

**“DELIVER ME FROM HIS INDIGNITY!”:  
COTTAGE HOSPITALS, LOCALISM AND NHS HEALTHCARE  
IN CENTRAL ENGLAND, 1948-1978**

*Victorian and Edwardian cottage hospitals, compared to infirmaries and workhouse institutions, have been neglected by social historians. Yet, they provided an infrastructure dedicated to localism and healthcare for the aged under the new National Health Service (NHS) after World War Two. This article focuses on two renowned Midlands cottage hospitals built in mid-Northamptonshire at Pitsford. In their patient case-histories we can engage with: dignity standards, medical regime, ward designs, staffing levels, budget provisions, and patient voices. These popular institutions had a well-deserved reputation for delivering high-quality geriatric medicine from 1948 to 1978. Human vignettes detailing the physical indignities of ageing nonetheless proliferate in the records. The longevity of these basic issues was to prove to be a recurring tension in NHS financial planning. Budget models lacked enough funds for aged patients to receive ‘stable’ bedside care. Instead, NHS accountants allocated resources to ensure the future ‘sustainability’ of the system itself. A new paradigm highlights the inherent financial contradictions and empty political promises that those needing geriatric care often experienced, and still do. Throughout, the rediscovered cottage hospital records contain important historical lessons for the present impasse about how to define, deliver and secure dignity for elderly patients in today’s NHS.*

*Introduction:*

In 1949, the *Lancet* published what would become one of its most influential and forward-looking editorials in modern medicine. Its leader page highlighted that there was a structural healthcare problem that had never been properly redressed since Victorian times in Britain. It was incontrovertible, it observed, that: ‘The plight of old people is one of *the* biggest and most embarrassing problems facing the National Health Service’ [hereafter NHS] (*Lancet* 1949: 740-1). That candid admission was the culmination of a century of welfare debates about how to pay for, from taxation, the healthcare needs of sick, older people (Hurren 2012). Civil servants had debated what to do about the long-term and expensive medical bills of the elderly, conducting two major inquiries into the rising costs in 1854 and 1889.<sup>1</sup> By the 1890s, the Treasury calculated that one in every three inmates that entered newly built infirmaries of workhouses for medical relief was ‘elderly...infirm...and frail’ (*BPP* 1854, 1889). Better diets, cleaner water supplies, improved sanitation, and faster disease notification had reduced mortality rates. Yet, those public health gains had also created structural demographic

healthcare problems and ones not dissimilar to population trends today (Thomson 1983 and 1984). People were living longer than ever before, and the majority were asking for publicly funded end-of-life care. After the publication of the findings of the *Royal Commission on the Aged Poor* (BPP 1894/5), one policy solution was the national introduction of a small old age pension in 1908 that was non-contributory for those aged over 70. Yet, the elderly already in ill-health, living on the threshold of relative to absolute poverty, were increasingly aware of, and anxious about, being a financial burden to their families (for a recent overview, see, Johnson and Thane 2014). They thus turned to their local cottage hospital to help them in their declining years (on the history of hospitals and care of the elderly, see, selectively, Pickstone 1985, Rivett 1986). For, in the past, just like today, each person's healthcare bill was the most expensive in the last five years of their life (see, Bradshaw and Merriman, 2007 on hospital, community care and home costs for the elderly). Although entry to a cottage hospital required the sponsorship of a donor, this gate-keeping practice was palatable to the labouring poor (for the classic study of hospital practices, refer, Abel-Smith 1964). It was preferable to being crowded together in relatively anonymous large infirmaries to obtain very basic public healthcare provision (on how services specifically expanded in the inter-war years, see, Cherry 1992, Powell 1997 and Mohan 2002). It is surprising then that compared to poor law institutions, cottage hospitals have been studied so little by social historians (exceptions are, Neville 2014, Hall 2012, Gibbon 2004, Ankins 2000, Cherry, 1991, Emrys-Roberts 1991 & 1990).<sup>2</sup> What follows next seeks then to redress that historical neglect.

As we shall see, cottage hospitals built in the Victorian and Edwardian periods were an important part of the medical mosaic that constituted the embryonic NHS. They proliferated in provincial areas, valued by their patients, and yet we still know so little about their healthcare provision and medical standards. Nor do we currently understand the historical lessons of a sense of dignity, or of family and community belonging, contained in

their records. The main reason that such potentially valuable records have been neglected is that their patient histories were absorbed into the NHS in 1948 where they often got filed and forgotten. Access to them today is sometimes not feasible for researchers because their paperwork got shredded in the 1970s to create more storage space in the records' departments of large teaching hospitals. Yet, those that did survive often do so in rich detail, even though they can have very specific access agreements (reflecting public sensitivities about data security and patient confidentiality). These patient histories often contain vital information about geriatric medicine and dignity standards at a pivotal time in the NHS formation. Researchers may hence have neglected to appreciate the potential modern policy angles in the available paperwork. As a consequence, throughout this article the important original, particular, and far-reaching, historical insights contained in the archives of cottage hospitals are highlighted. Our historical prism is two well-known geriatric facilities located at Pitsford – a village in mid-Northamptonshire about seventy miles from London. Their premises in the Midlands were absorbed into the NHS in 1948 before being closed on cost grounds by 1978. They have been chosen because their records were very comprehensive by World War II and have survived in sufficient numbers to facilitate a refined case-study analysis. They constitute a representative sample because both wartime evacuees and patients from across the region were cared for together on location. This meant that a spectrum of case-histories was created which reflect more broadly demographic and epidemiological trends in geriatric medicine. Integrating that local and regional picture with national dimensions, three research themes frame an analysis of their patient case histories.

The main thread throughout the article, introduced in Section 1, will be dignity in healthcare because it is such an important medical issue across time. New research seeks to better understand how it was defined, to what extent its human dimensions changed as policies were remade, or shifted with NHS chronologies. Closely related is the question of

what constituted ‘stability’ of healthcare at the bedside for elderly patients in community care. Hence the focus in Section 2 is all about exploring what ageing patients required in terms of staffing, hospital design, and medical regime to meet their most basic daily healthcare needs. A third strand is the thorny financial question of the ‘sustainability’ of cottage hospitals inside the new NHS system itself. We will be reconstructing in Section 3 tensions surrounding localism and healthcare funding versus the adoption of a financial model of centralised patterns of expenditure. A key unanswered question is to what extent actual patients’ needs were balanced carefully or got miscalculated within budget-planning schemes, and what were the longer-term consequences for dignity standards (Berridge 2010).

An additional layer of analysis will thus incorporate three human perspectives inside the Pitsford cottage hospital system in mid-Northamptonshire. It is essential to: firstly, locate and try to assess the value of localism and healthcare to actual aged patients; secondly, it is vital to engage with patients’ voices to ascertain whether the past can ever speak to the present to help shape current reform in dignity standards, or not; and finally, it is necessary to engage with the dysfunctional aspects of physical ageing. If these have had longevity then financial forecasts should have factored in the potential for substantial healthcare inequalities. By the conclusion it will be shown that the case-histories contain important historical lessons for the present impasse about how to define, deliver and secure dignity for elderly patients in the NHS. They reflect how cottage hospitals, in so many respects, appear to have contained a microcosm of the human challenges in geriatric medicine that continue to confront public healthcare staff in Britain today.<sup>2</sup> Having therefore identified this significant source, and located a set of records that have survived, what follows next provides an overview of relevant NHS historiography to set in context the importance of our chosen cottage hospital archives and their refined case-study analysis.

NHS scholarship broadly covers the complex development of a publicly-funded system of universal healthcare paid for by central taxation in Britain from 1948 (Gorsky 2008). Looking back to the nineteenth century, welfare historians have thus documented that the penny-pinching ideology of the workhouse system was unacceptable to voters in an era of widening democracy (Gestrich, Hurren and King 2008, Gestrich and King 2016). Moving forward from the Edwardian era (1901-10), after the economic crisis following the Wall Street Crash (1929), the privations of WWII, and the election of the Labour Party to office in 1945, the NHS exemplified a new cultural consensus that healthcare from ‘the cradle to the grave’ was a national priority (Webster 1988 & 1996). The degree however to which it has maintained widespread political support, the effectiveness of its healthcare delivery, and questions over its future financial basis, remain the subject of lively debate. Recently the culture created by the NHS – what ordinary people feel about it and whether they trust it – has been the subject of renewed historical scrutiny because of the pending seventieth anniversary of the NHS in 2018.<sup>3</sup> In many respects, a renewed emphasis on community, localism, and the patient experience at the point of delivery, represents a move away from the major ideological, political and policy histories that dominated the field of study from the 1950s (Gorsky 2008). The histories of emotions and pain management, within the medical humanities, are together stimulating new scholarly approaches too.<sup>4</sup> This article builds on this recent trend by exploring the value of engaging at a community level with actual patient histories and their human vignettes. Importantly, as Martin Gorsky observed when reflecting on the sixtieth anniversary of the NHS in 2008: ‘much remains to be learned about how policy translated into practice. Here the regional study offers rich possibilities for interrogating’ a literature that has been dominated by ideological, political and economic parameters (Gorsky: 454). He also posed an important research question: ‘But is it really

possible to assess how much is enough to meet demands for health care?’ (Gorsky: 451). In so doing, he identified the future importance of what he called ‘a subaltern history’ of ‘long-term care for the elderly’ which would augment recent policy studies (like, Bridgen 2001, Bridgen and Lewis, 1999). This article follows suit by providing a different sort of detailed picture of what it was like to experience early NHS geriatric medicine in former cottage hospitals. Record linkage work will elaborate what specific challenges confronted a new system that from its inception found that care for the elderly was a major logistical test of its healthcare delivery (see Section 2 on methodology). It will be shown that a continuous feature of the underlying health issues facing frail older people were routine indignities that were obvious to those managing cottage hospitals transferred into the new system, but often went unheeded by NHS forecasters. In this way, the article complements the scholarship of Tony Cutler who has questioned whether the Treasury estimates in 1944 for gross expenditure of all NHS activities were a ‘dangerous yardstick’ with which to judge the financial health of the entire system by the early 1950s when retrenchment became a popular political cry (Cutler 2003).<sup>5</sup> We begin Section 1 therefore with a brief history of two well-known cottage hospitals in the Midlands, how they came to be absorbed into the early NHS, and their *modus operandi* in terms of dignity standards.

### *Midlands Cottage Hospitals, WWII and the early NHS*

The late-Victorian cottage hospital system depended on inward business investment from philanthropists establishing family medical trusts from their wealth accumulation. They were run as small voluntary hospitals with a mixture of private patients’ fees being charged where feasible, supplemented by charity paid from the original benefaction that provided healthcare cover for the aged labouring poor (Welshman 1999). One such was funded by Pickering Phipps, the third generation of a family of brewers who expanded across central England

(company history at: <http://www.phipps-nbc.co.uk/2.html>). His family firm owned 'the largest pub estate in the Midlands' and the 'ninth largest in Britain' with some '242 tied public houses' by 1905. As a non-conformist, Pickering Phipps believed that charity was his moral duty and so at his death (childless) in 1937 he bequeathed his Pitsford property to local people to set up a cottage home for the elderly of the county. It was originally called 'Stone House' and was to become renowned for the work it did with the aged in the Midlands. Indeed, its reputation grew because conveniently there was a similar geriatric cottage hospital already in operation in the same village established by another local philanthropist called Philip Manfield who had made a fortune in shoe-making.<sup>6</sup> Pitsford's two famous cottage hospitals were hence situated in a picturesque village, some seven miles from the centre of Northampton town that became very well-known in the national press. Their high-profile in newspapers was also enhanced by the local presence of the Royal family. Two children of George V, namely Prince Edward (King Edward VIII who abdicated) and the Duke of York (King George VI) spent their weekends in Pitsford village, hunting on a regular basis from the 1920s to 1940s (Royal Photographs of their hunting-box can be found at: <https://www.bonhams.com/auctions/13861/lot/300/>). Such high-profile Royal connections meant that Pitsford's cottage hospitals soon attracted the attention of Middlesex County Council too.

In 1941, Middlesex County Council took a policy decision to evacuate all elderly patients out of London. Middlesex Hospital was made a priority since it could not cope with higher civilian casualty admissions in substandard infirmary and workhouse buildings built during the Victorian era. Hence the creation of a Medical Emergency Service in which the Middlesex Hospital served Sector 5 of the capital in Fitzrovia, led to extensive discussions about the degree to which the entire system was coping with the evacuation from Dunkirk and the Blitz of 1940-1 (Rivett [http://www.nhshistory.net/ems\\_1939-1945.htm](http://www.nhshistory.net/ems_1939-1945.htm)). Regardless

of the various funding semantics, there was general agreement amongst civil servants that it was desirable to instigate the start of a post-war hospital planning scheme. As part of that initiative it was decided that Middlesex County Council should lease a number of cottage hospitals in the Midlands to which they could transfer their ageing patients in need of longer term care. The decision to do so in Northamptonshire was based on two factors. Firstly, Royal patronage had attracted favourable publicity for Pitsford as a place of leisure, church-going and charitable endeavour, especially during the economic hard times of the 1930s. Secondly, this had not lessened, but rather had increased, the determination of local people to never again tolerate the old workhouse system. They were motivated to embrace better community care having experienced and rejected an infamous welfare experiment that had been conducted in the area during the late-Victorian era. For Pitsford was situated in the Brixworth Poor Law union that had tried to cut off welfare outside the workhouse; a policy that was hardest on the elderly, widows and disabled (Hurren 2012). Across the region, guardians championed the ethos of the Charity Organisation Society in an attempt to prove to the Local Government Board in London that they could eradicate outdoor relief. This traditional small dole was paid to vulnerable paupers being cared for at home and it tended to be for medical relief in old age. That harsh policy-line was reversed when all forms of local government were democratised for the first time in 1894/5. There was a well-advertised political awakening in the area promoted in national newspapers like the *Daily News* (the third largest in Britain). During the early twentieth century, ordinary working people, equipped with new voting powers, were influencing private and public welfare institutions for the first time in healthcare history. Cottage hospitals in the mid-Northamptonshire parliamentary constituency were thus run on very enlightened policy-lines by the Edwardian period and Royal patronage cemented their more charitable character in the public imagination. For the next three decades, their ethos of localism and healthcare did not fall out



of medical fashion but grew in importance across the central belt of England. Against this backdrop, Middlesex County Council decided to lease Pitsford's cottage hospital premises by 1941 so that they were seen to house the evacuated elderly in 'an ideal location for invalids' in the Midlands (*NM & H*, 18 August 1948).

Middlesex County Council distributed their geriatric evacuated cases out of the capital as follows: aged women went to Stone House now renamed Middlesex House cottage hospital (the Phipps brewery bequest) and sick men were housed at Pitsford House cottage hospital (the Manfield shoe bequest): one was on the high street, the other in manor road (*NRO*, 269P/129/1). Subsequent Royal patronage by Queen Elizabeth (the late Queen Mother) from 1938 meant that the cottage hospitals were the focus of considerable local, regional and national interest. 'If the elderly could be treated successfully here, then this might be matched everywhere' – was the election refrain of the local Member of Parliament (Bondfield, 1948).<sup>7</sup> Against this backdrop it is important to try to identify the main concepts of dignity in healthcare that were praised by local patients, and whether they had longevity in the early NHS because that is the overarching theme of this new study.

In 1948, the establishment of the NHS saw the transfer in to the new system of Middlesex's cottage hospitals with a total capacity of 3, 200 beds located across the Midlands (refer, Klein, 1983). The *Northampton Mercury and Herald* on 18 August 1948 thus informed its readers that: 'Pitsford Homes Cheer the Sick and Elderly.' An editorial leader explained that an investigative reporter had found that the renowned cottage hospitals provided a very high standard of geriatric care. He discovered that an NHS decision had been taken to triage the patients in the two cottage hospital premises: those aged females diagnosed as 'chronic' cases, some '67 patients', were still to be transferred to Middlesex House (*NM & H*, 18 Aug, 1948). Now however both males and females (not just the men, as had formerly been the case), were to remain at Pitsford House. This was some '82 patients', said to be 'sick

and frail', but not necessarily incapacitated by permanent debility. The majority in both cottage hospitals were aged over 60, with 20% in the age range 80 to 90 years old (again see, *NM & H*, 18 Aug, 1948). These were patients that previously would have had to enter the workhouse or try to make an outdoor relief claim to get medical help. Most were born in the 1870s when the social experiment to eradicate poor relief was at its political height. In many respects those that found themselves housed in the two local cottage hospitals of the early NHS believed that 'in the evening of their lives' they were the main beneficiaries of poor law democracy, and more enlightened attitudes to elderly care. They had no reason to resent or indeed complain about their treatment. For these reasons, their patient records are instructive about common perceptions of dignity and indignity for a generation that expected less than today's patients of the medical profession. Most expressed sincere gratitude for what was on offer under the early NHS compared to the old workhouse system. Two dignity themes emerge consistently in the records.

Contemporary accounts of the Midlands' cottage hospital system transferred to the NHS reported primarily on the main benefits of the 'environment' which aged patients said was 'so bright and airy' not 'drab and dark' (*NM & H* 18 August 1948). From the time of their conversion at Pitsford in 1937 there had been a refurbishment plan to 'create cheerfulness' in the choice of 'bright chintz curtains', 'colourful bedclothes', 'pictures on the walls', and 'lofty ceiling' heights. If patients were bed-ridden then they should be encouraged to think that this was '*their* space'. Large 'picture windows' were kept clutter free to give a feeling of being outside when trapped inside. It is informative that there was a lot of early discussion about the holistic design of the cottage hospitals that the NHS inherited. This was because it was an obvious but important observation that when the physical space someone could walk around in shrank to just a few unsteady steps it became very important to create more of a sense of environmental space for the aged person confined to a narrowing world.

As one male visitor to Pitsford emphasised in 1948: ‘There are some bedrooms – not wards – which contain only two beds, but in the larger rooms the number of beds goes up to 12. Even so, there is *plenty of space*’ ([sic], *NM & H*, 18 Aug, 1948). Here, he continued, ‘about 150 women’ were ‘not overcrowded’. In a generation that valued discretion, it was distressing to be cheek-by-jowl in geriatric wards that resembled poor law infirmaries under some early NHS facilities. The cottage hospital design by contrast created a dignity of personal space. The large-scale closure of cottage hospitals and the transfer of the elderly to very large but crowded geriatric units in the 1970s, therefore contravened some of the most basic principles of healthcare, well-known in the early NHS (Section 3 expands on its financial drivers). Meantime, it was the Oxford Regional Health Board that oversaw the transfer of aged patients from across the Midlands to Pitsford’s hospitals for the aged and chronic, and in so doing the patient notes record the importance of medical regimen, the second key archive theme, for the maintenance of dignity.

The early NHS was in many respects the culmination of a complex path to full professional recognition by medical staff (Waddington 2003, Hurren 2015). A lot of general practitioners needed convincing however that inward government investment would benefit the medical profession in the longer term. This ambivalence was very much an espousal of a medical ethos that promoted the future science of healthcare and paid much less attention to its holistic past. In many respects, this was understandable, after all the Medical Act (1858) and its extension in 1885 had been about outlawing quackery (Porter 2003). Scientific-based medicine had been ring-fenced by legislation overseen by the General Medical Council. It meant that the early NHS was about the promotion of new scientific frontiers to attract sceptical doctors into its rank and file, and justify the large costs of getting the new system underway. In the course of which, medical regimen started to be regarded as old-fashioned, except, that is, to those doctors pioneering geriatric medicine. Indeed the field was led by a

female doctor working for Middlesex County Council, the patient feeder for Pitsford cottage hospitals from 1941-8.

The formal break between Middlesex County Council in 1948 and its Pitsford cottage hospitals has tended to be summarised in general histories of the regional formation of the early NHS (Waddy 1974, Foss and Trick 1989). Rather than mistaking this small Northamptonshire village as a rural backwater, it was in fact connected to a number of medical innovations in the care of the elderly that reveal the importance of central-local relations for developing standards of dignity on a national platform from 1948. One of the most influential people who helped formulate localism and healthcare for the elderly was Dr Margery Warren (1897-1960), described as ‘the mother of British Geriatric Medicine’. Warren worked not only from a Middlesex base but her influence soon spread across the Midlands because of the established connections that already existed with local cottage hospitals in mid-Northamptonshire. Michael Denham her biographer has traced how Warren became a registered doctor, won recognition as a consultant physician to the NHS (one of the first female appointments), and promoted imaginative ward work with the aged:

The medical profession as a whole were unenthusiastic about treating sick older people because they had multiple pathologies frequently associated with social problems that required extra time and patience, took longer to recover from illnesses, blocked beds...Patients’ illnesses were not properly classified or investigated. Treatment was often limited to nursing care. Medical notes were of poor quality. Many patients were confined to a bed for years on end...Warren emphasised that ... chronological and biological ages should be differentiated...Good therapy lay in early diagnosis, appropriate treatment, adequate hydration and minimal sedation... (Denham 2011: 106).

Warren insisted that medical labels like ‘chronic’ and ‘senile’ were negative for aged patients. They were not a site of disease (the purely scientific approach) but needed a holistic health appraisal to maintain dignity. Medical regimen should include ‘care of the feet, ears, teeth, clothing and diet’. Environmental factors such as improved light, space, and colourful

walls in pastel shades were life-enhancing. Patients trapped in tight bedclothes often developed bed sores, very poor circulation, and needed to be encouraged to maintain mobility however limited. In an age of data collection, Warren recognised that she would need to compile patient histories and publish results if she was to influence the policy direction of Middlesex's cottage hospitals, both in-county, and in the Midlands. In all, she managed to show how she improved through localism and healthcare the well-being of about one third of her aged patients (Warren 1948: 337-8). Successive articles followed in the *Lancet* during the 1950s and indeed her continued emphasis on medical regimen attracted considerable comment in the medical press (see, for example, Warren 1950: 921-4, Warren 1960: 1876-9). It was this tenor that proved to be very influential at the cottage hospitals at Pitsford. Some evacuees even chose to stay on after the war, and of those that returned to the capital their place was quickly filled by a Northamptonshire resident wanting quality end-of-life care. The early NHS was thus developing the sort of 'subaltern history' of 'long-term care for the elderly' that Martin Gorsky has called for more research on (Gorsky 2008: 437). The next section looks therefore in more detail at the patient case histories themselves and in particular at the challenges of care in a cottage hospital system where the staff to patient ratio was better than today and in which older patients' expectations were lower than their modern counterparts. As we shall see, despite an emphasis on the importance of medical regimen, there were quintessential aspects of ageing that all patients found undignified. These could not be resolved however hard medical staff tried and they were to have long-term budget implications.

#### *Patient Case Records & Dignity Standards*

The rediscovery of patient records belonging to the old Pitsford cottage hospital site has facilitated the compilation of 2, 880 elderly patient cases from 1941 to 1977.<sup>9</sup> Significantly

this is a representative sample of the average-level of patient admissions that tended to occur in the majority of Midlands' cottage hospitals under the early NHS. Such cases have hence been analysed according to the 100-year rule so that research does not contravene the Data Protection Act (1988) in the UK. As a precaution, all personal information has been anonymised (*NRO*, Northampton General Hospital Records, NGH/6, Pitsford and Middlesex House Cottage Hospitals, NGH/6/4/1-3, NGH/6/4/4, NGH/6/4/5).<sup>10</sup> Most residents were aged over eighty by the 1970s, dying by the early 1990s. Nevertheless many could still have living relatives in the area, and so for ethical reasons general trends, edited highlights, and standard oral history techniques are used, with substitute initials denoting patient voices, since record-keeping predated informed consent (Berridge 2008 recommends this method).

In over 90% of the cases (some 2, 592) reported in the 'Accidents in Hospitals Book' using NHS standard form HMC 55(66) physically 'falling' was very common, with the evidence showing persuasively that this was 'really shocking' to patients, feeding into their sense of self-worth and dignity: themes explored throughout the rest of this article (all cases cited in this section 2 are located in, private collection & *NRO*, NHH/6, NGH/6/4/1-3, NGH/6/4/4, NGH/6/4/5). It is noteworthy that in most months over a thirty-six year period there was one 'fall' incident per day on site, and this, despite five members of staff on duty during each shift to care for up to twelve patients each. Seldom can histories engage with these everyday realities that fundamentally impacted on perceptions of dignity/indignity, and so here we are going to take that important opportunity in the record-keeping to do so. For, as Roy Porter reminds family and community historians, it is important to try to look up from the bed, rather than down onto the patient (Porter 1998).

In a typical example when patient ML was admitted she was very frail. On 13 August 1971, her medical notes described 'a swelling and bruising of the right knee; occurred during the morning and increased rapidly between 10.30am and 1pm'. When asked by the duty

doctor what happened, ML described how she ‘fell to floor at bottom of the bed when trying to get out to the toilet without any help’. This explained ‘how her right leg became fixed between the cot-sides’. As the accident had not been witnessed by a member of staff a decision was taken to put the patient ‘back into bed’ and calm her down. The shock of the fall appeared to have undermined her sense of emotional well-being and physical dignity. The patient was seen later that day by ‘Dr T...the Medical Officer’ and referred to the casualty department of the newly built Northampton General Hospital. An ‘x-ray of the right-knee revealed osteoarthritis and a diagnosis of Haematomis’; it necessitated ‘incision, cleaning and suturing’ before ML was returned to the cottage hospital. Yet, it was the absolute indignity of falling down, the sense that the knee might not be reliable anymore, and that further tumbles might follow, that the nursing staff paid close attention to. This 81 year old lady knew that ‘in the evening of her life indignities will come’ and ‘might be fatal’. As FH, another resident, reported on 17 December 1970 the fact of being ‘found on the floor in the ground floor toilets having apparently fallen when walking with her zimmer frame aid’ was ‘shocking’. Likewise when LG aged almost 90 ‘cut her head behind her ear’ she was ‘shocked’ to discover that using the medicine trolley to support herself from falling did not work – ‘the medicine trolley moved and the patient fell’. Meanwhile AK, aged 81, told nurses how she ‘slipped on the floor whilst getting to the commode’ and ‘feared more to come’ because that was what ‘ageing was all about’. So throughout the records we see the vital importance of maintaining patient: staff ratios, the need to fund these adequately, and that even when these were supported locally, the elderly might still feel undignified. It is apparent that these sorts of physical contradictions are often unacknowledged in political debates about what can and cannot be funded in the NHS; and this, despite practitioners continually highlighting the longevity of managing falls in gerontology (see, Tideiskaar, 2010). Here it is then worth looking more closely at the available patient records to bring into sharper focus those

commonplace aspects of ageing that have always been, and are always likely to, undermine a sense of dignity for the elderly.

Accidents involving the commode were very common in the Pitsford patient records, often resulting in laceration to the limbs and face. In the case of the patient CP she ‘hurt her back...caused by lifting patient from the commode chair to patient’s bedside chair’. By all accounts CP was a buxom lady aged 70 with little mobility. ‘Nurse S’ found it very difficult to handle her on 19 December 1967. CP often appeared in the patient accident book in subsequent years as her frail body became clumsy. On 7 November 1970 for instance CP ‘fell down and grazed the skin on her knees’ by slipping on a ‘step’. Getting out of bed in the middle of the night was though perhaps the most shocking fall of all. MB aged 87 on 14 March 1971 was typical of those who ‘got out of bed unaided to use the commode at 3am’ and was ‘shocked to fall down in a heap’. Increasingly the nursing staff struggled to help. GC on 9 October 1971 ‘fell forward from the commode whilst being wheeled to the bedside’ by a nurse ‘at 5pm’. She hit her head and the nurse applied a ‘cold compress – put her to bed – and treated her for shock’ before being checked by the Medical Officer on duty. It was an irony that the environment and medical regimen encouraged a level of independence and dignity of well-being, supported by staff-patient interactions, that could prove injurious; but, as the Medical Officer noted, ‘no ageing patient’ could avoid the dangers of ‘being broken’ in ‘some respect at the end of life’. Perhaps then it is unsurprising to discover patients like ED by 1971 declaring, ‘Deliver me from this indignity!’ She said ‘it is *the* Shock [sic]’ of a fall that most found very hard to absorb in old age.

Delving deeper into the patient records it is difficult to avoid the conclusion that the biggest cause of indignity was the physical fact of getting older and more unstable. Again it is important to engage with actual elderly patients’ experiences which have so often been overlooked in NHS forecasting. In a typical example when Mrs S at 4am on 11 August 1968



felt sick, she tried to get out of bed but as her medical notes state: 'slipped on vomit whilst trying to get to the commode'. The laceration of '1 ½ inches to her arm' and cut could be 'bandaged' but as the nurse on duty recorded the only way to alleviate the 'shock' of being feeble was a 'drop of brandy'. Mrs H likewise at 1.15am on 11 September 1968 'slipped to the floor whilst trying to get out of bed to turn off the radio???' The three question marks annotated in the case records by the night duty nurse expressed amazement that the patient thought there was a radio by the bed (there was not), and that it had been left on (it had not). It was a sudden urge to go to the toilet that woke Mrs H from a dream. In this case the 'shock' of discovering that she was not sure-footed and did not have a radio required a 'hot drink' and help to get back into bed. The dangers of sleep walking could be just as disorientating. Patient GG on 8 March 1969 tried to walk out the back door but it 'slammed back at her as she was opening the same and caught her right heel' whereupon she woke up. Her 'skin was broken on her right heel' and after a dressing she was made comfortable again in bed. Mrs P sleeping in the next bed on 12 March 1969, three nights later, determined she had had enough of lying down. She 'decided to sit on a footstool' but her 'knees doubled under her'. The nurse helped her to 'walk about several times' to calm her down and reassure her that her condition was not fatal. Not all patients passed pleasantries together. Mrs T on 5 July 1969 was 'struck a ringing blow on left ear by Mrs L' and evasive action taken by the nursing staff. Disputes about handbag ownership often caused difficulties. Thus Mrs L on 22 August 1969 refused to put her handbag by her bed but wanted to hold onto it. Hence 'she reached for the handbag while sitting on the commode and fell forward on her hands and feet'. The 'slight bruise to her leg' was superficial but the mental 'shock' of falling required 'rest in bed'. Likewise when Mrs G 'rolled out of bed' on 22 March 1967 she 'shockingly' did so 'onto a bag containing scissors at 6.15pm'; 'the stab wound from the scissors in the left abdomen' involved a transfer to Northampton General Hospital to 'suture the

wound...overnight'. Such cases personify the general lack of an historical appreciation of the physical impact of a shocking experience, even in a generation that was remarkably resilient and stoic; studies tending instead to pitch old versus young people as the 'new shock' of our times (see, Fishman, 2012).

It was never in fact the case that the elderly either abandoned each other or their stoicism in the patient records. Yet, good bedside relations between the elderly women were not a guarantee of patient safety or physical dignity either. On, for example, 9 November 1969 both Mrs G and Mrs D missed the commode together. The first 'shot under the bed after getting out of bed, pulling on shoes and wishing to use the commode'; the latter 'twisted the commode chair from the bedside bed attempting to stand and fell on the floor'. Side-by-side it was 'more shocking' not to be able to help each other. The feeling of physical powerlessness was palpable in the nurses' reporting of the incidents. Old age according to the Pitsford cottage hospital records has, then, always been a shockingly vulnerable set of physical experiences first and foremost. Staying dignified and injury free was often as much about good luck, rather than a new 'miracle-cure' drug, as a patient's world narrowed. Frail elderly patients were not however willing to simply give up on life. Most were determined to try to stay mentally active, even when debility limited their physical strength. Yet, reaching out often proved to be as debilitating to a sense of physical indignity as falling down in the Pitsford case notes too.

A gradual shrinking of the personal space that many of the elderly (males and females) could physically occupy appears to have been a consistent feature of their sense of humiliation and low spirits. Arms, legs, necks, and even heads could no longer turn, twist, reach, or stretch, as they once did and this was the essence of feeling undignified for the majority of patients. In a typical set of cases we see this slippage scenario on 16 May 1970 when three patients were 'found sitting on ward floor at 4am...got out of bed and slipped to

floor at 7am...and slipped to floor in sitting room whilst trying to sit up in chair'. Mrs G likewise on 20 February 1971 was alarmed by 'how often she just keeps sliding to the floor, several times in one day'. Life seemed literally to be ebbing from her frail body. Exacerbating this common situation was that when questioned many patients 'did not know' how they got where they did. This was not necessarily because of a failure of memory (though it was a factor for many who were confused) but often because their spatial awareness had been compromised and this disturbed their three-dimensional sense of what was normal. By way of example, before a fall or slippage, a chair was often an object of comfort, place of gossip, of being social, and a brief rest cure. The patients could pause in it on the way to and from the wards. After an accident it became the subject of a different type of conversation. Now it was a potential hazard, something to be navigated, with chair's legs that might cause a patient to trip up.

As patients became two-dimensional because of infirmity – needing a flat surface on the floor or a cot-bed with sides that contained their body – so the three-dimensional world of furniture was a potentially shocking experience. And this process of physical shrinkage was often exacerbated by sight problems. This might seem obvious but its undignified aspects have often been overlooked, again from the actual aged patient's perspective. In the case of Mrs W, on 9 March 1951 her world of infirmity had narrowed to the bed, but, even this, was too hazardous for her. Her medical notes record how she 'struck her head on a pillar behind the bed when the bed was being made' by a nurse. The 'patient thought the pillows were behind her and as she sat up in bed she hit her head on the post' which was metal. The 'large egg shape swelling and slight abrasion, complaint of a slight headache' would fade, but not her sense of 'shock'. Small wonder perhaps that patients born under the Victorian poor law could not deny the indignity of their ageing, despite the better nursing care standards and improved scientific medicine under the early NHS. Yet, these basic medical humanities

lessons continue to be downplayed or inconvenient facts of life in today's NHS culture of targeting-setting and performance indicators. Hence, the next section focuses on the funding issues that these cottage hospital case notes raise and how they relate to historical lessons at the point of healthcare delivery from 1948.

### *Future NHS Funding – The Restructuring of Dignity & Localism*

People get used to having small, homely hospitals on their doorstep, and when they hear of proposals to rationalise services involving the closure or change of use of the local unit they naturally object to what they see as a withdrawal of a service they value. They see the hospital as their hospital, they have visited patients there or have been patients themselves, it is convenient and patients can easily maintain contact with friends and relatives during a long stay in hospital, and they may even know some of the staff. However, in these difficult economic times health authorities must put these sentiments aside and make sound rational judgments about the cost effectiveness of their services (*BPP 1977*: c. 388).

Localism and healthcare across Northamptonshire from 1948 to 1978 underwent a radical NHS reorganisation, with large hospitals being constructed at Northampton, Kettering and Wellingborough (all were major manufacturing towns at the time). This facilitated the concentration of the elderly in geriatric wards whose finances were scrutinised for cost-saving efficiencies. As the above quotation aptly summarises, from June 1977 there was a stand-off between: the Minister of Health (at a national level); the Oxford Area Health Board (who managed healthcare delivery regionally); and all four of Northamptonshire's members of parliament (who disputed local NHS budget allocations). Antagonism was caused by a large population movement of 'some 900,000' from a London overspill to Northampton town and the new city of Milton Keynes that had not been matched by equivalent budget provision. As Arthur Jones MP for Daventry announced to the House of Commons on 28 June 1977: 'The serious position of National Health Service provision in Northamptonshire came to the notice of the general public towards the end of last year when it was disclosed that an overspending of £600,000 was predicted in the financial year up to 31 March 1977'. Senior

doctors working for the NHS had taken the ‘unprecedented step of issuing a statement so that...the public shall be fully aware of the circumstances’. Arthur elaborated that the county had ‘been historically under-funded for years, since 1952’ and despite its best efforts to keep ‘within the budgetary decisions’ the only way to respond to the local population movement crisis was ‘the delay or refusal of acute admissions’. The Northampton Community Health Council had highlighted in the strongest terms to central government that healthcare delivery for the elderly was particularly unfeasible without commensurate budget allocation. Jones again put the situation in stark financial terms:

This is in no way an exaggeration on my part but a quotation taken from a financial statement dated 17 June 1977 prepared by the county area health authority...The estimated shortfall for this year including the overspending for 1976–77, is £1,890,000 in a budget approaching £30 million (*BPP* 1977: c. 389).

Although these sorts of financial tensions are documented in general terms in the historical literature, they are seldom studied at the point of healthcare delivery in actual facilities for the elderly from the 1950s to the 1970s (Crook and O’Hara 2011).<sup>11</sup> It meant that cottage hospitals in the Midlands came under increasing pressure to save money and be remodelled on new financial terms regardless of the negative impact this had on aged patients in terms of the delivery and security of their dignity. More widely, this experience reflected what Jane Lewis has observed concerning the underlying tensions in the NHS system as a whole:

The boundary between health and social care was set in stone by central government in the immediate post-war years and the result was a constant battle between the two services over the kind of needs they would meet. The battle was of course about costs, but the problem was more deep-seated than the difference in methods of financing. Rather, it stemmed primarily from the way in which central government sought to define the nature of the responsibilities of the two services and, crucially, from the way in which the resource implications of this definition were never openly addressed. (Lewis 2001: 345).

To better appreciate this historical context, and its contemporary consequences – how cottage hospitals got caught in the middle of ever more complex debates about care in the community

options <sup>12</sup> – it is important to return to Pitsford and locate what happened to healthcare standards in the interim.

By the early 1950s Middlesex House (the original Phipps bequest at Pitsford) was home to never less than ‘150’ patients per annum who were defined generally by 70 years old as ‘nearing the end of life’ (again all cases in this section 3 are located in, private collection & *NRO*, NGH/6, NGH/6/4/1-3, NGH/6/4/4, NGH/6/4/5). A significant number of the females (who tended to live longer) were none the less found to be suffering from serious ‘heart complaints’ – some 70% - in an era when heart transplant was a new medical frontier and drugs were yet to be developed to alleviate basic circulation problems like blocked or faulty arteries and angina (Stark 1996). The cottage hospital was praised in the local press for the fact that – ‘Quite a large number – many of the heart cases – can get up for some part of the day and walk as far as the sitting room’ (*NM & H* often reported these results in the 1950s). Self-evidently the environmental setting of more space and a policy of medical regimen did work to alleviate some aspects of indignity at a time of more limited scientific breakthroughs (as we saw in Section 2). Yet, by the 1970s it was the thorny question of ‘sustainability’ of the system itself that occupied political debates in the Midlands region. The problem with this emphasis was that it was often purely financially driven by the time NHS policy was formulated and it ultimately impacted on patient well-being. Several representative examples from the patient records illustrate this outcome. The frailty of life – needing healthcare stability – are aptly summarised in the patient history of Mrs B on 16 May 1960: ‘The patient’s left femur fractured as she was being turned in the bed’. Seen immediately by the doctor on duty and hence taken for an X-ray to Northampton General Hospital, the patient was in a great deal of distress. As a nurse paraphrased in the patient records, pain was Mrs B’s priority caused by the medical fact of crumbling bones worn out with the indignity of ageing. Once her body started to close down what mattered was sitting still, not being moved

about: she cared most about the financial stability of healthcare delivery. In the case of MEB in her 90s on 21 February 1971 there was little else that could be done for her once it was discovered there was ‘a discoloured area on chest and left arm was noticed...with bruising, swelling, and deformity’ and later a ‘break’ in the ‘neck of the femur’ which together indicated that her vitality was ebbing. Since the safety-chain on her bed often got dislodged, a nurse sat with MEB every night until she died. Stable patient-staff relations were very important in her last hours.

When the Pitsford cottage hospitals were closed in 1978, patients in similar physical predicaments to MEB – having been born Victorians but survived into their 80s and 90s – were now being transferred as a large cohort to the big geriatric wards of Northampton General Hospital. This was done on a cost base analysis of ‘sustainability’. Department of Health records confirm that savings of £444, 000 were made by closing 4 cottage hospitals (2 at Pitsford, 1 in Northampton and 1 in Wellingborough) as well as a small maternity unit at Corby. In addition, Middlesex House was sold in 5 lots on the open market for £500, 000 in 1979. An accountancy exercise calculated that the funds generated of £944, 000 would off-set the building costs of ‘the 128 bed development at Northampton hospital’ (*BPP* 1987: 108 cc805W).<sup>13</sup> What the Pitsford cottage hospital records reveal however is that its patient cohort never saw their care as an investment in the future because they did not have that guarantee of life expectancy. There were few of the elderly who had a sense of ‘sustainability’ because in broad terms ‘stability’ of place, friends, staff, as well as maintaining their remaining physical capabilities and mental capacity, were the immediate priorities at the end of life. ‘Why think about tomorrow, when I may only have today’, was the typical attitude amongst aged patients in the Midlands cottage hospital system. Even for a generation that had survived the war, and were less demanding than today, they never in the patient records talked about bequeathing an NHS to the next generation that was in a healthy

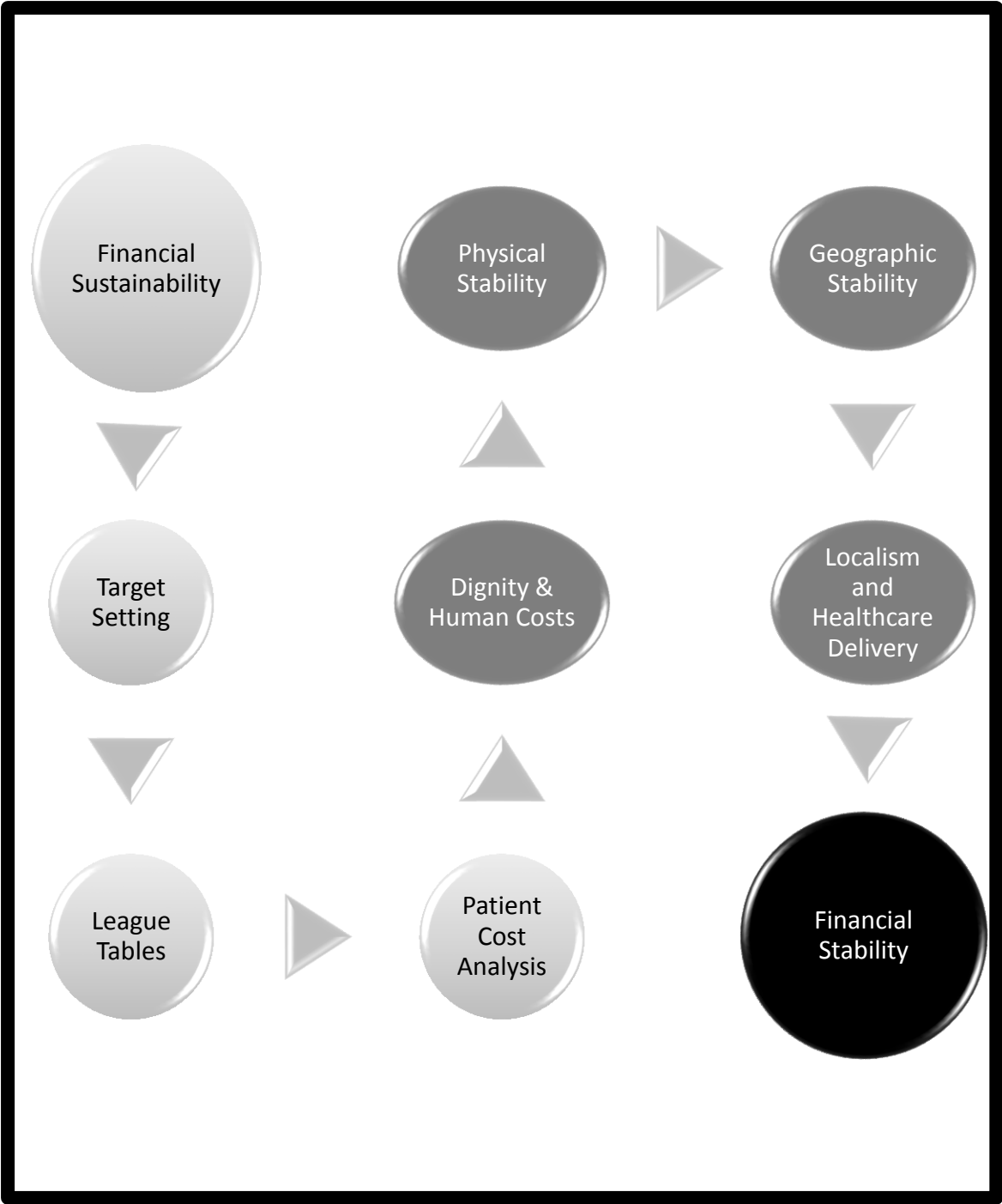
condition. They were offered something new that alleviated their pain, mobility problems, and poor diet, from 1948. And the expectation was that it would do so into the foreseeable future but without their input either in future taxes or immediate cost-savings. In other words, ‘sustainability’ was not to be their legacy. What they bequeathed instead were human vignettes of the indignity of ageing, and yet these were largely filed and forgotten because cottage hospitals ‘arrived’ at the turn of the century, ‘survived’ the transition to the NHS, and only very recently have they begun to be ‘revived’ in some areas where healthcare and social services are now becoming integrated for the elderly (Emrys-Roberts 1991). NHS accountants meanwhile heralded ‘sustainability’ (and still do) because financial planning is often all about centralised patterns of expenditure. Patient histories by contrast in the cottage hospital system record the high value placed on the fixed elements of ‘stability’ in narrowing lives that brought comfort and security.

Even therefore in an embryonic NHS, the patient records of those cottage hospitals it was absorbing highlight persuasively that what really mattered to the aged was not ‘sustainability’ – defined by the NHS Sustainable Development Unit *as development that meets the needs of the present without compromising the ability of future generations to meet their own needs* (Healthcheck Report 2016: <http://www.sduhealth.org.uk/>). Instead in cottage hospitals elderly patients cared more about their current healthcare ‘stability’ – defined in this study as the *healthcare needs of the present that take priority at the end of life when there can be less investment in a long-term medical future*. The fundamental financial differences between the two concepts are illustrated in *Figure 1.1* (see, next page).

***[Please Place Figure 1.1, here]***



**Figure 1.1:**  
**Sustainability versus Stability in NHS care for the Elderly**



Source: Author Designed©2016.

The first – *sustainability – ‘fit for the future’*, has tended to be based on a calculation that the NHS system from its inception was in the red and required target setting, league tables, and the concentration of resources in larger and larger units to maximise medical facilities.<sup>14</sup> The latter – *stability – ‘dignity for the undignified’*, starts with the human opportunity costs and arrives at the need for balanced medical judgements about the whole patient experience that require adequate financing now and often locally in their community-setting.

What is then noteworthy about the records of Midlands’ cottage hospitals is that the balance of their detailed evidence suggests that in terms of their basic running costs cognizance was taken of two funding levels of healthcare assessment. At level one, the basic costs of beds, bedding, medical equipment, cleaning costs, laundry bills, nursing salaries, drug therapies, and food were monitored. Then at a second level, calculations were made about those human costs that needed to be factored in. Fundamental healthcare issues like greater loneliness for a patient feeling isolated if they were returned home without practical support were recognised as social care issues with a human cost. It was thus judged to be more expensive for taxpayers to send someone vulnerable home alone, than leaving the aged person inside the cottage hospital system with their friends. It was likewise recognised that those transferred to large geriatric units in teaching hospitals generally increased the family expenses of their relatives who incurred more travel costs visiting the vulnerable further from home. The 1970s was a time of increased oil and petrol prices that could prohibit regular hospital visiting patterns, with all that this implied about the mental health status of elderly patients feeling more separated from loved ones. In other words, the definition of what constituted a financial burden in healthcare to society had much more joined-up thinking and was based on an experiential sense of the effectiveness of medical care standards. Patients being shifted around the NHS system did promise to reduce baseline expenditure figures, but those financial returns were also seen as a very crude indicator of dignity and healthcare for

the aged.<sup>15</sup> Human costs incurred had a corresponding financial impact on the community of taxpayers as a whole that valued localism and healthcare, and these were transparently important, as much as the budget setting of fixtures and fittings, and salaries in geriatric institutions. Indeed, in an equivalent refrain, Public Health England (hereafter PHE), which audits healthcare standards on behalf of the Department of Health, has warned recently that ‘528, 340 deaths in 2015 was higher than any year since 1968’ and represented ‘the greatest rise since the Second World War’ (*Daily Mail* 15 February 2016). If ignored it ‘could put the mortality rate on par with the 1940s’. Its conclusion is that ‘there is a strong and flashing amber warning light [that] something is making the elderly more vulnerable to avoidable death’. Professor Danny Dorling from Oxford University, an advisor to PHE, comments that: ‘We are not just seeing one bad year in 2015...we have seen excessive mortality, especially amongst women - since 2012...I suspect the largest factor here is the cut to social services – to meals on wheels, to visits to the elderly. We have seen these changes during a period when the health service is in crisis, while social services have been cut back’. If so, in this policy arena the NHS has then an opportunity to look forward to its past, to ascertain which has really worked in practice in central England, and elsewhere over the longer term, to which the conclusion now turns.

### *Conclusion*

Pitsford cottage hospitals were well-funded by generous benefactions from successful commercial enterprises like brewing and shoe-making from the Edwardian period. Their balance-sheets were healthy because they were given their premises free-of-charge, and they had the added advantage of attracting Royal patronage boasting their charitable coffers from the 1920s. This gave staff the financial support to create time to develop high standards of care for the elderly and these were copied across the Midlands region. The intervention of

Middlesex County Council from 1941 generated more revenue from leasing out premises. In the record-keeping we can thus see the commonplace physical indignities of ageing across a broad patient cohort, providing a representative sample size of almost 3000 urban and rural residents from across the Midlands and the south-east evacuated out of war torn London. Once Pitsford's cottage hospitals were absorbed into the early NHS, their experiences of localism and healthcare were to help shape the future direction of geriatric medicine in its infancy under the auspices of Dr. Margery Warren and those she trained. What emerges in the patient case-histories are the experiential aspects of ageing, and their strong links to dignity/ indignity perceptions which have tended to be forgotten from the patient's perspective. The elderly slipped, fell down, were shocked by debility, and this undermined their sense of physical and mental well-being as they aged and became more vulnerable, despite the good staff: patient ratios of the early 1950s. Once however the NHS system came under increasing financial pressure, not just to balance its books but to make profit-margins above and beyond normal nursing costs, the undignified aspects of ageing that were commonplace were treated as an inconvenient truth by accountants. Today, we have come full circle and find ourselves once more in need of the original, important and far-reaching historical insights contained in the archives of cottage hospitals which were neglected and urgently need to be re-located. For, there is no doubt that dignity in healthcare is still one of *the* greatest challenges facing the contemporary NHS in Britain.

Recent media coverage of the Mid-Staffordshire Hospital Trust scandal and the subsequent publication of the *Francis Public Inquiry Report* have been catalysts for improving patient safety and reforming nursing quality standards. Frontline NHS personnel are now committed to delivering *and* securing dignity, the two political commitments enshrined by central government into the White Paper *Caring for our Future: Reforming Care and Support* submitted to Parliament two years ago (HM Government 2012). The

General Medical Council has nevertheless warned that a new Dignity Charter may flounder because of financial constraints. It agrees with the Nuffield Trust's statement on the NHS in 2013 that – 'The reality is that more and more Trusts will be treating larger numbers of sicker and older adults in an atmosphere of pay restraints and frozen budgets' (Nuffield Trust 2013). In a similar refrain the Royal College of Physicians in 2015 declared: 'The NHS will not meet the challenges from an ageing population and limited funding growth simply by tinkering at the edges and finding small efficiency savings' (RCoP 2015: 18). The British Medical Association likewise believes there needs to be a financial health-check in geriatric medicine. Yet, as we have seen in this article, in many respects the contemporary NHS needs to re-evaluate its patient histories because at its inception - as the *Lancet* pointed out in 1949 (cited at the start of this article) - it did know all about the complexities of caring for the elderly. Indeed, the Pitsford cottage hospital archives indicate persuasively that dignity can be *delivered* with 'sustainability' but it cannot be *secured* without patient 'stability' for the aged. And when it comes to NHS economic forecasts – future system *sustainability* versus bedside *stability* today – it is this dichotomy that exposes the inherent contradictions in the political pirouetting from all sides of the House of Commons about the NHS of tomorrow.

Appreciating then the human costs in NHS patient care, involves looking forward to a future that has learned from its healthcare past. How to better manage the recurring tension between 'sustainability' and 'stability' was once the focus of financial forecasting at the NHS's inception, and needs to be so again because it was never properly resolved in the intervening years, as *Figure 1*'s new paradigm shows. This is what makes the patient records of the cottage hospital system in the Midlands from the 1940s to the 1970s so valuable to contemporary society in Britain. They reiterate in a timely fashion what the incoming Chief Executive of the NHS, Simon Stevens, admitted to newspaper reporters in 2014: 'A number of other countries have found it possible to run viable local hospitals serving smaller

communities than sometimes we think are sustainable in the NHS' (*Daily Mail* 20 May 2014). In a subsequent major speech he pointed out that 'most of western Europe had hospitals which were able to serve their local communities, without everything having to be centralised'. He said it was to be regretted how older patients had to travel longer distances, or became anonymous on admission to large geriatric wards where they 'do not receive care that is sufficiently designed to meet their needs as an individual'. The demographics were clear, he pointed out, with 'two-thirds of hospital patients over retirement age', redressing 'dignity and compassion' meant 'supporting them at home' and a return to the cottage hospital system of community care in some locations where they had been closed in the 1970s. This admission was tempered by the realisation that 'all medical services evolve', but with 'the *push* to larger hospitals' by the medical profession and NHS accountants there still a 'remained a *pull* to local ones' by patients (Stevens NHS Confederation Annual Conference 2014). This meant conceding the need to stop 'constantly debating the reorganisation of our management tiers' and instead 'ask the more profound questions about how care is actually delivered'. Stevens concluded that it was time to 'think like a patient and act like a taxpayer'. To do so however requires a more sophisticated historical understanding that since 1948, NHS accountants have been responsible for setting up antagonism between patients and taxpayers. They, in lacking financial compassion, and joined-up thinking about the longevity of basic human costs, have contributed to the dignity crisis in healthcare delivery.

During the House of Lords debate in July 2015 on '*The future of the NHS*' it was the headline economic figures on spending in 2013-14 - 'some £116 billion, close to 9% of GDP' - that framed concerns about efficiency savings, performance targets, and the productivity of long-term solutions to Britain's ageing crisis (*BPP* 2015, c. 237). Yet, in a carefully balanced speech Lord Warner forewarned: 'We must always remember that the best predictor of future behaviour is past behaviour'. There was cross-party agreement in the upper house that too

often this had been forgotten in NHS reorganisation schemes. These shuffled patients around a system to create the impression of improvements in healthcare delivery when the opposite was happening.<sup>15</sup> Either, Warren said, as a nation ‘we will have to face up to finding new streams of revenue or reducing the NHS services offer’. If patient voices predominated all parties would have to be responsive to localism and healthcare because as the *Select Committee on Public Services and Demographic Change* concluded in 2013: ‘the current healthcare system is not delivering good enough healthcare for older people’. That viewpoint is echoed by Melanie Reid health columnist in *The Times Magazine*, and a tetraplegic living with the indignities of premature ageing in her disabled body who explains: ‘Recently, the think tank *Civitas* asked me to contribute to a study of the NHS. Delighted, I said, as long as I can talk realities, not dry, academic theory’, observing that:

It was only after I finished writing it that I realised how frequently, in illustrating points, I had recourse to those eternal cheery themes of nausea, urine, blood, vomit, pain, puss, poo and mental distress. The more I thought about it, the more a profound truth emerged. Health services are fundamentally about bodily fluids in the wrong places, because that is what happens when people fall ill. And you can discuss agendas for change and clinical governance support units as much as you want, but really, the bottom line, what you’re talking about, is the management of bodies that are leaking, spurting, retching or suffering uncontrollably inside and out... We may have robotic surgery; we do not yet have a robot that speaks kindly to a weak, ill person, parts the cheeks of their backside, and washes it thoroughly (Reid 2015: 13).

Self-evidently this patient perspective is not alone; nor is it contingent on an historical revision of NHS chronologies, or detailed engagement with confusing business models, corporate mentalities, or obscure concepts of modernity. Instead it speaks eloquently about just how much the most basic needs of ageing bodies were the same in the past, as the present. Dignity is about human costs having stable NHS funding that ameliorates routine indignities. Medical staff cannot deliver the elderly from all of those physical realities – it is an empty political promise to claim otherwise – but they can secure, with the financial

resources, a better sense of being dignified for vulnerable patients. In reviewing the demographic indicators, it is difficult not to arrive at the conclusion that until the NHS engages with its patient records in a more sustained way it will continue to seek financial solutions that neglect historical perspectives that are recurring. These provide an important signpost about how to start to resolve the present impasse about dignity debates and their financial restructuring with a Janus-like imagination. For above all, what has been lost sight of across the political spectrum is that this is a history of healthcare, not simply in our collective keeping, but in our mutual making too. In twenty-first century Britain, as we all age, it might yet prove necessary for taxpayers to reopen the closed doors of a cottage hospital system, once praised by the previous generation of ageing patients for the next.



## Notes

<sup>1</sup> After the *Union Chargeability Act* (1865) small parish funding merged into larger poor law union units to create a bigger tax base to pay for public loans to commission new infirmaries.

<sup>2</sup> The original intention was to use health centres not GP surgeries as the focal point for patients under the NHS. This was never realised because of pressure from the British Medical Association and central government. Had it been implemented cottage hospitals would have had a much more pivotal role in localism and healthcare than became the case by the 1970s.

<sup>3</sup> [http://www2.warwick.ac.uk/fac/arts/history/chm/research\\_teaching/research/nhshistory](http://www2.warwick.ac.uk/fac/arts/history/chm/research_teaching/research/nhshistory) - This is currently the topic of a Joint Investigator Award held by Roberta Bivins and Matthew Thomson funded by the Wellcome Trust at the University of Warwick's history department.

<sup>4</sup> Refer, notably, in the USA the recent research led by Professor William M. Reddy on the history of emotions at Duke University and in Britain work on the history of pain at the consortium based at Queen Mary University led by Professor Joanna Bourke.

<sup>5</sup> Political opponents of Ernest Bevan referred to the gross cost estimates in the 1944 White Paper as those the system was expected to achieve. When these doubled – by 1949/50 the gross costs were £312m for England and Wales against a budget estimate of £152m gross in the 1946 bill – talk of retrenchment by about one third of total expenditure to bring the cost base down to £300m maximum, was spoken of by political figures like Herbert Morrison. Others like T. H. A Robb at Oxford University took the view that the original estimates were badly miscalculated yardsticks, and a long-term liability. Section 3 looks at financial shortfalls in the Midlands.

<sup>6</sup> The Manfield Shoe Company Ltd established in 1867 by 1908 had four large factories in Northampton town producing over a million pairs of shoes a year. By 1935 the family were

founding members of Norvic Shoe Company, the largest producer of shoes in Britain. Profits funded local cottage hospitals for the elderly.

<sup>7</sup> The Mid-Northamptonshire Constituency was abolished in 1918 and merged into the Northampton seat won by Margaret Bondfield (1923-1945), one of the first female Members of Parliament on the Labour benches. She was appointed by Ramsay MacDonald as parliamentary secretary to the Ministry of Labour in 1929 when the New Poor Law finished. Her papers can be found at, Vassar College Library USA, Archives and Social Collections, Margaret Grace Bondfield Papers, Folder 3.2, Parliamentary candidature, 1919-32.

<sup>8</sup> *Northampton Mercury and Herald* was the merged title of two Victorian newspapers - Liberal (*Mercury*) and Conservative (*Herald*) - in the county from 1900.

<sup>9</sup> The figures cited have been calculated from those sources held by this author (see *acknowledgement* below) and those cited in *NRO* references (refer note 10 below). It is noteworthy that the female patients were generally more descriptive of their daily physical plight than their male counterparts. On balance their voices appear to best describe the shared experience of ageing and its routine indignities for both genders in the patient records.

<sup>10</sup> *NRO* patient records are only available under the Freedom of Information Act for general consultation, and are closed for identifiable purposes for 100 years according to the Data Protection Act in the UK.

<sup>11</sup> There is a vibrant historiography on the production of health statistics and their financial veracity, hence Crook and G. O'Hara (2011) represent a concerted attempt by scholars to now interrogate their meaning over the duration of the Poor Law and NHS.

<sup>12</sup> Lewis points out that these fundamental financial tensions were examined in the 1990s by the Department of Health; yet, as events have subsequently proved with the NHS scandal at Staffordshire, they could not be described as being resolved. Lewis thought this might happen, and very sadly it did.

<sup>13</sup> Part of the New Town development of Northampton announced by Richard Crossman MP, Minister for Housing on 3 February 1965, and linked to NHS expansion plans.

<sup>14</sup> *Fit for the Future* is the policy slogan of the NHS Sustainable Development Unit.

<sup>15</sup> Hurren 2012 points out the New Poor Law from 1873 to 1893 tried to implement the same policy on cost-saving grounds, and then failed to make the predicted reductions.

### *Acknowledgements*

I am very grateful to Annegret Hagenberg, the present occupier of part of the old Pitsford Hospital called Stone House, for bringing these original records to my attention, now in the possession of the author. As they are fragile, having been found in an attic wrapped in newspaper, they will now be sent for conservation before archival deposit. I am also thankful to the anonymous referees who gave such valuable feedback.

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