh was a safe site for such injections, and refused to accept any alternative in normal circumstances, repeating this advice in 1971 when the issue was again raised, this time by the School of Nursing.⁷⁰³

While the examples considered here instance conflicts over aspects of clinical practice, there were also examples of cooperation between medical and nursing staff, facilitated by the support of the lay administrators and management committees.⁷⁰⁴ Nurses' ability to gain this appears to have been related to their scarcity as a skilled group of people whose availability was essential to the delivery of hospital-based treatment, particularly before the Salmon reforms gave them a formal role in the hospital's

⁷⁰² SA: SY 569/H1/15, MEX(73)14, Minute 161, 14 Dec 1973.

⁷⁰³ SA SY 333/H16/14, 4 Feb 1958 and 4 Mar 1958; SA SY 333/H6/14, 5 Oct 1971.

⁷⁰⁴ Several examples are given in Chapter 3, in relation to the medical staffs' response to shortages of nursing staff.

management structures. In 1969, the recurrent problem of nursing staff shortages in the NGH operating theatres prompted the formation of a working party to investigate staffing methods. The working party comprised representatives of all interested parties, including three nurses, two administrators, an anaesthetist and a surgeon. Their brief was set by the NAC, and initially it was limited to the examination of staffing issues. The scope of their remit was expanded within three weeks by the HMC to include general nursing staff issues. Their recommendations included not only the establishment at the hospital of a new grade of Nursing Auxiliary, the Operating Theatre Assistant, with a dedicated in-service training programme, but clear recognition of the skills and clinical accountability of the trained nursing staff. Students were to be allocated to the theatres, but as observers only; an SRN or SEN would be on duty in the anaesthetic room, the recovery area and an SRN would be present during all operations. Most significantly, the SRN would bear ultimate responsibility for nursing procedures and any consequences arising.⁷⁰⁵

5.5 Changing Relationships with Patients

Also, during the 1950s and 1960s the relationship between hospitals and the patients underwent changes. Such changes were made in nursing management of patient care, in the structure of the in-patient's day including later waking in the morning, in reviews of visiting arrangements, and in new approaches to the communication of information to patients and their relatives.⁷⁰⁶

Between 1948 and 1974, four different approaches to the management of patient care appear to have been employed, or considered for adoption, in Sheffield's general hospitals. In chronological order, the first of these was task or duty allocation, the

⁷⁰⁵ SA: SY 569/H1/11. MC(70)5, 'Report of the Working Party to examine the methods of staffing the operating theatres at Northern General Hospital' 13 Apr 1970.

⁷⁰⁶ SA: SY 333/H1/33, 1953 and 1954; SA: SY 569/H1/6, 1954; Ministry of Health/CHSC *In-patient's Day*.

second 'case assignment', the third 'progressive patient care' and the fourth 'total patient care'. All but Progressive Patient Care were concerned with direct nursing care - progressive patient care being concerned with the overall management of all patients in a hospital.

Task or job allocation or assignment was derived from the principles of scientific management, and broke the care of the patient down to a series of discrete tasks that could be allocated to members of the nursing team according to their ability and experience, some of which could be performed with minimal instruction. This had the supposed advantage of allowing a ward team composed mainly of untrained or learner nurses to deliver care safely under the supervision of often only one qualified nurse - or if necessary in the absence of direct supervision by a qualified nurse.⁷⁰⁷ Learners could simply put procedures learnt in the training school into practice in the ward or department. The disadvantages from the patient's point of view included the dominance of ward routine over the concerns of the patient, in which '...anything outside of routine was more apt to be forgotten - and yet these were the things so often much more important to the patient, as he saw it...'⁷⁰⁸

With the exception of one ward at the Infirmary, though, the organisation of the work appears to have followed the task or duty allocation system. In 1950, the first meeting of the Matron and Sisters' at the Infirmary examined the possibility of reorganising the work done by nurses, and agreed that they could provide all the care required by an individual rather than carrying out a limited number of discrete tasks for all or a large

⁷⁰⁷ SA: SY 569/H1/6, '2nd Supplementary Report on "Nursing and Nurse Training at CGH"', 8 Apr 1953; SA: SY 569/H1/8, GNC Report on Sixth Visit, 15 Feb 1967; SA: SY 569/H1/11, Nursing Advisory Subcommittee, 'First Report on the Consideration of the Secretary of State's Letter and Pink Circular HM(70)35 on "Action to Improve the Nursing Situation, 1970"'.
⁷⁰⁸ McGhee, *Patient's Attitude to Nursing Care*, pp. 39-40.

number of patients in a ward.⁷⁰⁹ However, implementation does not appear to have been effective. In 1954 they agreed to try this case assignment approach ‘...when additional nursing staff is available.’⁷¹⁰ The records make no further reference to case assignment during the 1950s and 1960s. Limited resources of staff and time combined with pressures to get work done in time for patients to visit other departments for investigations or treatments, or to be visited themselves by Doctors or relatives, appear to have been more pressing concerns.⁷¹¹

The patient-centred or holistic approach to the management of nursing care had however to be reconsidered. ‘Total patient care’ was sanctioned as an approach to the delivery of care. Total patient care, which required the nurse to deliver all the care required to the individual patient, was included in the GNC’s syllabus for examination from 1969. As the nurse would usually be working as one of a team of nurses, this approach to the management of patient care required that qualified nurses be able to prioritise the needs of the patients, to delegate to others, to teach these skills to students and above all, have confidence in the stability in the nursing team. The USH adopted Total Patient Care as policy and while the Nursing Committee minutes for February 1973 reported that, its advantages ‘far outweigh’ the disadvantages, the latter included difficulty on the part of the ‘less experienced sisters’ in delegating work, especially at busy times or if the patient was very ill.⁷¹² This suggests that changes in the organisation of nursing work were introduced without consideration of the training needs of the nurses on whom successful implementation relied. It also highlights the possibility that management training courses, introduced in concert with the

⁷⁰⁹ J Sharp, ‘Nursing by Case Assignment’, *Nursing Times* 46:1, 7 Jan (1950), pp. 4-6; SA: Acc 2001/98, Meetings with Sisters, 5 Jun 1950.

⁷¹⁰ SA: Acc 2001/98, Meetings with Sisters, Minutes 198 c and f, 5 Apr 1954.

⁷¹¹ SA: Acc2001/98, Meetings with Sisters, and, Matron’s Records, *passim*.

⁷¹² SA: SY 333/H16/12, 26 Mar 1973; SA: SY 333/H6/14, 2 Feb 1971.

implementation of the Salmon Committee's proposals, were not addressing nurses' management training needs fully.⁷¹³

From 1962, 'Progressive Patient Care', a system of patient management originating in the USA and promoted by Kathleen Raven during her term as Chief Nursing Officer at the Ministry of Health, was much discussed and some aspects were implemented in Britain.⁷¹⁴ Under this system, continuity of care would be assured by the organisation of services according to the different kind and level of care and therapy required, to which individual patients would be admitted according to need. The rationale behind the system was to allow for the more efficient use of nursing staff and scarce technical equipment and thereby to ensure that the patient received appropriate and continuous care at and between each of four or five phases from admission to discharge and beyond. In 1963, Pavitt described the four phases as: intensive care, intermediate care, self-care and continuation care.⁷¹⁵

In July 1962, Sheffield RHB's Nursing Committee received a report by one of its members on a Symposium run by Birmingham RHB on Progressive Patient Care, which indicated that project teams in that Region were considering the establishment of Progressive Patient Care in new hospitals. All stages of the approach were considered by the delegates, but her report focused on discussion that had taken place on the feasibility of self-care units. The RHB's Nursing Officer submitted a report on Progressive Patient Care to the Nursing Committee in January 1963. This concerned the Ministry of Health's establishment of a working group during 1962, comprising officers of the Ministry of Health and representatives of the hospital service, to

⁷¹³ R Ramsammy, 'Concerns regarding nursing leadership: 1948-1998', *International History of Nursing Journal* 4:3, p. 6, suggests that such criticisms were made by nurse managers she interviewed. These points are returned to in Chapter Six.

⁷¹⁴ SA: Acc 1987/55, SRHB – Nursing, Summary of Nursing Officer's Report on Progressive Patient Care, 21 Jan 1963; Starns, *March of the Matrons*, p. 125; See especially: SA: Acc 2001/98, Meetings with Sisters, *passim*, and SA: SY 333/H6/14, *passim*.

⁷¹⁵ L Pavitt, *The Health of the Nation* (London, 1963), p. 24.

consider the USA's experience of the system and UK opinions, 'with a view to suggesting how this method of care might be adopted in the National Health Service Hospitals.' By this time, the focus of attention appears to have settled on the most acute stage of the patient's care trajectory. The Nursing Officer reported that the working group had 'confined their attention' to the intensive care unit, only one of the five stages of the system, and the type of patients who might be admitted to such facilities. An Intensive Care Unit was to be created at Leicester Royal Infirmary in order to allow the RHB to assess the merits of establishing further such specialist facilities. An Intensive Nursing Unit was established at the General by 1965, although the HMC hospitals' Nursing Committee questioned during 1967 whether it was possible to introduce the whole range of Progressive Patient Care.⁷¹⁶

Conversely, the first mention of Progressive Patient Care in the Infirmary's records is of an invitation sent to Miss Gossop, then Matron, to attend a conference on the topic to be held in Nottingham in late 1963.⁷¹⁷ The USH Board of Governors' Nursing Services Subcommittee recommended in May 1964 that introduction of the system be left to the individual unit hospitals. In June, the Infirmary's House Committee established an Investigating Committee at their request, in order to deliberate whether Progressive Patient Care should be introduced at the hospital, and representatives of the medical staff, House Committee, Superintendent, Matron and a 'Ward Sister' were invited to give their views on the proposal. Over a month later, the Medical Staff Committee, while opining that there were 'many important disadvantages to patients and staff' in the proposal, 'agreed that Matron too should investigate this matter.' The medical staff raised strong objections to it in early 1965, describing it as a 'retrograde

⁷¹⁶ SA: SY 569/H1/7; SA: SY 569/H1/8, NUR(67)8, Minute 37 – 'Response to HM(67)58, *Training of Nurses* and student wastage', 15 Nov 1967. Note – the name of this unit was different to that adopted in Leicester, but its scope was similar.

⁷¹⁷ SA: Acc 2001/98, 14 Oct 1963.

step...unacceptable at best'. Miss Gossop, who was Matron between 1957 and 1967, was credited with implementing the system.⁷¹⁸

Progressive Patient Care became an integral part of central government guidance on the organisation of hospital nursing care, as exemplified in DHSS advice on the design of ward – or nursing – units, published in 1968. This assumed that new units and hospitals would be designed to accommodate its principles, especially as they related to patients requiring intensive or intermediate care or who were self-caring in the acute hospital setting.⁷¹⁹ The DHSS considered that intensive therapy units should provide between one and two percent of the hospital's acute beds. Most discussed in the records of both the USH and the HMC groups was the development of intensive and high dependency care facilities. In this, members of the medical staff and administrators were as important to implementation as were the nursing staff, in planning the facilities and in participating in the development of training programmes for nurses.

At the other end of the Progressive Patient Care spectrum lay continuing care following discharge from hospital. Until 1969, neither training for the general part of the Register nor training for the general part of the Roll of nurses required any nurse learner to spend time working with the district nursing services. Baly recalled her own experience of discovering in the late 1940s that community nursing was seen as an inferior choice of career for hospital-trained nurses.⁷²⁰ Poor communication, in part the result of lack of insight on the part of hospital-based nurses to the work of the district nursing service and the information they required in order to do this, combined with referral protocols that delayed the commencement of services, were considered to

⁷¹⁸ SA: SY 333/H3/31, 8 June 1964 and 14 July 1964; SA: SY 333/H6/14, 5 Jan 1965; SA: SY 333/H6/92.

⁷¹⁹ DHSS, *Building Note 4 – Ward Units* (London, 1968), p. 2.

⁷²⁰ M Baly, 'Dawning of a new age', *Nursing Standard* 12:33 (1998), pp. 22-24.

contribute to lack of continuity of care between hospital and community. Until mid-1958, protocol required that discharge letters should be sent to the General Practitioner who would then request a visit from the home nursing service. In May that year, the Infirmary's medical staff received a complaint from Sheffield's Medical Officer of Health that patients were frequently being discharged from hospital without adequate arrangements for the home nursing service.⁷²¹ In late 1965, complaints were again received at the Infirmary that patients were being discharged to difficult home circumstances, with no-one available to care for them. The nursing staff were asked to ensure that home circumstances were investigated prior to discharge.⁷²²

Despite the absence of reference to specific problems arising from the discharge of patients from hospital to community, the measures instituted in 1965 appear not to have addressed the general concerns adequately. In July 1967, the Infirmary nurses agreed to devise a discharge procedure.⁷²³ In 1969, they considered the recommendations of the Seebohm Report for the provision of better coordination of the various services for patients needing social care, and for clarification of the nurses' role in referring patients.⁷²⁴ In November 1971, the Infirmary started a programme of weekly visits by a district nurse to one of the surgical wards in order to discuss continuing treatment and social problems prior to discharge.⁷²⁵

5.6 Nurses' Changing Relationships With Visitors To The Hospital

Finally, a useful indicator of the relationship between hospital and community, and one in which boundaries were tested and redrawn following the establishment of the NHS, was the management of those entering the hospitals as users of its services, whether in-

⁷²¹ SA: SY 333/H6/14, 6 May 1958 and 3 Jun 1958.

⁷²² SA: Acc 2001/98, Meetings with Sisters, 14 Dec 1965.

⁷²³ SA: Acc 2001/98, Meetings with Sisters, 17 Jul 1967.

⁷²⁴ SA: Acc 2001/98, Meetings with Sisters, 11 Feb 1969.

⁷²⁵ SA: SY 333/H6/90, p. 3.

patients, out-patients or visitors, and the indications this gives of hospital staff attitudes towards them.⁷²⁶ The records of the various hospital house committees, both of the USH and the HMC, indicate that the regulation of visiting was discussed on more than forty occasions between 1950 and 1973.

During the 1940s, visiting at any of Sheffield's acute hospitals was permitted usually twice in a week for between one and two hours only. Visits to and by a child were particularly restricted. All three general hospitals increased the number of occasions on which visiting could take place to allow daily visits from 1950 or 1951, although the overall time during which visitors might officially be expected to be in the hospital remained approximately four hours in the week. Daily visiting was permitted for half an hour in the evenings, six days a week, and an hour on Sunday afternoons. The reasons for restricting visiting are not recorded, and this suggests that they were unremarkable to the staff at the time. All hospital units made exceptions if the patient was dangerously ill, or if the visitors had traveled a long distance.

In 1953, a consultant Paediatrician suggested that – for a three-month experimental period - parents should be allowed to go into the ward, rather than merely seeing their children through a window. At this time, parents were limited to two visits each week.⁷²⁷ Until the mid-1960s, records of discussions of visiting arrangements indicate that the timing and duration of visiting hours were both limited and arranged strictly around staff commitments. Patients and their visitors were expected to comply with the hospital's arrangements and intrusions into the routine of the hospital were tolerated only in highly circumscribed situations.

During the mid-1950s the House Committees again reconsidered their visiting hours, following discussion of a pamphlet issued in 1953 by the CHSC on the reception and

⁷²⁶ Howsam, *Memories of the old hospital*.

⁷²⁷ SA: SY 569/H1/5 CGH(52)4, 10 Apr 1952.

welfare of patients in hospital, which was implicitly critical of their treatment. This made suggestions for improvements in communication of information between hospital and patients and in the environment in the wards. Although they did not propose to increase the visiting time allowed, the USH hospitals asked the Ward Sisters to discuss the timing of the visiting arrangements with patients on the understanding that the preference of the majority would be adopted. At the General, it was noted that the Matron had given instructions that visitors should be made as comfortable as possible.

Ambivalence towards visitors was still evident, however. Separate discussions in 1956, at the Infirmary and at the HMC Secretaries' regional meeting, refer to the difficulty for Ward Sisters of 'controlling' visiting to the wards.⁷²⁸ The implicit right of staff to exercise exclusive control over the hospital environment was, though, under challenge. Visiting cards, which signified official recognition of the right of the holder to visit a patient, were discontinued at the HMC hospitals in 1950, and while Ward Sisters at the different hospitals requested their return during the 1950s, they were not reintroduced. It remained at the Ward Sisters' discretion to allow visitors onto their wards, and to restrict this either on the grounds of the patient's condition or the circumstances of the visit or visitor. Children under the age of twelve were only allowed into the ward in exceptional circumstances, for example, although Sunday afternoon visiting by children was begun on a trial basis at the Infirmary in summer 1963. Sisters at the Infirmary reported that visitors were unhappy at this restricted time allowance, describing them as 'truculent' when told that children could only visit on Sunday.⁷²⁹

⁷²⁸ SA: SY 333/H1/45, 7 Nov 1944; SA: SY 569/H1/3, CC(50)4, 22 Nov 1950; SA: Acc 2001/98, Matron's Records, 19 Mar 1951; SA: SY 569/H1/6, May 1953; SA: SY 333/H3/28, 13 Sep 1954; SA: SY 333/H16/14, 25 Oct 1954; SA: SY 333/H3.28, 12 Mar 1956; SA: SY 291/H1/1, 13 Dec 1956.

⁷²⁹ SA: Acc 2001/98, Meetings with Sisters, Minute 623, 17 Jun 1963.

The records of discussions about visiting relate to the timing and control of visiting primarily as they affected the work of the nursing and medical staff, despite reference to the views of patients and their relatives being consulted on one occasion. Yet the comfort of visitors, whether in the hospital for a brief visit or wishing to stay overnight, was addressed from time to time. In all, visiting hours were altered on fourteen occasions between March 1951 and December 1971 at the USH hospitals, while those at the HMC hospitals appear to have been changed less frequently. Objections raised by the medical staff to experimental changes in visiting hours at the Infirmary included concern that open visiting would make it 'impossible to maintain silence during teaching rounds and impossible to prevent cross-infection in the wards.' They also objected to the problems that might arise for Doctors trying to clerk patients in, and for medical students' learning.⁷³⁰

For nurses, the problems were expressed in terms of control over the numbers of visitors arriving and managing the demands of those who arrived outside the advertised visiting times. Ward Sisters enforced the visiting rules, but faced the disapproval of Consultant medical staff and objections from their colleagues that visitors 'disrupted' nursing work when they attempted to increase the hours and the resentment of the visitors when they restricted them.⁷³¹ 'They all agreed that the best point of control was at the ward entrance with the Sister being responsible for the operation of the hospital regulations concerning the number of visitors permitted.'⁷³² The Sister was thus the gatekeeper for the visitors, controlling access to the patient. In general then, while arrangements for visitors were remarkably different by the end of

⁷³⁰ SA: SY333/H16/14, 4 July 1961. 'Clerking in' is the detailed assessment that the doctor makes of a patient when the latter is admitted to hospital.

⁷³¹ SA SY333/H16/14, 5 Sept 1961; SA Acc2001/98, Meetings with Sisters, 5 Apr 1954 and 12 June 1963.

⁷³² SA SY291/H1/1, 13 Dec 1956. Interestingly, ward sisters at the Royal Infirmary in discussion with the matron in February 1956 expressed the view that their presence on the wards during visiting times would not 'make any difference' to difficulties then being experienced: SA Acc2001/98, Meetings with Sisters, 6 Feb 1956.

the period, with visiting permitted on a daily basis and some wards experimenting with open visiting over extended periods of the day by 1971, the emphasis was still on control by the staff, particularly the nursing staff, and on staff convenience. It is notable that the patient's view was rarely sought and where staff considered the patient's perspective they focused their attention on the impact of visiting on patient's physical health, concerns being raised about cross-infection from visitors for example, rather than its emotional and social benefits.

Between 1948 and 1974, basic nursing continued to be the core of nursing work, but in the context of increasing demands for care by a rising number of patients, untrained Nursing Auxiliaries made an important contribution to that care. Meanwhile expansion in the range and complexity of therapeutic interventions available meant that technical nursing skills also increased in importance in the work of nurses. Boundaries between nursing and non-nursing roles were clarified, affecting the work done by nurses, doctors and an expanding range of non-nursing ancillary staff. The redrawing of boundaries did not always proceed smoothly. Disputes over the return of venepuncture to the doctors' sphere, and the uncertainty over whether or not nurses could determine the capacity of individual patients to walk to the lavatory at night exemplify this. In addition, nurses were either unable or unwilling to challenge the assumption that they would fulfil the roles of domestic and clerical staff outside office hours or when those employed in these capacities were sick or on holiday. The final Chapter considers the role of organisational factors in these developments.

6. 'We are dealing with people and not things' – Managing Nursing in Sheffield's General Hospitals, 1948-1974.⁷³³

The matron is a personal link between the community and its hospital. Outstanding qualities are and will always be needed to fill this exacting post; good matrons are unlikely to be attracted in sufficient numbers unless their key position in the organisation of the hospital service is recognised.⁷³⁴

Between 1948 and 1974, the development of new technologies of care and reforms of nursing management contributed to fundamental changes in working relationships between nurse and nurse and between nurse and non-nurse, as much as to altering nursing roles. Some aspects of change were welcomed; the final Annual Report of the USH noted with approval that nurses were becoming more adept at 'questioning and challenging practice.'⁷³⁵ Others seemed less positive. A nurse writing in the medical press in 1970 gave a cautious welcome to the greater autonomy that had come with the changes in nursing practice and management, but regretted that '...[W]e no longer enjoy the support of our fellow [non-nursing] workers in medicine and in administration, and all too often we get the impression that not only do they lack appreciation of our difficulties but they just do not want to know.'⁷³⁶ This chapter explores the management of nursing work and the relationships between nurses and their peers in nursing and in other health care occupations, and in the administrative structures of the hospitals. In so doing, it considers the role that nurses in Sheffield played in the implementation of NHS policy, and the changes and continuities in nursing with which these processes were associated.

⁷³³ SA: Acc 2001/98, Meetings with Sisters, Minute 900, 14 May 1968.

⁷³⁴ Ministry of Health, *Internal Administration of Hospitals*, p. 42.

⁷³⁵ SA: SY 333/H16/8, p. 25.

⁷³⁶ M Powell 'The eternal triangle' *British Medical Journal* 2 (1970), pp. 416-418. She is identified as Matron of the Robert Jones and Agnes Hunt Orthopaedic Hospital, at Oswestry, Shropshire.

6.1 Nurses in the NHS Hierarchy

Nurses were not strongly represented in policy-making bodies either before or immediately after the establishment of the NHS – unlike Doctors.⁷³⁷ The reasons for this have been given as deliberate exclusion by the medical profession and or the civil servants of the Ministry of Health and, more recently, lack of political acumen on the part of senior nurses themselves - even when opportunities for participation were offered to them.⁷³⁸ The latter is consistent with Bevan's desire to avoid incorporating opportunities for political factionalism in the structure of the NHS. This is most overtly apparent in his resistance to making administration of the NHS a part of local government. Successful implementation of the NHS was more important than satisfying the interests of the individual occupational groups on which it depended. Nurses were not deliberately targeted for exclusion from a fuller role in the machinery of decision-making – others who might have asserted their own right to inclusion had been no more successful – but they were not, as a body, a political threat to its existence in the way that the Doctors were.⁷³⁹ Their representative bodies were not in a position to press for inclusion as of right on the RHBs. While the Minister of Health appointed nurses to various RHBs - including a Nurse Tutor from the General at Sheffield RHB - their number dwindled over the following twenty-six years.

The internal organisational structures of the RHBs and HMCs were not strongly prescribed by the Ministry of Health and this allowed for considerable variation in the pattern of committees and subcommittees established.⁷⁴⁰ The RCN approached the shadow Sheffield RHB in late 1947, offering to provide 'consultative liaison' on

⁷³⁷ Willcocks, *Creation*; Harrison, *Shifting the Frontier*, pp. 119-122; Stewart, 'Ideology and process', pp. 121-125.

⁷³⁸ Starns, *March of the Matrons*, pp. 47, 49; White, 'Nursing Profession', pp. 52-59; Dingwall, Rafferty, and Webster, *Social History*, pp. 109-110; Scott, 'Policies for Nursing', pp. 217-224.

⁷³⁹ Webster, *Health Service – Volume I*, pp. 277-278; Stewart, 'Ideology and process', pp. 126-127; B Donoghue and G W Jones, *Herbert Morrison, Portrait of a Politician* (London, 1973) pp. 356, 369; Foot, *Aneurin Bevan, Volume II*, p. 134.

⁷⁴⁰ Lindsey, *Socialized Medicine*, p. 246.

nursing education, and suggesting the formation of a committee on nursing affairs. The Board referred their offer to the General Purposes Committee, but the records indicate that no further action was taken for nearly a year. A nurse tutor from the General in Sheffield, Miss Wetherell, who was a member of Sheffield RHB, then revived the idea of a committee to deal with nursing issues. She was instrumental in achieving the establishment of the Nursing Committee in September 1948, in the light of 'the difficulties of the present position' in recruitment and retention. The functions of the Nursing Committee were confirmed on 31 March 1949, when a special meeting of the Board's General Purposes Committee was held to consider the membership and duties of all standing committees. The scope of the Nursing Committee as established was wide, being '...to consider and advise upon all questions relating to or affecting Nursing Staffs of the Hospitals in the Region.' Its duties encompassed advising the RHB on general nursing matters, the organisation of nursing services within the Region, and nursing recruitment and training. To assist itself, the Nursing Committee established a Standing Subcommittee on Nurse Training.⁷⁴¹

In January 1949, the Nursing Committee proposed the establishment of a Matron's Advisory Committee, in order '...to achieve uniformity and the coordination of nursing services throughout the Region' and advise the Nursing Committee on matters relevant to nursing. This was to be composed of two Sheffield representatives, and a further five representatives from the rest of the Region. However, the RHB decided to broaden the potential membership and in July 1949 established a NAC of sixteen people, comprising qualified nurses of all grades representing HMCs across the Region, including three nurses employed by the HMC. This met on a quarterly basis. Although it was expected to address issues referred to it by the Nursing Committee, the RHB's first Quinquennial Report indicates that the NAC was expected to take the

⁷⁴¹ SA: Acc 1987/55, Sheffield RHB – Board, 8 Dec 1947, 13 Sept 1948, 31 Mar 1949; SA: SY 709/H1/1, p. 80.

initiative in identifying matters that could affect patient care by nurses, and to advise the Nursing Committee accordingly. The minutes of the HMC do not refer to communication from those who served on that committee, nor to whether and how they sought the views of the hospitals' nursing staff in order to represent them. However, the requirement for a group of senior nurses able to provide strategic policy advice to the Region arose again. In April 1955, the Nursing Committee established biannual meetings of Matrons and Chief Male Nurses of HMCs, thus broadening the membership from that of the original Matrons Advisory Committee.⁷⁴²

However, the representation of nurses at hospital level was considerably slower to develop. Between April and October 1949, the RHB Nursing Committee discussed Matrons' attendance at meetings within the Region's HMCs.⁷⁴³ The minutes for April 1949 indicate that there was strong support for Matrons' views to be heard. 'The Committee indicated their desire that HMCs shall adopt the recommendations contained in Circular RHB(49)25 by permitting Matrons to attend meetings of their Management Committees or House Committees and by providing facilities for Matrons for presenting their reports.' Those HMCs without a committee structure that would permit this were to create one. Although the extant records do not refer to an implementation date, the Regional Nursing Officer – who had taken up her newly-created, salaried post in November 1948 - was instructed to report any non-compliance to the Committee.⁷⁴⁴

A letter from a member of Sheffield RHB Nursing Committee, read to its meeting of 20 June 1949, emphasised 'the need to consult Matrons and Nurses upon matters concerning Hospital Management.' The other members of the Committee supported

⁷⁴² SA: Acc 1987/55, Sheffield RHB – Board, 8 Dec 1947, 13 Sept 1948, 17 Jan 1949; SA: SY 569/H1/2, MC(49)7, p. 4; SA: SY 709/H1/1, p. 80; SA SY 709/H1/2, p. 61.

⁷⁴³ SA: Acc 1987/55, Sheffield RHB - Nursing, 25 Apr 1949, 18 July 1949, 17 Oct 1949.

⁷⁴⁴ SA: Acc 1987/55, Sheffield RHB - Nursing, 25 Apr 1949.

this view, and the minutes of that meeting indicate that they were hopeful that the formation of the NAC by the RHB would assist in ensuring that such matters were raised and discussed at RHB level.⁷⁴⁵ In spite of this, Matrons and Nurses did not have secure representation within their own hospital committees and thus consultation through the RHB, though important in principle, was of limited consequence in allowing consideration of a nursing perspective in policy development. Within the RHB, Miss Wetherell was able to argue for the creation of formal mechanisms for the consideration of nursing matters, but in June 1949 she resigned her post at the General, and it appears that she was experiencing ill-health. In July 1949 she asked the HMC's General Purposes Committee to grant her an incapacity pension, although she continued to serve in a voluntary capacity in hospital administration, joining the USH Board of Governors in May 1951.⁷⁴⁶

A review of usual practice in the Region's HMCs in June 1949 revealed that Matrons usually attended the House, or similar, Committee meeting, but only attended the HMC meeting if invited; practice varied within the Region. The Nursing Committee's response was to reiterate its desire that Matrons should attend at the House or Visiting Committee of their own hospital, be able to submit a written report and remain in attendance throughout the committee meeting in order to contribute to discussions arising from their report.⁷⁴⁷ The Staff and Establishment Committee of the HMC resolved in September 1949 to support the principle that Matrons should be able to submit written reports to Visiting Committees 'if and when they desired'.⁷⁴⁸

⁷⁴⁵ SA: Acc 1987/55, Sheffield RHB - Nursing, 20 June 1949.

⁷⁴⁶ SA: SY 569/H1/2, General Purposes Subcommittee, Minute 14, 15 July 1949; SA: SY 333/H16/1, Ad hoc committee on postgraduate nurse training, 19 Oct 1950; SA: SY 333/H16/1, Minute 1030(51), 7 May 1951.

⁷⁴⁷ SA: Acc 1987/55, Sheffield RHB - Nursing, 18 July 1949.

⁷⁴⁸ SA: SY 569/H1/2, Staff and Establishment Subcommittee, Minute 12, 16 Sept 1949.

In spite of the apparent enthusiasm with which they pursued the implementation of the Circular RHB(49)25, the RHB Nursing Committee's recommendations were challenged by one HMC, which suggested that the position of the Medical Superintendent as Chief Officer of a Mental Hospital would be challenged if the Matron were to present reports on nursing and domestic staff. The Nursing Committee wavered; they declared that their recommendations were not 'a formal instruction', and resolved that 'no further action be taken'. The issue then disappears from the records.⁷⁴⁹ As the Ministry of Health had issued the Circular, which would appear to lend it some authority, it is interesting that the Nursing Committee retreated from its original position. This may have been a function of the lack of clarity in the organisation and functions of the RHB on establishment, lack of confidence in their authority to make decisions and enforce them, inclusion of members who might recognise and sympathise with the medical superintendent's position and consequently feel disinclined to pursue the matter, or a combination of these factors. It is, though, consistent with Klein's general observation that in the early years of the NHS, enforcing the will of the Ministry was not the mark of a successful local administrator – quite the reverse. It also accords with the experience that Baly describes of defending a Matron sacked by her HMC for changing nursing rotas, in which the Chairman of the HMC questioned the RHB's authority – the latter body having been unenthusiastic about instigating the inquiry for which the RCN had appealed.⁷⁵⁰ However, the Chairman of Sheffield RHB, Sir Basil Gibson, was a member of the Committee on the Internal Administration of Hospitals, who 'expressed tentatively'

⁷⁴⁹ SA: Acc 1987/55, Sheffield RHB - Nursing, 17 Oct 1949.

⁷⁵⁰ Klein, *Politics*, p. 46; Baly, 'Dawning of a new age', pp. 22-24.

the recommendations that every group should have a nursing advisory committees and every hospital a nursing staff committee.⁷⁵¹

The incident is indicative of reluctance at a strategic level to challenge the inferior position of the Matron in the hospital hierarchy, and the ambivalence with which her role as putative head of the nursing service in the hospital was viewed. At such an early stage in the life of the NHS, it also appears to be a reflection of the transition for the hospital committees from control by local authorities to control through a new, regional structure and consequent instability and fluidity in relationships, which allowed the HMC to test the authority of the Regional committee. The Matron was held responsible for the functioning of the nursing service and expected to take direction from the HMC, but lacked the authority to participate in making the decisions that would shape that service, or even the formal right to advise them on the feasibility of their decisions. Moreover, as the Committee on the Internal Administration of Hospitals identified, the Matron acted as 'chief resident executive officer' with responsibilities for a wide range of non-nursing aspects of hospital activity, particularly outside office hours.⁷⁵²

Within the hospitals, Doctors dominated the administrative hierarchy with lay administrators and nurses second and third in line respectively. The subordinate position occupied by the Matron reflected the subordinate position of nurses generally within the health care system. Nurses, in their capacity as employees of the NHS rather than as private individuals with a professional qualification in nursing, were excluded from membership of the administrative committees that ran NHS hospitals for its first two decades, as they had been before 1948. After the Appointed Day,

⁷⁵¹ Ministry of Health, *Internal Administration of Hospitals*, paragraph 245, sections 1, 32-33, pp. 71, 73.

⁷⁵² White, *Nursing Profession*, Chapter 4; Clark, 'Nurses as managers', pp. 278-279; Ministry of Health, *Internal Administration of Hospitals*, paragraph 150, pp. 42-43.

although the Matrons or their deputies often attended meetings of those committees that dealt directly with nursing matters, not all hospitals considered even this necessary. In general, they attended to make reports to, at most to advise on nursing views, and to receive direction from the House Committee, not to participate in decision-making.

Despite their responsibility for various non-nursing functions, the Committee on the Internal Administration of Hospitals noted that there had been a 'progressive narrowing in scope and in kind' of the range of duties that senior nurses performed in hospitals.⁷⁵³ Hospital administration was an early focus of attention both in the Committee on the Internal Administration of Hospitals' Report of 1954, and as an issue considered by the Guillebaud Report in 1956. The *Report on the Internal Administration of Hospitals* attempted to clarify the role and status of medical, administrative and nursing colleagues in the hospital management structure, but its 'general recommendations', opening with a statement that the 'administrative pattern must remain flexible' and 'tentatively' expressed, permitted hospital authorities to ignore its suggestion for 'partnership' between medical, nursing and lay administrators.⁷⁵⁴ The hierarchical relationship between Doctor, Administrator and Nurse continued essentially unaltered until the late 1960s. In 1959 the Ministry of Health issued a further Circular referring to the Matrons' attendance at meetings, and the HMC's minutes indicate that the Matrons in the group were already able to attend House Committees and HMC meetings. The records of the Group Secretaries indicate strong support for the Matrons to attend the units' House Committees, '...and as Senior Nursing Officer they should, of course, be consulted about, and given the opportunity of commenting upon, developments and changes in policy.'⁷⁵⁵ It was not

⁷⁵³ Ministry of Health, *Internal Administration of Hospitals*, paragraph 144, p. 41.

⁷⁵⁴ Ministry of Health, *Internal Administration of Hospitals*, paragraph 245, sections 1-2, p. 71.

⁷⁵⁵ SA: SY 291/H1/1, Minute 803, 23 Mar 1959.

usual practice for Matrons to attend the HMC meeting, unless her advice was required on a particular matter, however. The HMC established a Nursing Subcommittee in 1959, but this comprised members who were either not nurses, or were not employed as nurses by the HMC.

The right of Matrons to submit written reports to the House Committee was long-established practice at the two former voluntary hospitals. At the Royal, the Matron attended to present her report and her Report Book had been used to inform the hospital's Governors of day-to-day nursing issues since at least 1924. The Infirmary's Matron also attended meetings of, and read her report to, the House Committee.⁷⁵⁶ Matrons of all four voluntary hospitals attended the meetings of the School of Nursing Committee and, through membership of its Matrons' Committee, were responsible for the day-to-day management of the venture. Percy Malby, one of the Children's Hospital's representatives on the School of Nursing Committee, attempted to gain a place for the Chairman of the Matrons' Committee on their hospital's House Committee during January and February 1948. As none was a full member of the School of Nursing Committee, and thus none was eligible to join a House Committee, this attempt came to naught.⁷⁵⁷

Conversely, the USH had established a Nursing Services Committee in September 1948. In general, Nursing Committees did not include working nurses – in contrast to Medical Committees, which did contain members of the medical staff – though they did include members of the medical staff. The USH Nursing Services Committee comprised representatives of all four constituent hospitals of the group, but while the Matrons were required to attend in an advisory capacity, this was only at the request of

⁷⁵⁶ SA: SY 333/H1/41, 1924-1946; SA: SY 333/H3/27, Minute I.57, 18 Oct 1948.

⁷⁵⁷ SA: SY 333/H17/1, Minute 221, 7 Jan 1948, and Minute 231, 10 Feb 1948.

the Committee.⁷⁵⁸ In 1952, the USH School of Nursing's Committees ceased to exist in their own right, and their functions were merged with those of the Nursing Services Committee. From this point on, the Matrons of the four hospitals of the USH, who had been an integral part of the School of Nursing committee structure, were given the right to be 'in attendance' at all meetings. This was governed by the terms of circular BG(49)19, which requested that Matrons should 'be present when nursing questions affecting the hospital are discussed in order to advise the committee on such matters' unless they decided she should be 'temporarily absent'.⁷⁵⁹ In 1960, the Infirmary's Sisters were asked whether they wished to be represented on the Nursing Services Committee, but 'None wished to stand for election.'⁷⁶⁰ The reason for this reluctance is not recorded. However, the records equally do not include information about the rights and responsibilities that representatives would have assumed as members of the Committee. Conversely, the minutes make frequent reference to the problems that Sisters faced in managing their ward and department workloads and, in the absence of clear incentives to participate, their individual and collective decisions not to stand for election is understandable.

The right of the HMC Matrons to attend their House Committee's meetings was established in 1959. Formally, the Matrons reported on the availability of nursing staff and factors that pertained to recruitment and retention, and might be invited to advise on the implications for the nursing staff of developments in the hospital's services. The hospital's nurses were not expected to develop and interpret nursing policy, and the committees that did were made up of lay people and medical staff, not members of the hospital's nursing staff.

⁷⁵⁸ SA: Acc 1994/64, Box 1, MC(59)2, 9 Feb 1959; MC(59)4, 13 Apr 1959; SA: SY 333/H16/9, 20 Sept 1948.

⁷⁵⁹ SA: SY 333/H16/9, 19 Nov 1951, 17 Dec 1951, 18 Feb 1952; SA: SY 333/H16/1, Minute 41(52), 3 Mar 1952.

⁷⁶⁰ SA: Acc 2001/98, Meetings with Sisters, 9 May 1960.

During the 1960s, the GNC began to require the representation of senior nurses on committees involved in the development of nurse education and, after their highly critical inspection of nurse training at the General in 1967, pressed for their inclusion in the committee advising the HMC on education:

There is no Education Committee, constituted in accordance with the Council's requirements. A sub-committee of the Management Committee deals with nursing service and education. The Tutors and Ward Sisters are not represented on this Committee and there are no members from the fields of general education or public health. This point was discussed at the meeting held after the visits, and the members of the Management Committee said that the need for a Nursing Education Committee had been conceded and they hoped that such a Committee would have been formed in two or three months time.⁷⁶¹

By 1967, the HMC's four Matrons belonged to the Nursing Services and Education Committee to which the GNC Inspector refers but, during its preparations for the inspection, the HMC's Nursing Subcommittee had already noted that this arrangement would not meet the GNC's conditions for approval to train nurses and had decided to take action to comply.⁷⁶²

The reconstituted committee was to comprise the Principal Tutor at the General, a Ward Sister from each unit hospital, a representative of the Medical Officer of Health for Sheffield, and a representative of the Director of Education for Sheffield. When it first met, in June 1967, the Nurse Education Committee included these representatives, along with other Doctors, one of whom took the Chair. The HMC Nursing Services and Education Committee was again reconstituted in September 1971, during the implementation of the Salmon Committee's recommendations, becoming a much larger body which included nurse learners as well as other grades of nursing staff. The new Committee included three members of the HMC, two medical lecturers, the Chief Nursing Officer (CNO), the PNOs, the Senior Nursing Officer (SNO) for midwifery teaching, two Ward Sisters each from the General and Geriatric Divisions, a Nurse

⁷⁶¹ SA: SY 569/H1/8, Report of GNC Sixth Visit, 15 Feb 1967.

⁷⁶² SA: SY 569/H1/7, NUR(65)7, 17 Nov 1965.

Tutor, a Pupil Nurse Teacher, a second year Student Nurse and second year Pupil Nurse, and representatives of the Public Health Department and Sheffield Education Committee.⁷⁶³

This only addressed one, albeit highly significant, aspect of nursing. Matrons dealt on a daily basis with maintaining the nursing service, balancing the availability of nursing time against the demand for nursing care, and this went beyond addressing the training requirements of learners. Professional nursing committees, with the remit of interpreting policy as it applied to nurses, and developing unit and group nursing policies, were only established from July 1968 onwards, when the Confidential Report on the Administration of Hospital Authorities, published in July 1968, recommended replacing non-professional Nursing Committees with professional committees. The HMC then established a NAC comprising the four Matrons and the Superintendent Midwife, with the Group Secretary and Treasurer in attendance. The first of the professional committee's meetings was held at the General on 23 April 1969, at which Matrons' reports to the HMC were retained as 'a very convenient means of advising the HMC on day-to-day nursing matters.' The NAC was reformed as the Salmon reforms were implemented in the HMC's hospitals in 1971, to include the CNO, the four PNOs, a Consultant nominated by the Group Medical Committee, the Group Secretary and the Group Treasurer.⁷⁶⁴

Although the membership of nurses on the committees of the NHS was limited, any description of the formal structures does not tell the full story. Between 1948 and 1974, the role of Matron in general hospitals encompassed responsibility for all matters broadly associated with the care of the patient (as distinct from 'cure'). They

⁷⁶³ SA: SY 569/H1/8, NEC(67)1, 21 June 1967; SA: SY 569/H1/12, NEC(71)2, 22 Sept 1971.

⁷⁶⁴ SA: SY 569/H1/8, NUR(67)1, 18 Jan 1967; SA: SY 569/H1/9, MC(68)7, 'Confidential Report on the Administration of Hospital Authorities', 8 July 1968; SA: SY 569/H1/9, 'Report of GNC on Visits to the Northern General and Nether Edge Hospitals', 26 July 1968; SA: SY 569/H1/10, NAD(69)1, 23 Apr 1969; SA: SY 333/H16/10, Minute GP18, 22 Feb 1971.

reported to the House Committee on the recruitment and retention of the nursing staff, the facilitation of conditions likely to be conducive to success in general and specialist nursing (and midwifery) training, and the standard of nursing care of the patients in the hospital. They were ultimately accountable for the general reception and welfare of patients and their visitors, and specific aspects of their safety such as both the control of infection and administration of medicines.⁷⁶⁵ They could provide the principle channel of communication from the hospital administrators and senior medical staff to the nursing staff, although their ability to represent the views of the nursing staff to their administrative and medical colleagues was often limited.⁷⁶⁶ These responsibilities predated the start of the NHS, and persisted beyond 1974. Until the implementation of the Salmon reforms of the nursing hierarchy from the late 1960s, the Matron was often also responsible to the Chief Administrative Officer for the domestic services.

The powers of the Matron between 1948 and the late 1960s specifically included the appointment of Student Nurses, Enrolled (Assistant) Nurses, and Pupil (Assistant) Nurses, under authority delegated to her by either the HMC or Board of Governors. Subject to their approval, following consultation on the views of the medical staff whose patients were admitted to the ward or department, she also appointed Sisters and Staff Nurses, and Tutors. Approval was not withheld during this period in Sheffield, although the medical staff in particular guarded their veto jealously, insisting that lapses in the policy of seeking their approval should not go unremarked. Following the implementation of the Salmon reforms, the CNO was responsible within agreed financial limits for appointments below the status of SNO.

⁷⁶⁵ Compare for example SA: SY569/H1/2, Staff and Establishment Subcommittee, 5 Sept 1949, p. 1, and SA: SY569/H1/9, MC(69)3, 'Appointment of Staff.', 14 Mar 1969; Ministry of Health, *Internal Administration of Hospitals*, paragraphs 149-150, pp. 42-43 and paragraphs 157-161, pp. 44-45; Rivett, *Cradle to Grave*, p. 109.

⁷⁶⁶ SA: Acc 2001/98 Meetings with Sisters, 5 Apr 1954; Ramsammy, 'Nursing leadership', p. 5.

House Committees at the General and Fir Vale regularly sought their Matron's views on the question of staff shortages, and their actions indicate respect for these and acceptance of their advice as to possible solutions to the recurrent problems of nurse staffing.⁷⁶⁷ The Matrons of the Infirmary appear to have had a less consistently supportive relationship with their House Committee, although the records of Miss Gossop's meetings with the Sisters at the Infirmary indicate that she expected them to become actively involved in developing nursing at the hospital and services to patients, within the constraints of the extant committee system.⁷⁶⁸ There is little information about the relationship between the Matrons at the Royal and their House Committee.

The Matrons' limited involvement in the committee structure before 1968 was reflected in lack of involvement on the part of their staff. Matrons established mechanisms to discover their staff's views and communicate the decisions of the HMC or Board of Governors to them. Miss Clark held regular meetings with the Ward and Departmental Sisters from June 1950, which her successors continued until January 1970. Meetings between the Matron and Sisters also appear to have been held at the General, although there is very little information about them beyond a passing reference in one of Miss Janson's reports to the House Committee.⁷⁶⁹ Miss Clark canvassed the opinion of Sisters at the Infirmary in 1952, over whether they wished to form a Staff Representative Council, but they rejected the suggestion. They 'thought the nurses had sufficient opportunities for discussing their problems with senior members of staff.'⁷⁷⁰ The records do not explain either how or why they came to this conclusion. Her successor, Miss Gossop appointed in 1957, sought the Sisters' active

⁷⁶⁷ Scott, 'Policies for Nursing'.

⁷⁶⁸ SA: ABC17, 1 Oct 1954; SA: Acc 2001/98, Aug 1957 *et seq.*

⁷⁶⁹ SA; SY 569/H1/6, CGH(53)2, Minute 22.

⁷⁷⁰ SA: Acc 2001/98, Meetings with Sisters, Minute 133, 12 Dec 1952.

involvement in decisions about purchasing of equipment for and making of alterations to the wards and departments.⁷⁷¹

The Salmon Committee was established in 1963 with the task of clarifying senior nursing roles and responsibilities, and the preparation required in order for individuals to fulfil them. Its recommendations, published in 1966, outlined a hierarchy of functional management roles for nurses, and clarified as far as possible the level of responsibility each should carry. Within the Salmon structure, the new post of CNO gave the incumbent responsibility for nursing services in all hospitals in a group, for developing and implementing group nursing policy, and maintaining 'a high standard of patient care'. In a small hospital group, a PNO might be the most senior nursing grade, but in Sheffield, the USH and the HMC were each large enough to appoint a CNO, with PNOs taking responsibility for 'Divisions' of the nursing service. The role of 'Matron' ceased to exist in name – and the reorganisation of senior nursing management meant that the new posts were only partly equivalent to those they replaced. Hospital authorities were required to appoint their most senior nurse, Grade Nine or Ten in the Salmon structure, through open competition, and absorb nurses of lesser seniority into the new structure on 'protected terms'.⁷⁷² Whether the appointee held a Grade Nine or Ten post was determined by the size of the hospital and the associated level of responsibility. The most senior nurse in a large hospital such as the General would be graded at a more senior level than someone who had previously also been known as 'Matron', but who carried responsibility for fewer staff and patients in a smaller hospital.

⁷⁷¹ SA: Acc 2001/98, Meetings with Sisters, Minute 336, 6 Aug 1957 and Minute 432, 9 May 1960.

⁷⁷² Prior to the Salmon reforms this term was also used for the most senior nurse employed by the RHB. The term 'Chief Nursing Officer (CNO)' in Sheffield before June 1969 refers to the RHB post, while thereafter it refers to the post-holder of the new Salmon grade at hospital group (USH or HMC) level.

Within the hospital groups, CNOs were the first to be appointed as the Salmon recommendations were implemented, and were responsible for planning and making recommendations for the allocation of senior nursing staff roles within functional divisions – General Nursing, Midwifery, Teaching, and Geriatric. At the USH, the two general hospitals formed one General Nursing Division. The HMC formed two Nursing Divisions – General and Geriatric. The General Division of the HMC encompassed the general nursing areas for which the General's Matron had previously been responsible. Each hospital group also created a Teaching Division based on its own nurse training school.

The first plan for the HMC's Geriatric Division was that a Grade Nine PNO would be appointed to take charge of services at the General, including the geriatric and mental subnormality wards and the day hospital, with an SNO acting as her or his deputy. The wards at the HMC's smaller, Nether Edge, Hospital would be managed by a SNO (Grade Eight). This would have given parity of status to the nurses in charge of the two Nursing Divisions at the General. However, the DHSS disagreed with the CNO's proposal, and required that one PNO take responsibility for both Geriatric Division 'Areas' – at the General and Nether Edge Hospital. This would cover geriatric, chronic sick, rheumatology, mental subnormality, child psychiatric and day hospital services at the two hospitals. The DHSS argued that experience in groups that had already implemented the Salmon proposals suggested that PNOs derived greater job satisfaction when given greater levels of responsibility.⁷⁷³ Responsible to that PNO would be an SNO at each of the two hospitals. The nurse with responsibility for the patients in the Geriatric Area at the General – which had been Fir Vale until April 1967 - was thus expected to assume responsibility for more patients over two geographically dispersed areas in order to achieve the status and salary achieved by her

⁷⁷³ SA: SY 569/H1/12, NAC(71)1, 20 Jan 1971; SA: SY 569/H1/12, NAC(71)2, Minute 75, 17 Feb 1971.

counterpart in the General Division on one site, where the range of wards and departments remained as it had formerly been.⁷⁷⁴ Concomitantly, the nurse responsible for the Geriatric Area at the General received a lower grade, and thus level of responsibility and salary, than her counterpart in the hospital's General Division. In this way, the implementation of the Salmon structure within the HMC, albeit at the behest of the DHSS, maintained the existing hierarchy of status within nursing between the care of patients with acute and chronic illness.

Nonetheless, there were important changes in the range of responsibilities assumed by senior nurses following restructuring of senior nursing management. For example, while Miss Jobling at the General retained responsibility for most of the same aspects of the clinical nursing service once she became a PNO in 1971, responsibility for the appointment of learners passed to the newly created Teaching Division, also headed by a PNO. She also became accountable to the newly created CNO of the HMC. The USH Board of Governors appointed a CNO, Miss Schurr, who took up her post in June 1969.⁷⁷⁵ Miss Oram, formerly Matron of the Royal, was promoted to take responsibility for both 'her' hospital and the Infirmary, as PNO of the General Nursing Division for which she became responsible in December 1969. Miss Lowarch became SNO of the Infirmary, having been Matron since Miss Gossop's departure in 1967. The Royal appointed a SNO, Mr Cubbins, who was then the most senior male nurse yet appointed in any of Sheffield's general hospitals.⁷⁷⁶

The impact of Salmon reforms appears to have been treated as an opportunity for the attainment of benefits for nurses and patients alike at the NGH. As they considered the purpose behind the changes, the Management Committee noted that the CNO's '...aim

⁷⁷⁴ SA: SY 569/H1/10, NAC(69)1, 23 Apr 1969; SA: SY 569/H1/12, NAC(71)1, 20 Jan 1971; SA: SY 569/H1/12, MC(71)2, 8 Feb 1971; SA: SY 569/H1/12, NAC(71)2, 17 Feb 1971.

⁷⁷⁵ SA: Acc 2001/98, Meetings with Sisters, 15 July 1969.

⁷⁷⁶ SA: SY 333/H1/36, 9 Dec 1969; SA: SY 333/H1/36, 14 Mar 1972.

should be to obtain a clear insight into the major problems of all the hospitals in the group, to explore possibilities for their solution and to formulate nursing policies in consultation with senior nursing staff and other officers; to act as nursing spokesman at meetings of the governing body and its standing committees; to take all measures to have the approved policy implemented.⁷⁷⁷ The CNO's right to be involved in decision-making processes extended to the right to 'attend and speak at' not only the Management Committee itself, but also 'its standing subcommittees'. At the HMC, she or he would also have 'a standing invitation to attend and speak at meetings of the Executive Committee of the Group Medical Advisory Committee, but not the Medical Division.'⁷⁷⁸ The Salmon reforms thus promised not only to ensure that nurses had access to decision-making bodies, but would thereby facilitate the longer-term aim of ensuring that staff's skills could be matched to patient dependency, so making the best use of scarce resources. Ultimately, not all that was anticipated was achieved. Members of the medical profession objected to the creation of a large number of non-clinical nurse administrators. While this claim proved to be untenable in the light of statistical evidence, there were many clinical nurses who questioned the necessity for the creation of new senior nursing roles, especially that of the Nursing Officer, which were to have been clinically based but, in reality, were not.⁷⁷⁹

6.2 The Matrons

Within two years of the establishment of the NHS, the Matrons of both USH general hospitals and of all three HMC hospitals had resigned their posts. Miss Warren (Infirmary), Miss Sampson (Royal), and Mrs Moss (Fir Vale), left during 1949, and Miss Perkins (General) and Miss Brown (Nether Edge Hospital), departed in 1950.

⁷⁷⁷ SA: SY 569/H1/10, 'Senior Nursing Staff Structure', 12 Feb 1969.

⁷⁷⁸ SA: SY 569/H1/12 'Action to improve the nursing situation – follow-up of HM(70)35'; SA: SY 569/H1/11, Nursing Advisory Subcommittee 'First Report on the Consideration of the Secretary of State's Letter and Pink Circular HM(70)35 on 'Action to Improve the Nursing Situation'.

⁷⁷⁹ Dingwall, Rafferty, Webster, *Social History*, pp. 114-115; Clark, 'Nurses as managers', pp. 284-286.

Miss Warren had been Matron of the Infirmary since 1947 and her departure followed her promotion to the new position of 'Principal Matron' of the Archway Group of hospitals in London, in order to take responsibility for 'combining and coordinating their work both in the training of Nurses and administration.'⁷⁸⁰ Miss Sampson was retiring after over twenty-five years as Matron at the Royal, so the timing of her departure appears to be coincidental with the establishment of the NHS rather than a result of unhappiness with the new administration. The reason for the departure of the three HMC Matrons is not clear; Miss Perkins had held her post at the General for at most five years. The resignations of Mrs Moss and her husband, the Master of Fir Vale Infirmary, brought to an end the custom of appointing a married couple to the most senior non-medical posts in the former Poor Law institution.⁷⁸¹

The new Matrons at the General, Infirmary and Royal came from outside Sheffield, and none appears to have worked in the city before her appointment. Two were promoted from posts as Assistant Matrons, one from a post as a Deputy Matron, at hospitals elsewhere in England. The Royal appointed a candidate from The London Hospital, while the Infirmary's new Matron had held a post at St Thomas's Hospital in London.⁷⁸² The General appointee had worked previously at Hope Hospital, Salford.⁷⁸³ In all three cases, the individuals had moved cities in order to gain promotion. The exception was the new Fir Vale Matron, Miss Greenep, who was promoted from the post of Assistant Matron at the hospital.

Of the seven women who held the post of 'Matron' at the three general hospitals from then until its abolition following the implementation of the Salmon reforms, only two

⁷⁸⁰ SA: SY 333/H6/68, June 1950, p. 1.

⁷⁸¹ Until at least 1944 the Matron at CGH was Miss Beacham: information from private collection.

⁷⁸² SA: SY 333/H16/1, Minute 437(49), 5 Sept 1949; SA: SY 333/H16/1, Minute 587(50), 2 Jan 1950; 'Matron, 35, can keep her bonnet' *Sheffield Telegraph*, 1 Apr 1950.

⁷⁸³ SA: SY 569/H1/3, Staff and Establishment Subcommittee, 20 Jan 1950; "'Matron One Day" Dream comes true', *Sheffield Telegraph* 13 Feb 1950.

appear to have undergone specific training in hospital nursing administration. Each had studied on a year-long programme in Nursing Administration (Hospital) run by the RCN, although not together. Each had gained experience of nursing in different hospitals and clinical specialities, at increasing levels of seniority, during her nursing career. Miss Clark, Matron at the Infirmary between 1950 and 1957, was supported financially by a scholarship from the Hospital Savings Association while studying nursing administration. Miss Jobling, who became The General's Matron in 1958, appears to have paid her own fee of forty-two Guineas – the RCN members' rate in 1951 when she commenced her studies – and two Guineas for Examination fees. Miss Clark's nursing experience was all gained in England, whereas Miss Jobling joined the Queen Alexandra Imperial Military Nursing Service (QAIMNS) in 1944, and for the following four years held a variety of nursing and midwifery posts in the UK, Europe, the Far East and India, before returning to civilian nursing in England. Miss Welbon, Matron of the Royal from 1949 until 1965, had gained a Master of Arts degree from Glasgow University, having intended to become a teacher until a change in family circumstances led her to take up a career in nursing.⁷⁸⁴

In each hospital, the Matron headed the nursing administration, but a hierarchy of Deputy Matron, Assistant Matrons, Administrative and Home Sisters supported her. Nurse Tutors, though not directly involved in the administration of the hospital's clinical work, also moved in and out of appointments to administrative posts. Miss Welbon had been a Sister Tutor at her training school, the London Hospital, before moving to Addenbrooke's Hospital in Cambridge to work as a Sister Tutor for four

⁷⁸⁴ "Matron One Day" Dream comes true', *Sheffield Telegraph*; SA: SY333/H6/14 5 Feb 1957; SA: SY333/H6/75: she went on to become Regional Nursing Officer at the South East Metropolitan RHB, and was elected to one of the fourteen general seats on the General Nursing Council in 1960; Bendall and Raybould, *General Nursing Council*, p. 247; SA: Acc 1994/64, Box 5, Exec(57)4, 16 Apr 1957; SA: Acc 1994/64, Box 1, MC(57)9, 14 Oct 1957; SA: SY 569/H1/12, MC(71)5, Minute 11, 10 May 1971; SA: SY 569/H1/14, NEC(73)1, Minute 22, 21 Mar 1973; SA: SY 569/H1/11, MC(70)1, Minute 109, 12 Jan 1970; SA: SY 569/H1/13, MC(72)5, 8 May 1972; Spritzer, 'A Matron retires', p. 44; additional information from private collection.

years prior to her appointment at the Royal. The Deputy Matron at Fir Vale from January 1950 to July 1953, Miss Nettleship, had originally been appointed Sister Tutor at the hospital in early 1949.⁷⁸⁵

The Infirmary experienced difficulty in filling senior administrative nursing staff posts in 1960, reflecting a nationwide problem, according to Miss Gossop who recommended that ‘...the only solution appears to be to train our own staff in administration.’ She proposed a long-term strategy, to second a nurse each year in turn to the RCN to undertake its Administration Course, commencing in September 1960. They would then return to Infirmary to work for three years on the hospital’s Administrative staff.⁷⁸⁶ This policy was implemented – although the hospital did not consistently enforce the requirement that the seconded nurse would stay to work for a full three years. From September 1964, the medical staff agreed that Miss Gossop could also offer periods of three months’ secondment to her office for Sisters who wished to gain administrative experience, as long as this was done on a voluntary basis. Management training courses were not routinely available until the late 1960s, even for the most senior in the nursing hierarchy.⁷⁸⁷

A criticism leveled at hospital nursing organisation by Salmon was that delegation of specific functions was poorly managed, and that Matrons were too willing to retain power and responsibility to themselves. During the 1960s, the Infirmary and General each appointed administrative staff with specific responsibility for the allocation of Student and Pupil Nurses, to wards and departments in order both to alleviate Matrons of this responsibility and to ensure that the hospitals met GNC requirements for

⁷⁸⁵ Spritzer, ‘A Matron retires’; SA: SY 569/H1/2, 4 Apr 1949; SA: SY 569/H1/3, SE(50)1, 20 Jan 1950.

⁷⁸⁶ J Green, ‘Nurses as managers’, pp. 278-279; White, *Nursing Profession*, pp. 80-84; SA: Acc 2001/98, Matron’s Records, 8 Feb 1960.

⁷⁸⁷ SA: SY 333/H6/14, 10 Sept 1964; SA: Acc 2001/98, Meetings with Sisters, Minute 698, 15 Sept 1964.

learners' clinical experiences.⁷⁸⁸ Assistant Matrons at the hospitals carried responsibility for specific aspects of nursing work – the General and Infirmary each allocated responsibility for nursing services in the Operating Theatres to an Assistant Matron, for example. Further, at the General, the implementation of the Salmon reforms meant that there would '...no longer be an Assistant Matron available to take medical histories, assist at medical examinations, ...' of newly appointed staff, prompting Miss Jobling, now PNO for the General Division, to propose that an Occupational Health Service should be established instead.⁷⁸⁹

Matrons' remuneration and status took little account of the size of the hospital or the degree of responsibility allocated to the post-holder – although it did recognise responsibilities for nurse training. Miss Greenep, Matron at Fir Vale from November 1949, held more qualifications in nursing – general, children's and mental – was a qualified midwife, and had responsibility for the delivery of nursing care to more patients at what was then one of the biggest hospitals in the country, than her colleague at the general hospital adjacent, yet earned less. Miss Greenep was to earn £475, increasing by £25 increments to £625, with emoluments valued at £225 annually. By contrast, Miss Janson, who held qualifications only in general nursing and in midwifery, would earn £530, with increments of £30 increasing her salary to £710 after six years, and emoluments worth £250 each year. However, Fir Vale's patients were chronically sick, mainly elderly or mentally ill or disabled, and its relatively small nursing staff establishment was primarily composed of Enrolled Assistant and Pupil Assistant Nurses, whereas the General's patients were acutely physically ill and the nursing staff was mainly composed of Registered Nurses and Students. As noted above, this disparity of status was maintained even after the Salmon reforms were implemented.

⁷⁸⁸ SA: SY 569/H1/8, CGH(67)2, 9 Feb 1967.

⁷⁸⁹ SA: SY 569/H1/13, 'Policies and Priorities, 1972/73', May 1972.

6.3 Preparation for the role of Matron

Analysis of the role of the Matron and the associated duties and responsibilities has tended to emphasise the problems that the women in these posts faced.⁷⁹⁰ At an individual level, both Rowden and Scott have suggested that this was a function both of a lack of specific training in nursing management or administration, and of a narrowness of vision attendant on lack of a broad range of life and career experiences.⁷⁹¹ The career trajectories of Sheffield's Matrons from 1949 onwards and the extant records indicate that this was not necessarily so. Information in the nursing registers and the *League of Trained Nurses Magazine*, suggests that nurses' careers often involved employment at different hospitals in different parts of the country, and even that some nurses combined a nursing career with employment in other fields. The *League's Magazine* also included occasional articles by Infirmary-trained nurses who had gone to work in various countries overseas, including one former Matron who was posted by the Ministry of Health to Iraq as a Nursing Officer.⁷⁹² The Royal's *Nurses' Register* includes information about the origins of its nurses, including their home (usually parental) address and previous occupation, and destination on leaving the hospital, which confirms that nurses moved to different hospitals around Britain and abroad either to train or to seek new posts.

In general, though, these sources also support the stereotype of the nurse who does not stray from her training school for many of those working in Sheffield. Miss Clark and Miss Welbon, for example, had each returned to her training school to gain promotion to the post of Assistant Matron before becoming Matrons in Sheffield, while Miss Jobling was returning to her training school when she became Matron of the General.

⁷⁹⁰ DHSS, *Progress on Salmon* (London, c1972); Starns, *March of the Matrons*, pp. 101-102; Ramsammy, 'Concerns', pp. 4-8.

⁷⁹¹ R Rowden, *Managing Nursing – a practical introduction to management for nurses* (London, 1984), p. 4; Scott, 'Policies for nursing', p. 220.

⁷⁹² SA: SY 333/H6/52-96, *passim*.

Furthermore, the majority of nurses working in Sheffield between 1948 and 1974 for whom information is available had limited – if any – experience in fields other than nursing during their careers.⁷⁹³

Information concerning the general experience and specific training undergone by Sheffield's hospital Matrons prior to their appointment is inconsistent. Reference has been made to the careers of two, but accounts of the other Matrons' nursing experiences and training are lacking. The RCN established its programme in Nursing Administration in 1944, and it is likely that Miss Clark was a student in one of the first cohorts, as she went from there to become Assistant Matron at Hyde Stile, Godalming 'where St Thomas's Hospital was evacuated during the war' before returning to 'London' as an Office Sister in 1948.⁷⁹⁴

One important change attendant on the implementation of the Salmon reforms was the expansion of management training programmes, and standardisation of curricula. While these had been available before 1968, their content and duration varied. Access to training in administration was not guaranteed, and the possession of a qualification in administration or in management was not a requirement for prospective senior nurses.⁷⁹⁵ In addition to the RCN's course, the King Edward Hospital Fund for London established a four-month training programme in nursing administration in 1949, and nurses particularly from the USH units were seconded to this and to management programmes run by the Nuffield Centre at the University of Leeds and by Aston University.⁷⁹⁶ Rowden states that opportunities for specific management training were limited, with almost no preparation beyond experience for Staff Nurse, Sister or Departmental Sister roles. However, the King Edward Hospital Fund offered

⁷⁹³ SA: Acc 2001/98, 'Royal Hospital – Nurses' Registers', 12-26.

⁷⁹⁴ "'Matron One Day' Dream comes true', *Sheffield Telegraph* 13 Feb (1950).

⁷⁹⁵ SA: SY 569/H1/4, Exec(51)1, 23 Apr 1951; SA: Acc 1994/64, Box 1, MC(58)7, 14 July 1958.

⁷⁹⁶ SA: SY 333/H1, SY333/H3, and SY 569/H1, *passim*.

a programme for Ward Sisters to which the Infirmary and Royal seconded staff, and the RCN also offered refresher courses for Ward and Department Sisters that the USH hospitals enabled members of their nursing staffs to attend.

The Salmon report nonetheless identified that improvement in the provision and availability of management training was required. Sheffield's experience, with the richer USH able to use its non-NHS derived funds to support staff training while the HMC hospitals long supported only compulsory updates for its midwives, suggests that in that city at least the broadening of opportunities was particularly important for the former municipal hospitals.

Following the Salmon reforms, first, middle and senior management courses were written within a national framework, and hospital authorities developed a more coordinated approach than had previously been the case to sending nurses, initially at Nursing Officer but later at Sister or Charge Nurse and Staff Nurse grades, on appropriate programmes. From 1969, the National Nursing Staff Committee, established in 1968 to expedite the Salmon Committee's recommendations, took responsibility for negotiating the content and availability of senior management courses for nurses with institutions such as the King Edward's Hospital Fund.⁷⁹⁷ RHBs assumed responsibility for a new level of middle management courses and developed them in conjunction with polytechnics and colleges of further education. The Department of Health and Social Security required the establishment of 'appreciation' courses, also to be run by polytechnics and colleges of further education, to prepare nurses for middle management programmes. The latter became known as 'First Line Management' courses and were increasingly available for Staff Nurses, as well as for Ward Sisters and Charge Nurses.

⁷⁹⁷ Ministry of Health/Scottish Home and Health Department, *Senior Nursing Staff*; DHSS, *Progress on Salmon*, p. 6; Rowden, *Managing Nursing*.

From 1968, the USH developed management courses in liaison with Sheffield City Polytechnic, which were available to community as well as to hospital-based nurses from the USH and HMC groups.⁷⁹⁸ Miss Lowarch's comment on the introduction of these courses at the USH reveals that she perceived that married nurses, many of whom worked on a part-time basis, were as worthy of the opportunity to participate – and, by implication, to contribute to management as well as the delivery of care – as the full-time, single woman.

I am pleased to report that [the] USH is now able to start management courses....This course will be centred on Sheffield and be available to staff of all the Sheffield Hospitals, Teaching Hospital and RHB...This will be very advantageous to the staff, as in the past we have always had the problem of married staff not being able to leave Sheffield in order to take desirable Post-graduate study.⁷⁹⁹

By March 1973, most Nursing Officers at the NGH had attended a Middle Management course, and nearly thirty Sisters, Charge Nurses and Staff Nurses had attended First Line Management courses. Nonetheless, this figure represented less than a third of the Sisters and Charge Nurses then employed in the hospital's General Division and Geriatric Area.⁸⁰⁰

6.4 Matrons and Non-Nurses

In spite of optimism to the contrary, from 1948 onwards the NHS operated within very tight resource limits, largely beyond the control of local hospitals. While some – though not all – Consultants may have been able to protect the interests of their speciality and those who worked and were treated there, all those people working within any hospital were doing so within financial and human resource constraints. In

⁷⁹⁸ SA: SY 333/H6/86, pp. 11-12; SA SY 333/H6/87; SA: SY 569/H1/10, Exec(69)2, 24 Feb 1969. All these refer to programmes attended by nurses run by, respectively, the RCN, the University of Aston, Nuffield Centre; SA: SY 569/H1/13, NAC(72)2, 6 May 1971-31 Jan 1972; SA: SY 569/H1/14 NGH(73)2, 'Annual Report' 21 Mar 1973; SA: SY 333/H16/8, '25th Annual Report', p. 25; SA: SY 333/H16/16, Section 4.

⁷⁹⁹ SA: Acc 2001/98, Matron's Records, 10 June 1968.

⁸⁰⁰ SA: SY 569/H1/14, NAC(73)2, 'Annual Report – General Nursing Division', 21 Mar 1973.

this context, the three main interest groups within the hospitals – Doctors, Administrators and Nurses – were working together in a situation of latent conflict over the management of these resources. Harrison's research into the management of the NHS suggests that the organisational politics of the early NHS was typified not by pluralism but by ideological corporatism, with Doctors 'free to act as they wished', limited only by the resource constraints imposed by government, and facilitated rather than opposed by administrators.⁸⁰¹ The freedom accorded to Doctors was predicated on not only an administrative norm of facilitation of their clinical requirements – underwritten by Bevan's undertaking to the medical profession in 1948 – but on the impotence of the nursing staff. Occasionally the underlying tensions, which arose from having to meet the complex endogenous and exogenous requirements of health care within restricted budgets, became overt. Disputes that could persist for considerable periods of time arose over resource limitations, exacerbated on occasion by requirements to make specific economies and changes in service delivery, and differences over specific clinical procedures.

In Sheffield, the records of the Infirmary indicate that two of the Matrons experienced very different treatment at the hands of the medical staff. The first, Miss Clark, appears to have encountered numerous disputes with the Medical Staff Committee, particularly over nurse staffing arrangements, for which she was frequently called to account. Her predecessor, Miss Warren, had been 'interviewed' over staff changes and the 'general standard' of nurses, prior to the Committee's meeting of 8 December 1947. A letter from her, read at the meeting of 28 January 1948, drew the Staff's attention to her view that the nurse staffing situation was worse than they appreciated. In 1950, Miss Clark was 'interviewed by the Secretary' of the committee over the nursing of private patients by junior nurses. She was further criticised over the

⁸⁰¹ Harrison, *Shifting the frontier*, Chapter 3, especially pp. 51-55.

frequency of nursing staff changes and their notification to the medical staff in 1951, 1952 and 1954. Her claim in 1953 that problems arose because of the need to manage recruiting problems were investigated by the Medical Staff who surveyed hospitals of similar size and standing in the north of England and expressed 'great disquiet' when they found that the Infirmary's problems were not replicated elsewhere. Finally, in 1956 she organised a Study Day for Sisters, and although she ensured that the wards and departments where they worked were staffed, the Medical Staff criticised the 'Absence of Sisters from Duty on the 24th October 1956'. They insisted that they should receive notice of such events in future – also suggesting that only half the Sisters should in future attend such an event. She also broke with tradition and lived out of the Infirmary from 1951, contrary to the preference of the medical staff.⁸⁰²

Another perspective on her situation is provided by correspondence between the Chair of the USH Board of Governors and the group's Chief Administrative Officer, written in 1954 and indicating that the circumstances in which she was working were themselves difficult. This indicates that the Consultant staff were, as a matter of policy, furnished with whatever they required without delay, while the needs of the other staff groups received no corresponding consideration. The Chairman speculated that the Matron's difficulties in providing staff had been accorded scant regard. Miss Clark left Sheffield in 1957 for a post that involved promotion.⁸⁰³ Her treatment can be contrasted with the support given to the General's Matron over the same period, when bed closures were sanctioned in order to address nursing staff shortages.

Miss Clark's successor, Miss Gossop, encountered disputes with the medical staff over clinical procedures, such as the giving of intramuscular injections and the precise method for administration of an inhalation, but appears to have avoided being

⁸⁰² SA: SY 333/H16/14.

⁸⁰³ SA: ABC17, 1 Oct 1954. The letter goes on to observe that Miss Clark would be difficult to replace.

'interviewed by the Secretary'. Neither she nor her successors succeeded in persuading the Medical Staff to change their view of the site for administration of intramuscular injections, nor did Miss Gossop persuade the one Consultant who did not like inhalations to be administered in the manner required by the GNC to change his mind.

Another example that indicates a difference in the relationship between these two Matrons and the medical staff relates to venepuncture, the obtaining of blood samples from a vein. This did not appear on the 1952 GNC syllabus and should not have been a 'normal' part of the nursing role. In January 1955, Miss Clark drew the Medical Staff's attention to the question of whether Sisters and Staff Nurses should be performing venepuncture. They noted the information but recorded that it could not be avoided, although they agreed to draw the Board of Governors' attention to the fact that this practice was going on.⁸⁰⁴ When Miss Gossop informed them in May 1958 that she had told the qualified nurses to stop performing venepuncture, they complained that it added to their burden and suggested that they might find it necessary to 'interview her'.⁸⁰⁵ There is no indication that they did so, but she did appear to have succeeded in putting an end to the performance of venepuncture by the nursing staff.

The records both for the Medical Staff Committee and for the Matron's Meetings with Sisters indicate that during Miss Gossop's tenure as Matron a number of innovations were considered and introduced, and that she was responsible for several of them. For example, she is credited with having implemented Progressive Patient Care, although the medical staff found it 'unacceptable'. She appears to have persuaded the Staff to negotiate over nurse staffing levels, and to cooperate with the nursing staff over

⁸⁰⁴ SA: SY 333/H6/14, 17 Jan 1955.

⁸⁰⁵ SA: SY 333/H6/14, 6 May 1958.

working hours and practices in order to ease the burden of work at particularly difficult times.⁸⁰⁶ She did 'ask the advice' of the Medical Staff Committee, and the indications that her dealings with them were more cordial than Miss Clark's had been, including her ability to introduce innovative approaches to management training for Sisters at the hospital, suggest that she was skilful in managing her relationship with the senior medical staff.

However, in July 1961, she and the Ward Sisters introduced a patients' rest hour, as recommended by the report on the *Pattern of the In-patients' Day*. The records of their meeting in September indicate that this had caused difficulties with the work of departments, but the wards did not wish to stagger the timing of the rest period, preferring to allow emergency work to continue during the allotted hour of one until two in the afternoon. The medical staff though were unhappy, declaring in their meeting the same day that they would not be prevented from visiting their patients during the rest period, and that these should be staggered in order to allow departmental work to continue. On this occasion, there appears to have been a lapse in the usual negotiation prior to implementation, as the Medical Staff 'deprecated any changes without their prior consultation'. Miss Gossop's report to the House Committee informed them that the rest period was appreciated by the patients, although she noted the objections raised by the departments and offered to stagger the timing, and she sought permission to continue with the scheme. The date and contents of her report, six days after both her meeting with the Infirmary's Sisters and the medical staff's meeting, suggests that she was aware of the Consultants' misgivings, and that the compromise she offered may have been negotiated with the Sisters in order to achieve the goal of retaining the rest period. In this, she was successful.⁸⁰⁷

⁸⁰⁶ SA: Acc 2001/98, Matron's Records, 8 Aug 1961.

⁸⁰⁷ SA: Acc 2001/98, Meetings with Sisters, 25 July 1961; SA: Acc 2001/98, Meetings with Sisters, 5 Sept 1961; SA: SY 333/H6/14, 5 Sept 1961; SA: Acc 2001/98, Matron's Records, 11 Sept 1961; SA:

Miss Gossop also introduced several new specialist 'post-graduate' programmes for nurses and invited medical staff to comment on these innovations. She asked their advice and appears generally to have maintained productive working relationships between nursing and medical staff at the Infirmary.⁸⁰⁸ She not only negotiated with the medical staff, but also consulted the Sisters over reports relating to nursing, and established working parties to discuss the implications of these and matters such as non-nursing duties.⁸⁰⁹

She was also able to secure the Medical Staff's agreement to allowing Ward Sisters to exercise their professional judgment over whether ambulant patients should be allowed to get up to use the lavatory in the middle of the night. This appears at one level to be quite a minor detail, but the minute referring to this decision indicates the possibility that the senior members of the Medical Staff influenced or even controlled this activity, though there was not a uniform policy throughout the hospital.

The Secretary read a letter from the Matron asking for the Staff's agreement for patients who were capable of getting up at night to go to the toilet should be allowed to do so. It appears that the practice in this matter varies from ward to ward. It was agreed that this was a matter about which the Consultant Staff could not give any instructions, but that it should be left to the good sense of the Sisters concerned.⁸¹⁰

Whether the Staff, or some of the Consultants, had previously given specific instructions to the Sisters on whether patients could get up during the night, or had merely left them uncertain as to their authority to make decisions for themselves is unclear. The formal agreement of all to allow senior nursing staff to make decisions based on their judgment as nurses was important because it represented the relinquishing of some medical control over nursing decisions. As noted in Chapter

Acc 2001/98, Meetings with Sisters, 5 Feb 1962. Introduction of the rest hour at the Royal Hospital is simply recorded; there is no indication of controversy: SA: SY 333/H1/33, 13 Feb 1962.

⁸⁰⁸ SA: Acc 2001/98, Meetings with Sisters, *passim*. SA: SY 333/H6/14, *passim*.

⁸⁰⁹ SA: SY 333/H6/14, Minute 5, 1 Dec 1964.

⁸¹⁰ SA: SY 333/H6/14, 2 Jan 1962.

Five, the continuing dispute over the optimum site for intramuscular injections, and over the administration of inhalations, indicates that concessions were being made over aspects of patients' personal care – use of the lavatory, rest, visiting – but not over those that involved the implementation of medically prescribed therapeutic interventions.⁸¹¹ Thus nurses established control over basic, but not technical, aspects of nursing care.

The staffing of the hospitals was another matter over which disputes between medical and nursing staff arose on occasion. When it became necessary to adjust the demand for nursing staff by reducing the work done and the number of beds available to patients, disputes were more likely to arise. Overt bed closure was politically difficult, being unpopular with the local press, General Practitioners, the RHB and the Ministry of Health. Conversely, the Matron of the General, Miss Janson, received the full support of her HMC when she proposed the closure of large numbers of the hospital's bed complement in February 1951, indicating that their relationship was not a simple hierarchical one with the Matron in a subordinate position. The RHB, though initially reluctant to accept the HMC and their Matron's decision, agreed to the closures in May 1951. This public show of unity hid some misgivings on the part of HMC members. One of the medical staff represented on the HMC noted that the reduction in bed numbers could lead to refusal of admission to people with urgent medical needs, as well as those requiring non-urgent care.⁸¹² Most significant in this situation was the support the Matron received, even when the HMC faced trenchant criticism from RHB, General Practitioners and the local media alike.

⁸¹¹ SA: SY 333/H6/14, *passim*; SA: Acc 2001/98, Meetings with Sisters, *passim*.

⁸¹² SA: SY 569/H1/4, MC(51)2, Minute 14, 12 Feb 51; SA: SY 569/H1/4, GP(51)2, Minute 28, 26 Feb 1951; SA: SY 569/H1/4, MC(51)4, Minute 36, 9 Apr 1951; SA: SY 569/H1/4, Exec(51)2, Minute 61, 28 May 1951; SA: SY 569/H1/4, MC(51)7, Minute 71, 9 July 1951; SA: SY 569/H1/4, MC(51)8, Minute 77, 10 Sept 1951; SA: SY 569/H1/4, CGH(51)7, 23 July 1951; SA: SY 569/H1/4, Exec(51)4, Minute 122, 23 July 1951.

Miss Janson's report to the General's Committee in April 1952 indicates that conditions for staff had been improved thereby. The older two-storey ward blocks at the Hospital now had a Ward Sister each, and she refers to better conditions for patients as new amenities were provided.⁸¹³ Nor were her decisions criticised by the medical staff, as Miss Clark experienced at the Infirmary over the same period. A further example of the respect with which Miss Janson's decisions were treated was the HMC's support of her decision to dismiss three Pupil Assistant Nurses for 'misuse of the Committee's property', although their trade union, the National Union of Public Employees (NUPE) had made a representation for leniency on their behalf.⁸¹⁴

Later examples of bed closures appear to indicate that the overt approach was not favoured thereafter, by either the USH or HMC. Instead, closing wards for extended periods of cleaning and redecoration allowed beds to be put out of use for a reason that the HMC or Board of Governors could present to the hospital's staff and to the general public in a positive light, as an opportunity to improve services. The situation was complicated both by a lack of agreed, objective criteria for determining the number and qualifications of nursing staff required to care for patients, and by the constant requirement to economise, which meant that funding was only available to pay for a proportion of the number of staff required. The first of these was not helped by either the lack of agreement on what nurses of different grades should be doing, by changes in the range of therapeutic interventions available that meant that the nature and level of intensity of care required also changed, and by the changes in terms and conditions of service that reduced the hours that any individual nurse was available to work.⁸¹⁵ The second was remarkable in that the funding limits were set by the very people

⁸¹³ SA: SY 569/H1/5, CGH(52)4, 'Matron's Report', 10 Apr 1952.

⁸¹⁴ SA: SY 569/H1/3, GPC(50)9, Minute 223, 23 Oct 1950.

⁸¹⁵ Rivett, *Cradle to Grave*; Nuffield Provincial Hospitals Trust, *Work of Nurses*; Prices and Incomes Board, *Pay of Nurses and Midwives in the National Health Service*; SA: SY 569/H1 and SA: Acc 1994/64, *passim*.

whose review had led to the determination of the establishment in the first place. Perverse incentives arose from this to make up the numbers of staff performing nursing duties by employment of unqualified non-training and training grade nurses.

Efforts to address the issue of nursing establishments were thus inconsistent. The discomfort that arose from this recurrent problem even led one administrator in 1967 to try to conceal the results of reviews, so that the Matrons would not know how many nursing staff they should be allowed to employ: 'He asked that the final findings of such reviews should be kept confidential to save embarrassment when Matrons asked for staff increases for which money was not available.'⁸¹⁶

However, the implementation of the Salmon Report's key tenets from 1969, and the presence of nurses on committees, meant that such information could less readily be concealed from them. The 1973 *Nurse Staffing Report* for the General noted that the CNO and the Group Treasurer had decided in January 1972 to employ trained nurses whenever it was possible to replace a Nursing Auxiliary vacancy. This was because while the cost of so doing was higher, they anticipated that the quality of work of trained nurses would lead to overall improvement in the service provided. That decision had prompted a review of the hospital's nursing staff requirements, which commenced in February 1972. The RHB published its report six months later, in August 1972.

The CNO, Miss Ward, then decided to undertake her own review 'as a matter of urgency' because in her view, the RHB's assessment had taken little account of changes such as the increasing level of workload in the General Nursing Division. Patient turnover had increased, specialist units with high demand for trained staff had opened, there had been changes in nurse training, night duty cover, and post-

⁸¹⁶ SA: SY 291/H1/2, Minute 11, 10 Mar 1967.

registration courses. In addition, the hospital was recognised as having teaching hospital status, increasing the range and interest of nursing work, and a forty-hour working week had been introduced for nursing staff, reducing the number of working hours contributed by each nurse employed.

The RHB's revised staff objectives still did not meet those of the CNO, as they increased the number of trained nurses allowed, but decreased the number of learners to be recruited. This would mean that the proportion of Registered and Enrolled Nurses would increase in the immediate future but, after only two to three years, the hospital's supply of trained nurses would diminish. On one night in July 1973, the month when the revised figures were received, the hospital's records note that five wards were staffed only by untrained Nursing Auxiliaries. In September 1973 the HMC was contacted by a City Councillor, F R Butler, who had received a complaint of shortage of nurses, low morale and poor care on geriatric wards from a group of NGH nurses. The HMC agreed that the shortage of staff existed, but denied that it had affected the quality of care given to patients. The HMC then resolved to ask the CNO to contact each nurse and ask him or her to meet Mr. Carlisle, the Chair of the HMC, to discuss his or her concerns. The minutes do not provide any information about the nurses themselves, or how they perceived this management of their complaint, since they had wished to remain anonymous.

Within four months of the RHB's agreement to the revised objective, five wards had to be closed because there were insufficient nurses to staff them. One reopened within a month of closing, but the others remained closed for one and a half months in all, between 16th July and 3rd September 1973. Further ward closures were anticipated during weeks in November and December, 1973, and January, March and early April, 1974. In September 1973, the Group Medical Committee decided that the situation

left only two options open to them. Either they could agree to the 'large scale' closure of wards that mainly admitted 'cold' cases, and end with a much longer waiting list, or they could agree to reorganise wards on a 'Progressive Patient Care' basis in order to match nursing skills to patient needs.⁸¹⁷ Meanwhile, a 'steady trickle' of nursing recruits averted the need to close wards in November 1973 and January 1974.

Funding for nursing staff from the RHB was calculated according to the crude number of staff employed, not taking the mix of different grades of staff into account, and the establishment became 'over weighted to lower grades'. Initially the Group Treasurer was able to divert other funds to allow for further nursing recruitment, but he could not guarantee to continue this. By September 1973, £30,000 had been reallocated within the hospital's revenue budget to fund nursing salaries. Furthermore, while the RHB had agreed a revised staffing objective for the Geriatric Nursing Division, no extra money was made available to fund it. The General's nursing establishment was already staffed at 87%, although the Board's policy across the Region was that only 85% of the establishment should be funded. Further finance was unlikely to be provided. This was confirmed in October 1973, when the RHB Treasurer made it clear that no more reserves were being held for nurse recruitment and informed the HMC that even if more money became available, the RHB would require the HMC to use its own funds first. The HMC estimated that they already required an additional £30,000 from the RHB in order to finance 85% of their revised objectives. Of the revenue allocation to staff costs, 15% would then be needed to cover legitimate and expected absence, and the most optimistic outcome would have been an effective nursing

⁸¹⁷ SA: SY 569/H1/14, MC(73)1; MC(72)11, 11 Dec 1972; MC(73)2, Minute 108, 12 Feb 1973; NGH(73)2, 21 Mar 1973; GMC(73)2, Minute 69, 27 Mar 1973; MEX(73)9, 8 June 1973; MEX(73)10, Minute 65a), 13 July 1973; FGP (73)7, Minute 71, 25 July 1973; GMC(73)4, Minute 12a), 24 July 1973; MC(73)8, Minute 55, 10 Sept 1973; GMC(73)5, Minute 22b), 25 Sept 1973; MC(73)9, Minute 61, 8 Oct 1973; MEX(73)12, Minute 110a), 12 Oct 1973; MC(73)10, Minute 80, 12 Nov 1973; 569/H1/15, GMC(73)6, 27 Nov 1973; FGP(74)1, Minute 241, 30 Jan 1974; MEX(74)3, Minute 209, 8 Mar 1974; MC(74)3, Minute 117, 27 Mar 1974.

strength of 70% of total requirements. The HMC resolved to bring the Agreed Funded Establishment (AFE) gradually into line with the revised objectives, funding permitting. By March 1974, the estimated additional funding required to fund 85% of the objectives had risen to £104,000. By April 1974, when the NHS was restructured, the CNO and Group Treasurer had received no response to their joint report on Nursing and Midwifery objectives for the hospital.

The period from 1948 to 1974 opened with few nurses having the right to a place in NHS decision-making processes, and closed with a clear, formal, hierarchy of roles, responsibilities and representation at all levels. Senior nurses carried heavy responsibilities for the operation of the hospital service on a daily basis, yet were relatively powerless to control the resources with which to discharge those responsibilities. While individuals – Miss Janson and Miss Gossop, for example – were able to circumvent these difficulties by developing good working relationships with the administrative and medical staffs of their hospital, the vulnerable situation in which this placed the Matron is revealed by the difficulties faced by Miss Clark in her dealings with the medical staff of the Infirmary during the 1950s.

Even after the implementation of the Salmon reforms of senior nursing roles, training some of these problems persisted. However, the implementation of the Salmon reforms was still important in confirming the place of nurses in the hospital's decision-making bodies. Unfortunately, the period covered by the study ends in 1974 and it is difficult, therefore, to assess whether such formal changes made a real difference to the ability of nurses to effect changes not only in their own circumstances, but also for the NHS in general.

Conclusions

The NHS has been subject to analysis since its inception, its decennial anniversaries usually occasioning further reflections on its impact. Although not entirely absent, the contribution of clinical staff has not featured strongly in the historiography. This study began with the objective of redressing some of that deficiency, at least with respect to a perspective from the periphery. Sheffield was selected as the focus for this analysis because of its apparent ordinariness, although certain particularities about the city and its hospital services were identified in the preliminary reading of the available literature. The relationship between the population and its hospitals, mediated through the 'penny-in-the-pound' scheme and latterly by the municipality's determination to modernise its hospitals before World War Two interrupted its plans, was one such feature of the city. Another was the continued involvement of the community – or some sections of it – in the management and operation of the NHS through membership of committees and boards, and voluntary contributions that permitted activities and services that could not be funded out of allocations from the Treasury.

The study identified four main issues that were of particular concern to nurses and those with whom they worked in Sheffield during the period between 1948 and 1974. These were the availability of nursing staff, their knowledge and skills, nursing practice and the organisation of the nursing function within the hospitals. Although treated separately for the purposes of analysis, each of these issues interacted with the others in reality, producing challenges to the successful operation of the nursing service. The findings on each of these is now summarised in turn, before general conclusions are reached and recommendations made.

The records reveal the persistence of recruitment difficulties, throughout the period from 1948 to 1974, for Sheffield's hospital authorities. Sheffield's hospitals were not unique in the difficulties they faced in the recruitment and retention of nursing staff during the first phase of the NHS, nor in the fact that this was a recurrent situation, frequently discussed in committees and boards at every level. Demand rose faster than the hospitals' ability to recruit staff, with some specialist wards and departments especially likely to be affected. Those planning the future development of hospital services recognised that, without sufficient nurses, their aspirations would be thwarted – and they believed that this was very likely to happen. However, for those who were responsible for the day-to-day delivery of hospital services, the problems were even more pressing. They faced an almost continual threat to their ability to provide a service.

On a daily basis, the Matrons were responsible for managing this and providing the nurses who would care for the patients. Their attempts to deal with the problems they faced fell into two main categories. Either they could improve the supply of nurses or they could reduce the level of demand for them. One way in which the supply of nurses could be improved was to make those available more flexible. For example, in 1952 the General's Executive Committee decided that the shortage of nursing staff was such that all nurses should be seen as interchangeable, regardless of grade and whether qualified or not, in order to meet the patients' needs for basic nursing care. Similarly, between 1954 and 1962, the Infirmary recruited an increasing number of auxiliary grade nurses in order to address the shortage of student nurses. However, by 1962, this had achieved the effect of giving the General the advantage in student recruitment, while also reducing the number of Nursing Assistants employed there to its lowest during the 25-year period. Thereafter, the number of Nursing Auxiliaries employed by the Infirmary gradually fell, although a long-term effect of the hospital's earlier

recruitment policy was to exacerbate the difficulties of restoring the proportion of qualified nursing staff during the late 1960s. By the end of the period, the proportion of auxiliary grade staff was similar at each hospital, having reached approximately 19%. The records indicate that the free substitution of grades was increasingly questioned as the quality of the nursing workforce came to be perceived as of at least equal importance to the numbers employed. The two remained closely related, inasmuch as when simply staffing the wards and departments was difficult the question of who was there became less important. However, rather than disappearing altogether, substitution became less crude in some respects, and trained nurses of SEN or SSEN grade were substituted for SRNs, especially in those areas of the hospitals that were concerned with the care of older people and those with chronic diseases.

Nonetheless, nurses in training were initially the most flexible group of nursing employees and, during the early part of the period, this meant that some clinical experiences during the training period were of very short duration. GNC Inspectors' Reports and the demands of the consultant medical staff at the USH hospitals led to a gradual lengthening and stabilisation of the duration of clinical experiences in training. However, the use of learners to meet the need for nursing care, at weekends but especially on night duty when direct supervision by qualified nursing staff was difficult to achieve, was viewed with ambivalence. The GNC criticised the practice in its 1950 Inspection Report on nurse training at the General, and did so repeatedly in its Inspection Reports on both the USH and HMC thereafter, and the minutes of meetings occasionally record hospital administrators' and senior nurses' discomfiture with the situation. Nonetheless, they were unable to abolish the practice locally, and the records give no indication that they attempted to influence national policies on this matter, whether through professional or NHS committee structures.

In addition to making more effective use of the staff already in employment, hospital authorities also sought additional staff. The General's Management Committee sought the approval of the Sheffield RHB, and the USH that of the Ministry of Health, for improvements in the nursing staff establishment, whether generally or in respect of the balance of numbers in the various grades, although any gains made were often offset by limitations on the budget available to fund the agreed numbers. Recruitment of school leavers was encouraged through liaison between the hospitals and local schools, and other groups of potential recruits, such as local women who had left the labour market while childrearing, overseas and male candidates were also recruited, although specific evidence on these groups is limited.

However, the numbers had to be recruited and retained, and the inducements available to hospital authorities were limited. Nonetheless, improvements in the attraction of nursing work and life were essayed, including the extension of opportunities for postgraduate training and promotion, flexible and part-time working hours, childcare facilities, improvements in the clinical environment and the refurbishment of nurses' homes. Advertisement of the opportunities available was also used to attract candidates, whether through pamphlets and the local and nursing press, or the expedient of senior nurses visiting schools and women's groups or encouraging prospective employees to visit the hospitals.

Another approach to improving the capacity to provide care was to reduce demands on the staff available. An example of this was the closure of beds, whether overtly or covertly, permanently or temporarily, although this was unpopular with the local community, expressed through protests from GPs and media, and with the hospitals' consultants. Conversely, the latter were occasionally persuaded to reduce their demands on the nursing staff by 'regulating their work' – reducing the number of

surgical operations or planned admissions to the wards. This was always a very short-term and temporary arrangement, tolerated in strictly exceptional circumstances.

The most striking difference between managing the demand for and supply of nurses was the degree to which the latter required the cooperation of the medical and lay administrative staff. Of course, the refurbishment of wards, departments and nurses' homes required this too, because it involved disbursement of funds from the hospital's ever-limited finances. Nonetheless, this did not affect the provision of services to patients directly in the way that restricting the level of clinical activity did. Overall, what is most striking about approaches taken to dealing with the problems of nursing availability is that they were characterised by reactive responses, 'muddling through', a lack of strategy. The persistence of the problems themselves made it difficult for those responsible for managing them to do so in any other way. The challenge of nurse recruitment and retention had endured despite the recommendations made by a plethora of reports since the 1930s, and the Matrons, their lay and medical colleagues and the members of the Management Committee and Board of Governors had mostly worked in the hospital services since then. The relentless demand for hospital services and the limited resources – financial, human and physical – to supply this, each of which were largely externally determined, meant that all those involved whether nursing, medical or lay administrators were so engaged with managing the day-to-day business of hospital work that looking beyond that would have been the exception.

While the need to recruit and retain nurses was the most pressing issue, a second and related theme was their preparation for the job of nursing. The content of Student and Pupil Nurse training was determined by the syllabuses prepared by the GNC, and this addressed the training needs of upwards of 45.5% of the nursing workforce. However, this meant that sometimes as many as over half of those engaged in providing nursing

care did not have statutory access to or a requirement for a regulated and evaluated programme of training. Increasingly, the hospitals developed study days, programmes and other opportunities for learning that addressed this absence, recognising both the boost they could provide to recruitment and retention, and the possibilities for improving the quality of nursing care given to patients.

With respect to pre-registration training, an interesting finding is that in spite of the statutory basis of the GNC's regulation of nurse training, including controlling the content of the syllabuses and enforcement through regular inspections of training schools, there was a considerable degree of local freedom in interpreting and implementing their requirements. For example, at the General, study days rather than study blocks remained the norm until the 1960s, whereas the USH's Sheffield School of Nursing had introduced study blocks during the early 1950s. The GNC also tolerated delays in the local introduction of new pre-registration syllabuses.

Conversely, the records also indicate that the GNC's recommendations were taken seriously – albeit that action to implement them might be slow or limited by financial or other factors. Furthermore, it was the GNC's recommendations for inclusion of professional nurses on nurse education committees that led to the creation of professional nursing committees at the General, preceding changes made at the behest of the Ministry of Health.

Before leaving pre-registration training, there is a final point to be made concerning the contribution of national policies on local developments in nurse education. In the first case, an apparently innovative development – the Sheffield School of Nursing – was in fact largely the result of a pragmatic local response to GNC rules for nurse training. In another, what would have been a genuinely innovative development, a multi-disciplinary pre-registration training school, was lost in the reorganisation of the

NHS. Conversely, there was sufficient local autonomy to frustrate the suggestion that a group training school be established through the amalgamation of the three training schools within the HMC. Objections to this were based in part on the risk that the Matrons' status as head of the nursing service could be compromised, in part on the fear that this would compromise recruitment to the smallest hospital, and increase wastage from both Fir Vale and Nether Edge Hospital.

Training opportunities for qualified nurses and nursing auxiliaries were also developed between 1948 and 1974, although the absence of a clear national strategy for either of these meant that they characteristically responded to operational rather than educational imperatives. Thus, with the exception of programmes leading to a second registration in midwifery or another branch of nursing, postgraduate – post-registration – programmes were devised around the interests of recruitment and the advice of the specialist medical staff working in the speciality wherein a programme was developed. At least until the creation of the JBCNS, little or no attention was given to whether the programmes were based on sound educational theory, or on a strategic approach either to therapeutic developments in the specialist field or in nursing itself. Moreover, access to such programmes was not assured to nurses, who might experience a financial penalty in pursuing some postgraduate training. The effect of the absence of a clear national policy was even more pronounced in the case of training for auxiliaries, which developed sporadically and existed discontinuously.

Nursing practice was overwhelmingly 'a manual but highly personal process'.⁸¹⁸ Yet the first quarter-century of the NHS' existence coincided with therapeutic innovation and associated specialisation in the practice of hospital-based medicine. In parallel, nursing also became more specialised and the amount of technical nursing care

⁸¹⁸ Fir Vale Infirmary, Sheffield Number One HMC, *A Simple and Practical Course*.

required by patients rose as a proportion of the overall nursing care delivered, whether this was in the acute wards and departments with an increasingly rapid turnover of patients or in those caring for people with long-term conditions. Thereby, the internal structure of nursing changed, but so did the working relationships between nurses and their non-nursing colleagues in the hospital setting.

Therapeutic change was not the only influence on nursing practice, which had also to take place in the context of considerable resource restrictions. Financial constraints contributed to insufficiency in the number of nurses available and to the quality of training and experience they received. They also governed the quality of the buildings in which patients were nursed, the availability of basic equipment and the possibility of replacing obsolete and potentially dangerous equipment with better facilities and apparatus. The lack of lifts at the General was at best inconvenient, but as indicated above, it could also hinder the evacuation of patients in an emergency. The age of buildings was also considered to be a barrier to recruitment.

Another example of the problems posed thereby was the length of time taken to provide wash hand basins on the older wards, and fit those used by clinical staff with elbow rather than screw taps. Once early ambulation had been accepted as the optimal approach to recovery, patients required more access to lavatory and bathroom facilities, but the structure of the older hospital buildings limited the options for providing these. Prevention of cross-infection also required nurses to be able to wash their hands and, particularly prior to aseptic procedures, to do so without the risk of recontamination in the process. While from the mid-1950s GNC Inspectors' Reports recommended the installation of elbow taps, which can be operated without requiring the user to handle the tap itself, the Ministry of Health did not require this until 1968 – and thus one hospital with limited budgets was able to delay their installation.

The necessity to use obsolete equipment, or to manage without sufficient supplies, also hindered nurses in their daily work. For example, the use of mackintoshes to protect mattresses from dirt involved a considerable amount of nursing time in maintenance of the equipment itself – but this had to be done in sluices that were crowded and so inadequate for the task. Furthermore, nurses complained frequently that there was insufficient linen and too few pillows available on the wards. This was exacerbated by the presence of extra beds on the wards, which meant that the stock of linen was even less adequate to meet demand.

Change in the environment in which nurses worked was simultaneously rapid and protracted. Rapid in the introduction of new treatments and protracted because changing the configuration of services depended on the availability of appropriate facilities and staff, and making these available could take months or even years. An example of this was the development of intensive therapy facilities in the USH. Nursing staff could also resist changes, thus delaying their introduction. The starkest instance of this was the continuation of four-hourly patient observations at the Infirmary during the 1960s, even where it had been agreed that this was not necessary for all patients.

If the content of nursing practice was changing, so was its focus, the patient. The most obvious, and symbolic, aspect of this was early ambulation. The patient was expected to be more mobile, and this was reflected in the more rapid turnover of the patient population and both contributed to the development of the patient as an actor in the hospital setting. The introduction of the 'kardex' system illuminates this. Before this, the status of the patient was that of one of many people, whose treatments were all recorded by the nurse in a central Ward Report Book, the individual's experience becoming part of the whole ward community's. Thereafter, the patient became an

individual, whose care was recorded separately in such a way that it would tell their 'story' and follow them – at least within the hospital itself.

As with the availability, knowledge and skills, and practice, the organisation of nursing in the NHS continued features that had been present before 1948, particularly in the limited role that nurses had in the formal administrative structure of the NHS. Sheffield RHB's creation of professional, representative committees was not matched in the HMC hospitals, so apparently undermining the opportunity to engage nurses in discussion and decisions about nursing issues. Nurses made use of chances to engage in discussion and provide professional advice about the organisation of their work – whether in response to reports issued by the SNAC at the Ministry of Health, or by the RCN, for example in groups established by the Matron and Sisters' meetings at the Infirmary, or the working parties at the General. However, while formal change was effected in the creation of professional committees in the hospitals, coincident with though not entirely the result of implementation of the *Report of the Committee on Senior Nursing Staff Structure*, informal power structures were not.

Another element of continuity was present in the role of the Matron as head of the nursing service until the late 1960s. It is apparent from the records of Sheffield's hospitals during the period from 1948 to 1974 that the relationship that the Matron established with the lay administrators and medical staff was central to her ability to achieve successful representation of the interests of the nursing service. Conversely, her relationship with nursing staff, whether in the nurse training school or in the clinical wards and departments, was also crucial to effecting change in nursing practices. This was particularly important prior to the implementation of the *Report of the Committee on Senior Nursing Staff Structure*, because of the absence of clear rights

of representation of nursing services in the administrative structure of the hospital service.

The availability, knowledge and skills, practice and organisation of nursing thus display elements of both continuity and change over the first period of the existence of the NHS. The problem of matching the supply of nurses to the demand for nursing care persisted, and the nature of the bulk of that care required nursing knowledge and skills that had been practiced for decades. Moreover, the circumstances in which that care was delivered, both in the physical environment of the hospital buildings and in the socio-political dimensions of the relationships between nurses and their colleagues – particularly medical and lay administrative staff – were slow to change.

Many of the factors that influenced developments in nursing in Sheffield were likely to be found in most other parts of the NHS. These include the central control of funding and many aspects of its deployment by the Ministry of Health and RHB, which delayed the long-awaited building of new hospitals by the USH and the HMC, in the latter case until after the period covered by the study. National determination of pay and conditions for nurses, through the Whitley Council system, also shaped local nursing services, and thus the care delivered to hospital patients.

Conversely, local circumstances determined the pattern of hospital provision locally and shaped responses to the problems of providing services. The USH was able to make use of existing funds to make good deficiencies in both the built environment and in funding for research and staff development, in a way that was not open to the HMC, for instance. The example of the Management Committee at the General, which chose to work with its Matrons and act on their advice in the management of bed closures when these were deemed appropriate gives the lie to the general assumption that former municipal hospitals were more hierarchical than were former voluntary

hospitals. This is also consistent with the observation that locally, personalities and the quality of interpersonal working relationships were essential to the successful operation of the hospital service.

This study has examined a period of only 26 years, albeit one that is significant in the history of the NHS, when plans and aspirations were being realised through the creation of working relationships within the new administrative structure, and when the relationship between hospitals and communities was being re-evaluated. It has also focused on specific aspects of the hospital services in one city only. Each of these limitations has implications for what can be learned from Sheffield's experiences.

However, the opportunity to examine the development of the NHS at the periphery, and from the perspective of one occupational group has highlighted some interesting issues. For example, the shortage of nursing staff available to deliver the care required prompted nurses in Sheffield's hospitals to ask important questions about their own roles. By the late 1960s, nurses were increasingly confident in articulating their own views about what they should and should not be doing, and were assuming greater control over and responsibility for their working roles and relationships with colleagues and patients. Further local studies would be helpful in exploring this phenomenon, and its contribution to the development of nursing since, in particular the 'New Nursing' with its emphasis on patient-centred care and the concurrent development of specialist clinical nursing roles. Such studies might also help to illuminate further the role of central or national policy in facilitating or frustrating local hospital services during the early years of the NHS.

The findings of this study also suggest that there is a requirement to examine the experience of specific groups of nurses in more depth. For example, the increasing attention to improving the quality of nursing and rehabilitative care provided to older

people in hospital has been alluded to, but this field of nursing during the period warrants further attention, particularly in the light of contemporary developments in gerontological nursing and services for older people in the NHS. Tangentially related to this, the current study indicates that research into the history of the role of the SE(A)N would be of general interest and has the potential to contribute to an understanding of the development of the Health Care Assistant's role.

The recruitment of overseas nurses, which was an expedient adopted in order to make good a shortfall in the availability of recruits born in the UK, was subject to analysis by contemporaries in the RHB, who attributed these nurses' poor representation in the higher echelons of the profession to individual lack of ambition. This demands further exploration, particularly following concern expressed in reports by the Department of Health, Unison and the RCN and others since the mid-1990s, over both institutional racism in the NHS and its effects on nurses from black and minority ethnic communities and the ethical dilemmas occasioned by the recruitment of overseas nurses to the NHS since the late 1990s.

The focus of this study has been primarily on nursing, albeit that the thesis opened with an explanation of the development of NHS hospital services in Sheffield. It thus considered the role of the local community in the work of the hospitals in several ways from their management to aspects of the funding and the provision of services to the patients that were not included in the remit of the NHS itself. Finally, therefore, the impact of the NHS on relationships between hospitals and local communities warrants further exploration. Again, this has specific relevance to the development of Foundation Trusts and the expressed desire of the Department of Health that local communities should be involved in the development of services through membership of these new bodies.

In sum, the main argument of this thesis was that nurses' contribution to the development of the NHS during its first quarter century was more significant than the limited space given to nursing issues in most general and policy histories of the service appears to indicate. A case study of the history of general hospital nursing in one provincial city, Sheffield, was undertaken in order to explore the relationship between local circumstances and the implementation of national policy. It was suggested that such an approach '...offers an ideal opportunity for an in depth examination of the contribution of nurses and their work to the interplay between local and national circumstances in the implementation of the English NHS, as the central plank of post-Second World War health policy'.⁸¹⁹

The present study made use of primarily locally available primary source material, and sought answers to the following four questions: 'what were the issues that concerned nurses in Sheffield during the period between 1948 and 1974?' 'in what respects did specific aspects of nursing, identified as a result of a reading of the primary source material, change between 1948 and 1974?', 'what factors influenced continuity and change in nursing in Sheffield during this period?' and 'what was the relationship between local and national factors in influencing nursing in Sheffield?'.⁸²⁰

The main findings of this thesis were that long-standing nurse recruitment and retention problems inhibited development of the new NHS throughout the first quarter-century of its existence. This was discussed by a document outlining the Sheffield RHB's hospital planning proposals, published in 1955. However, it was also apparent in the routine records of the general hospitals of the city throughout the period, which reveal that the availability of nursing staff in the hospitals' wards and departments was consistently less than the senior nursing, administrative and medical staff considered

⁸¹⁹ See p. 8 of this work.

⁸²⁰ See p. 14 of this work.

necessary to provide appropriate levels of care. This was most starkly evident in the occasional recourse to bed closures, delays in opening new wards and departments, and in the frustration of senior nurses working in the Fir Vale unit, which provided long-term care for older people.⁸²¹ The constraints imposed by restrictions on capital and revenue allocations to hospital authorities have been accorded considerable attention in the literature on the NHS, at least since the mid-1950s. This study suggests that the specific, local effects of nursing – and possibly other staff - shortages should also receive further attention, and that this is of continuing relevance to those planning and delivering health services.

Secondly, the contribution of nurses to the development of hospital services was constrained by compromises in the training of nurses of all grades, at pre-registration and post-registration stages.⁸²² The reasons for this were in large part attributable to the shortages of staff noted above. This is not a surprising finding, although the present study adds interesting evidence of collusion on the part of senior members of hospital nursing, administrative and medical staff, and the GNC in its perpetuation. Pre- and post-registration courses served the dual function of recruitment and training, to the detriment of their capacity to do either particularly well. Changes in the provision of nurse education in Sheffield were largely the result of the need to respond to events and resource constraints, while often attempts to innovate were undermined by a combination of similar factors.

Thirdly, the work that nurses did was influenced by both the factors just discussed, as well as by continuities in the basic care needs of their patients, by therapeutic innovation, and by the physical environments in which care was delivered.⁸²³ Lack of direct evidence makes it impossible at this stage to state that poor provision for

⁸²¹ See p. 108 *et seq.* of this work.

⁸²² See p. 163 *et seq.* of this work.

⁸²³ See p. 201 *et seq.* of this work.

personal hygiene, lack of bathroom and wash hand basin facilities in clinical areas actually inhibited the implementation of early mobilisation and rehabilitation of patients, although it is likely that this was the case.

Fourthly, the evidence found in local records dealing with general hospital nursing in Sheffield suggests that the imperative on senior nurses to deliver nursing services with insufficient staff occupied so much of their time, and limited representation on administrative committees considerably curtailed their opportunity to assume a leadership, as opposed to an administrative, role.⁸²⁴ This was as much the case where the Matron had undertaken specific training in hospital administration as it was for those – the majority - who had not. Locally, the ability of individual Matrons to form effective working relationships with senior medical staff in particular, and administrative colleagues to a lesser extent, was crucial to their ability to overcome the disadvantages inherent in their absence from decision-making bodies.

Furthermore, histories of nursing are in danger of contributing to occupational introspection if they become concerned more with the nurses themselves than with the relationship between nurses and non-nurses, and when their focus is on very particular aspects of nursing as an occupation. Nurses should be self-conscious, but also other-conscious in their accounts of the profession, whether their concern is to write history, sociology, anthropology or to analyse from any other interdisciplinary perspective. The choice appears to be between this and splendid isolation. Conversely, histories of the NHS that underplay the importance of the role of nurses, not as consciously political actors as at least the most vocal sections of the medical profession have been but - nonetheless – as being as important to the continued existence of the service, are challengeable. The case study of Sheffield suggests that fresh insights to the

⁸²⁴ See p. 243 *et seq.* of this work.

implementation of the central aspect of post-war health policy, the creation of the NHS, can still be added to the existing literature.