

**DISTRICT NURSING:  
PROFESSIONAL SKILLS AND KNOWLEDGE IN DOMESTIC  
SETTINGS – LINKING NATIONAL AND LOCAL NETWORKS  
OF EXPERTISE 1866 - 1974**

**Thesis submitted for the degree of  
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# ABSTRACT

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This research produces a deeper understanding of the transition of district nursing from nineteenth century voluntarism to the twentieth century welfare state, with particular emphasis on Leicester within the context of the national scene from 1866 to 1974. The thesis takes Leicester as an example of urban society to explore the collective attributes, networks of expertise and the initiatives that promoted the development of a district nursing service for the sick in their own homes. The evidence shows the challenges presented by limited human and financial resources; reveals the range of skills and responsibilities practised by district nurse; traces the course of professionalisation through the adoption of national standards; sets out the biographical characteristics and career rhythms of Queen's Nurses, a sub-set of district nursing; and highlights the contribution made by district nursing to the empowerment of women.

The study exposes the shifting and often contradictory attitudes of society towards district nursing. District nursing was most valued by the recipients of care and by people closest to the service in the community; it was least valued by those who were not in direct contact with district nurses and had little appreciation of the expertise involved. A most telling finding was the attitude of the government and the extent to which that attitude threatened the development of district nursing through a lack of recognition of the skills and responsibilities involved.

The research shows that throughout the three phases of transition, 1866 – 1908, 1909 – 47, and 1948 – 74, district nursing rose above constraints and hostile policies to build on the traditions and values that lay at its core. The evidence makes a contribution to social policy and the social history of health care in Britain, and points to significant issues for future research and social policy decisions.

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# ABBREVIATIONS

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CETHV	Council for the Education and Training of Health Visitors
CNAs	County Nursing Associations
CMB	Central Midwives Board
CSL	Clinical Sciences Library, University of Leicester
DHSS	Department of Health and Social security
DNAs	District Nursing Associations
DRO	Derbyshire Record Office
GNC	General Nursing Council
GP	General Practitioner
HV	Health Visitor
ITNL	Institution of Trained Nurses for the Town and County of Leicester
LCC	Leicester City Council
LCHR	Leicester Corporation Health Reports
LDNA	Leicester District Nursing Association
LHA	Leicester Health Authority
LHCM	Leicester Health Committee Minutes
MOH	Medical Officer of Health
MW	Midwife
NA	National Archives
NHS	National Health Service
NRO	Northampton Record Office
PADNT	Panel of Assessors for District Nurse Training
Patient	Includes the sick person and his/her family or other immediate carers
PHCT	Primary Health Care Team
QN	Queen's Nurse
QNI	Queen's Nursing Institute
ROLLR	Record Office for Leicester, Leicestershire and Rutland
RCN	Royal College of Nursing
SEN	State Enrolled Nurse
SRN	State Registered Nurse
SW	Social worker
WIHM	Wellcome Institute for the History of Medicine
	- CMA    Contemporary Medical Archives
	- SA      Supplementary Archives
WNMW	Village nurse midwife

# 1

## RESEARCH FRAMEWORK

### Defining the discipline of district nursing:

A discipline is a community characterised by a tradition; a history and the discourse of its forebears; a network of facts, writings, and scholarly work associated with that field; a corps of human beings with a common intellectual commitment; a community of human imagination and creativity; and a specialised language or other system of symbols.

King and Brownell, *The Curriculum and the Discipline of Knowledge* (1966).<sup>1</sup>

King and Brownell's definition encapsulates the essence of this study and its focus on the development of district nursing and the knowledge and skills practised in domestic settings. The term district nursing is applied to a branch of nursing that operates outside the hospital setting.

The evolution of district nursing from earliest times has been an ingrained part of society's utilitarian value-system and the caring ethic.<sup>2</sup> The sick, disabled and dying poor were a particular focus of an obligation that was fulfilled initially through self-help and neighbourhood solidarity, and later through organised voluntarism, church provision and increasing state intervention.<sup>3</sup> District nursing changed over time to become part of a statutory comprehensive health-care service for the sick, irrespective of creed or social class and free at the point of delivery.<sup>4</sup> This research is concerned with the period between 1866 and 1974, using Leicester as a case study.

<sup>1</sup> King, A. R and Brownell, J. A, *The Curriculum and the Disciplines of Knowledge* (London 1966) Extracts, in *The Open University: Curriculum Philosophy and Design* (Milton Keynes 1974), E283, 6 – 8 and 29 – 33.

<sup>2</sup> Merry, E. J and Irlen, I. D, *District Nursing* (London 1948), 1 – 3; Schurr, M. C and Turner, J, *Nursing – Image or Reality?* (London 1982), Chapters 1 and 5; Hallam, J, 'Ethical lives in the early nineteenth century. Nursing and a history of caring', in Mortimer, B and McGann, S, eds. *New Directions in the History of Nursing International Perspectives* (London, 2005) 22 – 37; Maggs, C, 'A history of nursing: a history of caring', *Journal of Advanced Nursing*, 1996, 23, 630 – 5.

<sup>3</sup> Dock, L. L and Stewart, I. M, *A Short History of Nursing from the Earliest Times to the Present Day* (New York 1938); Rafferty, A. M, *The Politics of Nursing Knowledge* (London 1996), 9 – 22; Deloughery, G. L, 'Historical overview - ancient beginnings', in Deloughery, G. L, *Issues and Trends in Nursing* (London 1977), 1- 28.

<sup>4</sup> Jones, C, 'Sisters of Charity and the Ailing Poor', *The Society for the Social History of Medicine*, 1989, 339 – 48; Prochaska, F, *Women and Philanthropy in Nineteenth Century England* (Oxford 1980);



The central hypothesis is that, although the work of district nursing was valued by all levels of society, the district nurse's full range of skills and potential for social benefit was not sufficiently recognised, and, arguably, was even damaged by attitudes within the medical and nursing professions. At the same time, scholars of women's history ignored district nursing<sup>5</sup> even though nurses comprised a significant element of the female work force and, of all professions, nursing was arguably the 'closest to people....' and 'to the largest number of people'.<sup>6</sup> Furthermore, nursing made a significant contribution to the emancipation of women by establishing an elite and, through it, a role and function that promoted health and empowerment to women in adversity.<sup>7</sup>

### The research: rationale and aims:

The rationale for the research stems from the acknowledged dearth of research into pre-1960 district nursing and the need for local studies as 'the most productive means of extending knowledge of district nursing as a service'.<sup>8</sup> The researcher's own research<sup>9</sup> and her experience in health visiting and district nursing in Leicester and Plymouth, brought an awareness of the scope for valuable research to be carried out in this area. The ambiguity surrounding district nursing, as indeed is the case for nursing *per se*, is in part reflected in the contradictory socio-economic classifications used to fit the conceptual mould which scholars and statisticians from different eras have adopted.<sup>10</sup> In general, a tripartite typology emerged – namely; the medical ancillary, the saint, and the servant.<sup>11</sup> This research examines such interpretations by analysing the need for district nurses, the work they did, how they did it, and the outcome of their ministrations. In addition it provides a systematic assessment of the

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Stocks, M, *A Hundred Years of District Nursing* (London 1960), passim; Baly, M. E, *A History of the Queen's Nursing Institute (QNI) 1887 – 1987* (London 1987), passim.

<sup>5</sup> Vickery, A, ed., *Women, Privilege and Power. British Politics 1750 to Present Day*. (California 2001); Lewis, J, *Women in England 1870 – 1950* (Brighton 1984); Purvis, J, ed., *Women's History: Britain 1859 – 1945* (London 1995).

<sup>6</sup> Skeet, M, *Notes of Nursing* (London 1998), 9.

<sup>7</sup> Kelly, A, Mabbett, G and Thome, R, 'Professions and Community Nursing', in Symonds, A and Kelly, A, *The Social Construction of Community Care* (Basingstoke 1998), 78 – 92.

<sup>8</sup> Fox, E. N, 'District nursing and the work of district nursing associations (DNAs) in England and Wales, 1900 – 1948', University of London Ph. D thesis, 1993, 357.

<sup>9</sup> Damant, M, 'A comparative study of shared learning between health visitors and district nurses', Polytechnic South West MPhil thesis, 1991.

<sup>10</sup> Davies, C, 'Making sense of the Census in Britain and the USA. The changing occupational classification and position of nurses', *The Sociological Review*, 28, 3, 1980, 581 – 609; Abel-Smith, B, *A History of the Nursing Profession* (London 1977), passim.

<sup>11</sup> Dock and Stewart, *A Short History on Nursing*, frontispiece schematic, also used by Merry and Irven, *District Nursing*, 3 to illustrate the development of district nursing.



type of people who became district nurses – their biographies, career rhythms and working practices.

The purpose of the research is to make an original addition to the knowledge and understanding of the societal significance of district nursing as a specialist branch of the nursing profession and its contribution to health-care, using Leicester as a point of reference. The research provides new knowledge and historical understanding in two major domains: firstly, an analysis of the biographical characteristics of a distinctive subset within district nursing known as Queen's Nurses;<sup>12</sup> and secondly, an evaluation of the historical landscape of district nursing in the urban setting of Leicester between 1866 and 1974, in which the origins of the professionalisation of district nursing and dynamics of voluntarism are examined and interpreted within the context of health-care. The systematic analysis of the development of district nursing and the lives district nurses led is incorporated within a social system and complex process of continuity and change – a dynamic interaction between society and its institutions. As a consequence, district nursing can be regarded as the focus for a piece of historical research which is not solely about nursing but about wider issues and relationships between vocationally orientated occupations, urban society and state governance.

The main contributions to this work are several. Firstly, the sustained analysis of these primary sources highlights the distinctive range and complexity of the knowledge and skills exhibited by district nurses and the achievements of the district nursing service. This enables an interpretation to be made that offers a challenge to the limited perceptions of the value and significance of district nursing often held by other health-care professionals. Secondly, the study provides a new assessment of the significance of the QNI, both on a local and a national stage, and one which departs significantly from the interpretations of previous scholars. Thirdly, tracing the detailed development of district nursing over time in Leicester, brings to the fore a distinctive trajectory of development involving tensions over funding, voluntary and state provision and inter-professional working, going on to show how these have shaped and limited practice. The notion of a transition from what will be called 'embedded' to 'institutional trust' will be introduced as a way of characterising these developments. Finally, the insights generated by this material have the potential to be of wider interest in areas such as the field of women's history, which to date has almost completely neglected district

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<sup>12</sup> Queen's Nurses (QN) a sub-section of district nursing designated by virtue of specialist nurse training, accreditation awarded by Queen's Nursing Institute (QNI) and entry on the Roll of QN maintained by the QNI.



nursing, and in contemporary social policy in its discussions of matters such as localism and voluntarism, accountability and the role of professionals in decision making. Such possibilities are noted at appropriate points in the course of the argument, and are taken up briefly again in the conclusion.

### **Approach, methods and resources:**

The approach is founded on an analysis of the values with which district nursing was imbued, on the way in which the service and care was structured and functioned, and on the reciprocal relationships within the community, with particular interest in the Leicester situation. District nursing is compared and contrasted with other occupations in terms of the struggle for professional recognition. Growth and survival, consensus and conflict, power and control are assessed and explained as part of the transition of district nursing.

The historical research method is employed because its holistic approach, time-focused dimension and objective empiricism provide the most effective means by which to systematically investigate and analyse more than a century of continuity and change in the nature, scope and character of district nursing.<sup>13</sup> During the years between 1866 and 1974 district nursing in Leicester experienced a continuous period of structural and cultural change, developing from a local voluntary organisation to a national network of formalised voluntarism and the beginnings of professionalisation, and finally to a system of state control. Essential interconnections between agencies and networks of expertise, which themselves were not static, formed part of the process. Empiricism is central to the methodology. On the one hand, it facilitates the assessment of the key factors and processes which influenced the reciprocal relationship between district nursing and society. On the other hand, it enables the integration of statistical analysis and substantive data within an empirical study from which economic trends, group characteristics and patterns of governance can be identified. Historians seek a measure of objectivity in the interpretation of their archival and other material but this is complicated by the partiality of the evidence. Multiple sources have been deployed on the subject matter in an effort both to minimise subjectivity and predilection, and to overcome gaps in the evidence. With regard to subjectivity two factors are worthy of note: firstly, the researcher's professional background in health visiting and district nursing in Leicester; and secondly, the use of personal testimonies.

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<sup>13</sup> Dyos, H. J, 'Essays in urban history', in Cannadine, D and Reeder, D, *Exploring the Urban Past*, (Cambridge University press, 1982), 9-36; Dyos, H. J, ed., *The Study of Urban History* (London 1968); Marwick, A, *The Nature of History* (Open University Press, 1985); Elton, G.R. *The Practice of History*



The research methodology utilises six major elements: firstly, a broad-based review of the literature in different disciplines; secondly, a systematic analysis of published reports and documents; thirdly, a detailed analysis of material drawn from several archives including an extensive statistical analysis of materials derived from primary documents; fourthly, oral testimony; fifthly, a variety of additional sources including photographs, newspaper articles and local studies; and sixthly, cross-referencing and triangulation.

Several factors influenced the choice of Leicester as the focus for an assessment of the historical development and characteristics of district nursing and its reciprocal relationship within urban society from the mid-nineteenth century through to the late twentieth century. Firstly, there is no comprehensive and systematic study of district nursing in Leicester, and local empirical analysis is long overdue. Secondly, Leicester's long commitment to the provision of a trained district nursing service was well established within the local economy.<sup>14</sup> Thirdly, the voluntary sector in Leicester and its environs was generally regarded as an integrated, active and stable force within the community – a relationship that had implications for the voluntary culture of district nursing.<sup>15</sup> Finally, Leicester presents a paradigm of post-industrial urbanisation within middle England (see Figure 1), sharing similarities with its neighbours but also exhibiting important differences in relation to its geographical position, population structure, means of production and sources of wealth, all of which influenced the course of local health-care policy and welfare provision.<sup>16</sup>

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(London 1967); Lumus, T, *Listening to History* (London 1987); Gardiner, J, ed., *What is History Today* (London 1988).

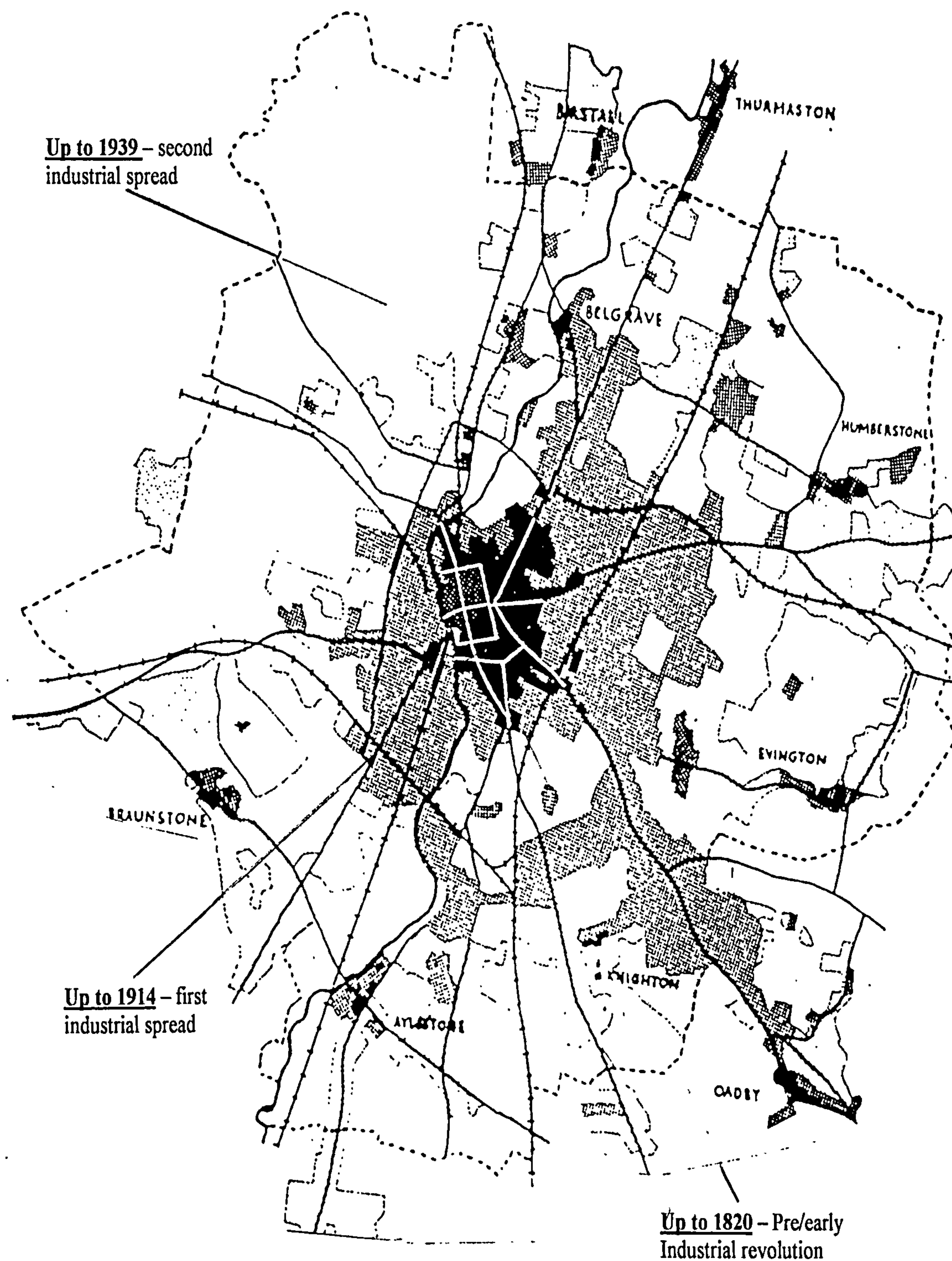
<sup>14</sup> Merry and Irven, *District Nursing*, 5 and 26; Leicester District Nursing Association (LDNA), *A History of the LDNA 1867 – 1953* (Leicester 1953), 4 –7 and ; Wellcome Institute for the History of Medicine (WIHM) Contemporary Medical Archives (CMA)/Queen's Nursing Institute (QNI), Morris, S. G, *Progress and the Provident Contributory Scheme for District Nursing Associations* (London 1930), 3.

<sup>15</sup> Seaton, D, *Light Amid the Shadows. The Royal Leicestershire, Rutland and Wycliffe Society for the Blind 1858 – 1993* (Leicester 1994), passim; Seaton, D. *From Strength to Strength. Leicester, Leicestershire and Rutland Guild of Disabled People 1898 – 1998* (Leicester 1998), passim; Howes, C, *Leicester Civic, Industrial and Social Life* (Leicester 1927), 270.

<sup>16</sup> Nash, D and Reeder, D, eds., *Leicester in the Twentieth Century* (Leicester 1993); Brown, A. E, ed., *The Growth of Leicester* (Leicester 1972); Beckett, J, ed., *A Centenary History of Nottingham* (Manchester 1996); Richardson, K, *Coventry Past into Present* (Surrey 1987); Craven, M, *A History and Guide to Derby* (London 1994); Calvert, C, *A History of Stafford and Guide to the Neighbourhood* (Stafford 1986).



**FIG 1: THE GROWTH OF LEICESTER (1820 – 1939)**



Source: Brown, A. E, ed., The Growth of Leicester (Leicester 1972), 7.



The years 1866 to 1974 were specifically selected because they represent the beginning and the end of an important phase in the history of district nursing in Leicester. The mid-nineteenth century was a period of considerable change in health-care and social welfare generally.<sup>17</sup> Leicester was at the forefront of this process, as collaborative developments between social reformers and the Leicester Infirmary led to one of the first provincial trained nursing services in the country.<sup>18</sup> Throughout peacetime and war, fluctuations in the local economy, numerous structural and organisational changes, and advancements in medical science and technology, the district nursing service continued to grow but the importance of its development was overlooked by historians.<sup>19</sup> The debates and conflicts surrounding deterministic versus individualistic ideologies also continued from a previous era to affect concepts of poverty and attitudes towards destitution and squalor that had implications for perceptions and expectations of the district nursing role.<sup>20</sup>

The research period encompasses important watersheds in the occupational, social, political, economic and organisational transition of district nursing. For instance, the formation of Queen Victoria's Jubilee Institute for Nurses in 1887, now known as the Queen's Nursing Institute (QNI), represented an important stage in the professionalisation of district nursing. The QNI offered a central voluntary organisation setting standards of entry to district nursing, together with rules for training, practice and professional conduct in this country and overseas through a system of affiliation.<sup>21</sup> Accreditation and the title of Queen's Nurse (QN) was awarded by the QNI to candidates who met the criteria and successfully completed its course of training. The QNI did not possess mandatory powers of regulation, however, in spite of frequent petitions to the government of the day, with the result that a two-tier system developed, as this study will show.

Another watershed was created by the implementation of the National Health Service (NHS) Act in 1948, which, together with far-reaching statutory welfare provisions, introduced a new

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<sup>17</sup> Thane, P, 'Government and society in England and Wales 1750 – 1914', in Thompson, F. M. L, ed., *The Cambridge Social History of Britain 1750 – 1950. Social Agencies and Institutions* (Cambridge 1990), Vol. 3, 1 - 62.

<sup>18</sup> Frizelle, E and Martin, J. D, *The Leicester Royal Infirmary (LRI) 1771 – 1971* (Leicester 1971), 134 – 59.

<sup>19</sup> Abel-Smith, B, A, *A History of the Nursing Profession* (London 1977); Dingwall, R. Rafferty, A. M and Webster, C, *An Introduction to the Social History of Nursing* (London 1988); Perkin, H, *The Rise of Professional Society in England since 1880* (London 1996).

<sup>20</sup> Donnison, D, *The Politics of Poverty* (Oxford 1982), 6; Chinn, C, *Poverty Amidst Prosperity – The Urban Poor in England 1834 – 1914* (Manchester 1995), 4 – 7; Gaskell, E, *Mary Barton* (Oxford 1981); Stocks, M, *A Hundred Years of District Nursing* (London 1960).

<sup>21</sup> Baly, M.E, *A History of the Queen's Nursing Institute (QNI) 1887 – 1987* (London 1987), passim.



ethos of collectivism, developed a welfare mentality, and introduced a tripartite organisation which continued the separation of key health-care functions for the community.<sup>22</sup> At this stage, district nursing relinquished its voluntary status and roots within the local community to be incorporated within local authority provision under the aegis of the Medical Officer of Health (MOH), but theoretically it retained a place within the local economy by being funded through the local rating system. Nevertheless the statutory controls and provisions significantly changed the relationship between district nursing and the community it served, and began to erode the networks that had bonded and empowered individuals and communities.<sup>23</sup> A similar process of disintegration affected the stability of district nursing both through internal conflict and through external forces, stimulated by the increasingly powerful bureaucratic statutory control of health-care and welfare.<sup>24</sup> Numerous changes in the 1970s represented a third watershed for district nursing, but in 1974 at the re-organisation of the NHS it was finally detached from its local roots to become part of an integrated hospital and community health service supported directly from the Treasury. In addition, further attempts to resolve the internal conflict and external pressures to revitalise and re-model district nursing reached fruition. The forces that steered this process form an important part of the study but the outcomes are outside its remit.<sup>25</sup>

Research resources were drawn from both primary and secondary sources deposited in national and local archives and in private collections. National sources included The Wellcome Institute for the History of Medicine (WIHM) Archives, The National Archives (NA), and the Royal College of Nursing (RCN) Archives.

An initial approach to the QNI revealed that all its archival material had been deposited with the WIHM and the NA. The main components of the QNI collection held by the WIHM can be broadly summarised here as follows: the Roll of QNs; QNI constitution, policy making, administrative and ceremonial records, including Minute Books and Accounts; QNI internal and external interactions with government, other institutions and local District Nursing Associations (DNAs); an index and record of staffing, training and administrative details of

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<sup>22</sup> Allsop, J, 'What do we mean by the Welfare State?', in Gaffin, J, ed., *The Nurse and the Welfare State* (Aylesbury 1981), 20 – 32; Lowe, R, *The Welfare State in Britain since 1945* (Basingstoke 1999) 9 – 16.

<sup>23</sup> Coleman, J, 'Social capital in the creation of human capital', in Dasgupta, P and Stiglitz, J, *Social Capital – A Multifaceted Perspective* (Washington, D.C 2000), 13 – 39; Cooper H, Arber, S, Fee, L and Ginn, J, *The Influence of Social Support and Social Capital on Health* (London 1999), 3 - 43.

<sup>24</sup> Gibson, S, J, 'A history of the Panel of Assessors for District Nurse Training (PADNT) 1959 – 1983', University of Surrey Ph. D. thesis, 1993, *passim*.



all DNAs in Britain (with sub-branches of the QNI being established in Ireland and Scotland, and selected records retained within these countries); miscellaneous artefacts in the form of newspaper articles and correspondence from dignitaries; publications including commissioned work and film archive (the latter being deposited with the National Film and Television Archives in 1992).<sup>26</sup>

The Roll of QNs formed the main source from which a database was constructed and from which the analysis of the hitherto neglected biographical characteristics and career rhythms of a distinctive cohort of nurses who qualified as QNs was made, thus providing a powerful empirical base for this study. The QNI Roll of QNs was originally contained in several large red-leather bound volumes, but by 1930 the records had been transferred to microfilm. Each QN was allocated two full pages on the Roll as can be seen from the example included as Appendix 1.<sup>27</sup> The data was collected and collated manually retaining the 14 categories under which each nurse's details were entered. The categories changed from time to time. For instance, by 1960 the recording of the father's occupation and civil status was discontinued and three new categories were introduced: the number and age of children, and child care arrangements; more detailed educational qualifications; and nationality. By 1968, the weight and height measurements of each nurse were also entered on the record.

Two main problems were encountered. Firstly, the volume of data was such that a decision was made to collect the data on a decennial basis. The year 1910 was chosen as the starting point for the collection of the data because it coincided with the date when the LDNA became affiliated to the QNI. The collection terminated in 1968 because it was then that the QNI withdrew from district nurse training and closed the Roll. A total of 3555 cases were recorded using Microsoft Excel but this resulted in a database that was too difficult to manage. Each of the 3555 cases had to be analysed across 253 fields, the large number of which arose from the fact that some categories, such as hospital experience and district nursing career profile, covered several fields. A decision was made to transfer the data to Filemaker Pro – which in itself brought problems of synchronisation. Secondly, a problem common to all historical research was that of illegibility and gaps in the data. The most notable gaps were those in certain areas of the records maintained by the Scottish Branch, particularly in the 1960s when the Branch introduced a new form that was somewhat incompatible with the format of the

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<sup>25</sup> Baly, M, E, ed., *A New Approach to District Nursing* (London 1981), 222- 64.

<sup>26</sup> Dixon, S, WIHM/CMA 'Index of QNI Collection (Unpublished 1998) a detailed index of the QNI deposits.

<sup>27</sup> All Appendices are located at the end of the chapter throughout the document.



QNI record. The results of the data and a contextual analysis are presented in Chapter 4. Two categories were omitted from the analysis; firstly, the contents of the annual reports produced by the QNI Inspectors for each QN; and secondly the height and weight measurements of QNs. It was felt that the former, although a rich resource, would warrant another doctoral thesis, while the latter had the potential to form part of a valuable future health survey to assess changes in the body-mass index between yesterday's and today's district trained nurses, and perhaps to provide an indicator of social change generally.

The NA collection of QNI records comprised the QNI Inspectors' Reports on their annual visits to local district nursing associations. This collection was separated from the WIHM QNI archive because the contents were deemed to be of public interest. The resource supplemented the limited Leicester District Nursing Association (LDNA) records between 1909 and 1947. The Inspectors' handwritten reports open with the LDNA's application for Affiliation to the QNI and the process of the investigations that led to its approval in 1909. Thereafter the results of the annual inspections are fully recorded with commendations for good practice as well as recommendations and requirements for change. The NA also held a similar record for small industrial conurbations and mining towns in Leicestershire, which provided a valuable facility for cross-referencing of local developments and the assessment of linkages of expertise in district nursing. The textual analysis of the data is contained in Chapter 5.

This research has been deliberately limited in its focus to investigate solely the wealth of material available about district nurses who were qualified as QNs. It is important to note, however, that the term "district nurse" was used indiscriminately; and there were many nurses who were not specifically district nurse trained but were still given the title of district nurse. Unfortunately, information about this group is almost non-existent, and even in such records as were maintained by local associations there is no equivalent detail about their biographical characteristics and career rhythms. In a doctoral thesis published recently, Sweet attempted to provide a more balanced perspective and to rectify the tendency to view district nursing as a homogeneous profession;<sup>28</sup> her methodology included oral testimonies to capture the social background and experience of 54 'health professionals' and 'retired district nurses'.

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<sup>28</sup> Sweet, H. M, 'District nursing in England and Wales 1919 – 1979, in the context of the development of a community health team', Oxford Brookes University Ph.D thesis, 2003.



The RCN archives centre in Edinburgh was visited almost at the commencement of the research, primarily in an attempt to search for evidence of the participation by the Leicester district nurses in the political arena, for example as members of the RCN Public Health Section, or at the RCN Annual Representative Body Meeting. Whilst the research yielded some examples of discrimination against district nurses by health visitors, the records did not provide conclusive evidence relevant to the question under review. Since that time frequent and very helpful contact with the Archivist has been made via Email.

Local archives were deposited with the Records Office for Leicester, Leicestershire and Rutland (ROLLR). The ROLLR is the only official local depository for the area's collection of district nursing, public health, and local government records. The main categories searched comprised largely secondary data and included the following material: The Annual Reports of the Institution of Trained Nurses for the Town and County of Leicester (ITNL); LDNA records; Leicester Health Reports; Leicester's local authority archives; and a collection of miscellaneous archival material. The ROLLR also holds a collection of published work, reference books, doctoral theses and other relevant archival material, which added to the historical understanding underpinning this research.

Although the ITNL was inaugurated in 1866 and ceased to exist in 1908, the only Annual Reports available were those for the years 1898, 1899, 1900, 1901, 1905 and 1907. The printed pamphlet-type documents contained a detailed account of the organisation's constitution, administration and financial situation. The work of the ITNL was undertaken in districts managed by a Committee, and the Annual Report of each District was included within the same document. The District Reports provided evidence of the day-to-day work of the district nursing service, and its challenges and opportunities, together with interagency activities necessary to provide for the wide spectrum of needs exhibited by the patients and their families.

The LDNA archives were virtually non-existent. The LDNA was formed in 1908 initially from the ITNL but, following affiliation with the QNI in 1909, the constitution, administration and the standard of district nursing changed radically. Two LDNA Annual Reports were traced for the years 1908 and 1937 but a brief history of district nursing in Leicester, published by the LDNA,<sup>29</sup> provided an outline summary of its history and revealed

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<sup>29</sup> Leicester District Nursing Association (LDNA), *A History of the Leicester District Nursing Association 1867 – 1953* (LDNA), (Leicester 1953).

some significant landmarks. The LDNA publication gives the year 1867 as the commencement of district nursing in Leicester but searches conducted in the local press archive at the ROLLR located a report of a public meeting held in July 1866 at which the ITNL was launched. Hence, the year 1866 is used as the commencement date for this research period.

Leicester Health Reports 1866 – 1974 are the annual reports compiled by the Medical Officer of Health, a statutory appointment to the local authority. The Reports give an annual account of the main challenges to the health of the City and to health-care resources, and provide a useful dimension of the context within which the district nursing service functioned. The public health appraisal was based on demographic trends, patterns of mortality and morbidity, and changes in the population structure and physical environment of Leicester that were put into context through comparison with national trends and towns of similar size and character. The Reports contain an account of the appointment of MOH staff and a statistical analysis of the work undertaken. Following the introduction of the National Health Service in 1948, the district nursing reports formed part of this publication.

Leicester's local authority archives provided a different but complementary source for this research, particularly following the introduction of the National Health Service in 1948 when district nursing matters were included in the Minutes of a sub-committee of the Health Committee. The term district nursing is used throughout the thesis to define the subject of the research although a new title of 'Home Nursing' was introduced in the NHS Act (1946) and different terms were coined thereafter, such as community nursing.<sup>30</sup>

The Leicester City Council's Legal Department archives were held in the council offices. Primary data in the form of Abstract Title Deeds and supplementary legal documents were searched to assess the LDNA's collateral the form of buildings and land, the role of the Trustees, and the disposal of assets following the introduction of the NHS. In addition, the City Council's Estates Department facilitated an inspection of two LDNA properties, then in disuse, to trace the missing records referred to above.

Repositories in other parts of the Midlands, such as the Derbyshire Records Office (DRO) in Matlock, the Harborough Museums and Records Office (HMR) in Market Harborough, and

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<sup>30</sup> National Health Services Act 1946 (HMSO, London 1946), Part 3, Section 25.



the Northamptonshire Records Office (NRO), were searched and even the smallest and incomplete collection of records and artefacts contributed to the wider context and historical understanding of district nursing in Leicester.

A number of private collections were identified. One of these, located at the Charles Frears Campus of the De Montfort University, included St John Ambulance training records for its Home Nursing Branch and complemented material contained in the ITNL Annual Reports. There were also facsimiles of pre-1919 Leicester Infirmary nurse training certificates which gave greater historical understanding of the early traditions in district nursing, and numerous other important historical documents such as the minutes of early Hospital Sister Tutors' meetings, journals and artefacts. All of this material was stored in an open environment and had never been catalogued.

Another small private collection of historical district nursing records, publications and artefacts was created by the late Denis Cuthbert, a Leicester City QN. Some artefacts in the form of early district nursing uniforms, other symbolic emblems and nursing equipment were on display in the Charles Frears School of Nursing from its establishment in 1976. A small part of this collection of artefacts was deposited with the Leicester Royal Infirmary Museum (another useful private collection). Denis's collection of manuscripts, photographs and press items held by his widow was sorted and indexed by category, and was then accepted by the ROLLR and catalogued as 'The Cuthbert Collection'. The 'beautifully illustrated book on LDNA' described by one informant has never been located.<sup>31</sup>

Oral history data was obtained from the spoken and transcribed testimonies of 30 district nurses and health visitors – practitioners, managers and tutors, patients and relatives, and members of other professions – general practitioners, a consultant geriatrician, and social workers. The evidence is evaluated and presented as an integral part of the thesis in Chapters 5, 6 and 7. Oral history was an important feature of the historical appraisal of district nursing in Leicester in three ways. Firstly, it provided first-hand accounts of district nursing in Leicester pre-1974. Secondly it identified people with a heritage in which they had played a significant part. Thirdly, it prompted a wider range of historical questions. Informants were recruited mainly by word of mouth, through known contacts, opportunistic encounters, and, as the research became more widely known, self-referrals. There were, however, limitations in terms of recruitment and possible distortion because of infirmity and the time-lag between

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<sup>31</sup> Copson, L, QN Leicester and later Social Worker (Personal testimony, 2002)



practice and recollection, which for many was a period of over 50 years. Most interviews were recorded, but some interviewees preferred to respond in writing supplemented by general discussion; a minority of respondents spoke freely about district nursing but did not wish to make a formal contribution. At the piloting stage of the interview questions, it became clear that many health and social care professionals were reluctant to cite individual patients to illustrate their perceptions of district nursing, and such reservations were respected in subsequent interviews.

Consultations also took place with three people on account of their relevant expert knowledge. The first of these was Dr Lizbeth Hockey, retired Professor of Nursing, Edinburgh University, whose understanding of the philosophical and pragmatic challenges of district nursing is highly respected. Dr Hockey was familiar with the position of district nursing in Leicester both as a consultant for its educational developments and as a researcher.<sup>32</sup> Secondly, an approach was made to Dr Helen Boynton, a local historian, whose research into the nineteenth century south-eastern suburbs of Leicester added to the historical understanding of Leicester's wealthy industrialists and professional elite, some of whom pioneered the development of a district nursing service in Leicester, and subsequently became the recipients of professional district nursing care in their homes.<sup>33</sup> Lastly, information was gathered from Derek Seaton, retired Leicester social worker, whose research into the development of voluntary services for the blind and handicapped people of Leicester represented an important part of the inter-agency welfare environment in which the district nursing service functioned.<sup>34</sup>

An appeal for informants, records and artefacts through the Internet, local press, the Retired Leicester Community Nurses Group, and the Leicester Health Services News Letter had a limited response. In addition, an unsuccessful approach was made to Leicestershire Health Authority senior officers, some with special responsibility for research and development. This step was taken in the expectation that the instalment of computerised district nursing records in Leicester in the 1970s would have produced a comprehensive database.<sup>35</sup> Equally

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<sup>32</sup> Hockey, L, *Feeling the Pulse* (London 1966); Hockey, L and Potter A, *Co-operation in Patient Care* (London 1970); Hockey, L. *Use and Abuse?* (London 1972).

<sup>33</sup> Boynton, H. *The Prospect of Oadby* (Oadby Local History Group, 1993); Boynton, H and Pitcher, G. *Desirable Locations* (Leicester City Council 1996); Boynton, H and Seaton, D, *Tolegate to Tramshed* (Private Publication, Leicester 1999); Boynton, H, *The Changing Face of London Road* (Private Publication, Leicester, 2001); Boynton, H, *The History of New Walk* (Private Publication, Leicester 2002); Boynton, H, *Knighton and Clarendon Park* (Private Publication, Leicester 2003).

<sup>34</sup> Seaton, *Light Amid the Shadows*; Seaton, *From Strength to Strength*.

<sup>35</sup> Eccles, T. 'Community nurses and the computer, *Queen's Nursing Journal*, May 1977, 391 - 2.



unsuccessful contact was also made with individual officers and officials who had been involved with the computerised database, including a city councillor and ex- Chairman of the Health Committee, a retired Chief Nursing Officer, and senior administrative staff.

### **The three main sections of the thesis:**

**Section 1: The National Scene.** This Section provides the context for a historical appraisal of the nature of district nursing, although not always known by that name, and its social significance. Chapter 2 provides a background to the study by surveying the trajectory of visiting nursing in domestic settings pre-1866 as a means by which to understand the nature of the project and the social phenomenon of district nursing. Chapter 3 examines political, economic and cultural forces, as well as structural, organisational and professional relationships and their implications for the development of district nursing between 1866 and 1974. Chapter 4 presents an analysis of the biographical characteristics and career rhythms of Queen's Nurses.

**Section 2: Leicester – the local context.** This section analyses three phases in the transition of district nursing in Leicester, the health and welfare risks associated with urban society, voluntarism and communities of civil society, and the role of the district nursing service. Chapter 5 evaluates a local initiative in voluntarism between 1866 and 1908 and the formation of a district nursing service in Leicester. Chapter 6 evaluates the transition to a formally structured district nursing voluntary organisation from 1909 to 1948 and its affiliation to a national network grounded in the professional ethic. Chapter 7 focuses on the relinquishing of voluntary status to state control, and provides both an assessment of the rationale for change between 1948 and 1974 and an evaluation of the effects of the structural, professional and political developments for district nursing within the wider context of health-care and concepts of risk.

**Section 3: Conclusion and recommendations:** Critical features in the historical development and social significance of district nursing and its contribution to health-care and welfare are extrapolated from the evidence to make recommendations for future research and social policy decisions, and to highlight the significance of district nursing to women's history.

# APPENDIX 1: EXTRACT FROM QNI ROLL OF QNs (1910)

[illegible]

\* Superintendent's Report. A very dependable man but lacks self-confidence. In character's Report. An intelligent and conscientious worker, suitable for single post.



# SECTION 1

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## THE NATIONAL SCENE

## 2

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# HISTORICAL CONTEXT OF DISTRICT NURSING PRE-1866

‘The district nurse is a State Registered Nurse (SRN) with a district nurse qualification who provides skilled nursing care to people in the community’.<sup>1</sup>  
[S/he] ..... ‘works in the community and ....is professionally accountable for assessing and re-assessing the needs of the patient and family, and for monitoring quality of care’.<sup>2</sup>

These quotations represent the distilled wisdom of the purpose of district nursing as it came to be established by the late twentieth century. The term district nursing was first used in 1863<sup>3</sup> but the concept of this type of nursing as a response to human distress is a phenomenon that is deeply rooted and nurtured within the culture of society, whose needs it served from a time beyond the reach of history.<sup>4</sup>

The main purpose of this chapter is to explore the historical context of district nursing prior to the research period of 1866 to 1974. A broad-brush approach is adopted to identify significant landmarks and tensions and to understand the cumulative and uneven process by which the legacy that was inherited in 1866 was created. Each age is unable to begin from ground zero and the purpose here is to isolate core features of district nursing that can be traced from earliest times. There were three features: the centrality of the home; pastoral care and secularisation; and organisation and training.

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- <sup>1</sup> Panel of Assessors for District Nurse Training (PADNT), *Report on the Education and Training of District Nurses*, (London 1975).
  - <sup>2</sup> Department of Health and Social Security (DHSS), *Nursing in Primary Care*, (London 1977), Chief Nursing Officer (CNO) (77) 8:2.
  - <sup>3</sup> Stocks, M, *A Hundred Years of District Nursing* (London 1960), 27 – 28, includes William Rathbone’s experiment in 1861 of a nurse training scheme for hospital and home based care in Liverpool - a specific service was introduced in 1863 when the style ‘district nursing’ was applied.
  - <sup>4</sup> Jones, C, ‘Sisters of Charity and the ailing poor’, *Social History of Medicine*, 2, 3, 1989, 339 – 48; Eagleton, T, *The Idea of Culture* (Oxford, 2000), 34 culture here is ‘loosely summarised as the complex of values, customs, beliefs and practices which constitute the way of life of a specific group’; Baly, M. E, *A History of the Queen’s Nursing Institute 1887 – 1987* (London 1987), 6, here the process is likened to ‘a seamless cloth....with a few women responding to the needs of each age’.



The home is the centre of activity for district nurses. It is there that they work as an integral part of the private and complex world of the family, and as the primary unit of care within the context of a wider landscape of religious society, public institutions and socio-economic networks.<sup>5</sup> The very act of pursuing shared objectives in providing for the sick, dying and disabled in their own homes, whether influenced by religious or by sectarian values, fostered and developed a mutually feeding relationship that had social and economic value. This cultural phenomenon, which results in behaviour of benefit to others and not just to oneself is, somewhat controversially, defined by Coleman et al. as social capital because it does not directly arise out of physical and economic investment activities.<sup>6</sup> Although others would dispute this interpretation of the way in which individuals, groups and societies interact,<sup>7</sup> there are aspects of this theory that might seem to be applicable to the situation found in district nursing, where interpersonal and community relationships and networks were integral to its development. Utilitarian values and the activities associated with caring in its widest context are as old as time and form the essential element of core relationships and networks in district nursing.<sup>8</sup> Whilst these core values remain constant, nursing historians writing to inform the nursing curriculum in the 1930s identified periods in history from earliest times to the present day when external forces, such as war, political ideology, fluctuations in the economy, changes in the world of work and government action, have both promoted and distorted these relationships.<sup>9</sup>

District nursing, like the spore of a mushroom, was embedded within the soil of natural caring and nurtured by the value systems of society, from which it produced remarkable

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<sup>5</sup> Loane, M, *The Queen's Poor. Life as they find it in Town and Country* (London 1909); Cohen, S, 'Miss Loane, Florence Nightingale and District Nursing in late Victorian Britain', *Nursing History Review*, 5, 1997, 83 – 103.

<sup>6</sup> Coleman, J. S, 'Social capital in the creation of human capital', in Dasgupta, P and Serageldin, I. eds., *Social Capital a Multifaceted Perspective* (Washington, D. C 2000), 13 –39; Cooper, H. Arber, S. Fee, L and Ginn, J, *The Influence of Social Support and Social Capital on Health* (London 1999), 22 – 7; Organisation for Economic Co-operation and Development (OECD), *The Well-being of Nations; The Role of Social and Human Capital* (Paris 2001), 17 –36 and 39 –61, the concept of. social capital, insofar as it is seen to reside in social relationships and trust in collective endeavours, is as a resource for the common good rather than an economic end in itself. The literature distinguished between four types of capital according to their function; economic, physical, social and human – health is viewed as a constituent of human capital because of its value to well-being and the economy.

<sup>7</sup> Ostrom, E, 'Social capital: a fad or fundamental concept', in Dasgupta and Serageldin, *Social Capital*, 172 – 241.

<sup>8</sup> Serageldin, I and Grootaert, C, 'Defining social capital: an integrating view', in Dasgupta and Serageldin, *Social Capital*, 40 – 58.

<sup>9</sup> Dock, L. L and Stewart, I. M, *A Short History of Nursing from Earliest Times to Present Day* (New York 1938); Putnam, R. D, 'Tuning in, tuning out: the strange disappearance of social capital in America', *Political; Science and Politics*, 28, 4, 1995, 664 – 683 explored the factors that arguably distort and erode social capital.



initiatives in informal and formal voluntarism.<sup>10</sup> For centuries district nurses, not necessarily by that name but by a form of practice relevant to the needs, resources and values of a given culture, and the state of medical knowledge, have developed the role and function for which they are now renowned. The threads from ancient times have infiltrated the practices and values of modern district nursing and its standing in society, however shadowy and uneven in provision and progression. Nursing historians have produced distinctive insights into the social embeddedness of home-based caring which continued beyond the medieval and early modern times with a move away from the magic and mystique of folk medicine.<sup>11</sup> For instance, the ancient Chinese culture in circa 26 BC exhibited a systematic approach to medical practices and routines, which can be recognised in modern nursing, such as those involving the healing powers of touch. In addition, in circa 3 BC the Buddhists in India set out the desirable qualities of nurses, who were usually young men, in terms of practical and intellectual skills, devotion to the patient, and moral fibre, just as the 'Kos school' in the pre-Christian era named and defined a nursing role and practices in detail. The rudiments of these early standards can be identified in contemporary district nursing practice. The administration of home-based care, which pre-dates the Victorian district system, can be found in Roman times. The Roman system of civil administration extended to local 'Districts' also formed the basis on which the Roman Matrons of the early Christian era used their position, abilities and resources to develop a form of visiting care in the homes of the sick. The work of the visitors was organised on a district basis and supervised by the Matrons whose efforts were co-ordinated by a central administration managed by their peers – a system subsequently adopted by late nineteenth to mid-twentieth century district nursing. The roots of district nursing can also be found in the monastic communities, of both men and women, which developed throughout Western Europe from the sixth century AD as the monks and nuns combined Christian ministry with pastoral care. One of the oldest religious orders in this country to provide visiting-nursing to the sick in their own homes was founded by Queen Matilda at St Katherine's Royal Hospital, London in 1148. St Katherine's made an important contribution to the development of district nursing and continued to provide care until 1545, when it became a closed order.<sup>12</sup>

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<sup>10</sup> Prochaska, F, *The Voluntary Impulse – Philanthropy in Modern Britain* (London 1988), 7 – 9.

<sup>11</sup> Deloughery, G. L, 'Historical overview: Ancient beginnings', in Deloughery, G. L, ed., *Issues and Trends in Nursing* (London 1977), 1 – 28; Dolan, J. A. D, *History of Nursing* (London 1966); Austin, A. L, *History of Nursing Source Book* (New York 1957);

<sup>12</sup> Merry and Irven, *District Nursing*, 1 – 2.



In Leicester, institutional care and hospital treatment was also part of a long history of *ad hoc* provision for the sick and socially distressed that developed largely through the philanthropic endeavours of religiously inspired individual benefactors. For example, Leicester boasted one of the oldest of such charitable institutions in the provinces: Trinity Hospital and almshouses, founded in 1331 by Henry Plantagenet, provided a warden, chaplains and nurses to attend to the spiritual and physical care-needs of the residents.<sup>13</sup> Prior to the closure of Trinity, Cocks records the founding of a new institution for the sick poor in 1513 - 'Wyggeston's Hospital', named after its benefactor. Such provisions identified and met a need that spanned institutional and home-based nursing care for six hundred years, during which time these early institutions survived social, economic and political change, eventually to be augmented by and redefined within the peripatetic spheres of health-care, such as district nursing.

District nursing is closely associated with the effects of poverty and the relationship between health and the quality of life, especially for the labouring and poorer classes.<sup>14</sup> Early strands of district nursing were observable as a buffer to suffering and a mechanism that arguably contributed to the prevention of pauperism.<sup>15</sup> Concern for the poor and the effects of physical, social and spiritual impoverishment were central to the position of the church, as seen in views such as those expressed by the Primitive Methodist Church in its mission for the 'runder classes ... the poor, the ignorant and degraded'.<sup>16</sup> Snell argued that the non-conformists saw themselves as 'untrammelled by the silken chains which bound the Establishment,' and were therefore free to 'reassert the social obligations of religion with a vigour denied to the Church of England' because of its alliance with the monarchy and aristocracy. In the early nineteenth century, the Baptists were so well represented in West Leicester that the city was known as 'the metropolis of dissent', and their activities, together with those of the Unitarians, were arguably a reflection of utilitarian values and

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<sup>13</sup> Cocks, T. Y, 'The hospital of Holy Trinity Leicester' in Hinks, J, ed., *Aspects of Leicester* (Barnsley 2000), 9 – 24.

<sup>14</sup> Wellcome Institute for the History of Medicine (WIHM), WY100, 1889, C89g, Craven, D, *A Guide to District Nurses and Home Nursing* (London 1890), 1-5.

<sup>15</sup> Baly, *QNI*, 8-9. Here the district nurse is referred to a moral agent to combat pauperism, supported by Nightingale's perception of the district nurse as a teacher of the disorderly on the use of imperfect dwellings; Dean, M and Bolton, G, 'The administration of poverty and the development of nursing practice' in Davies, C ed., *Rewriting nursing history* (London, 1980), 76 – 101 – district nursing is seen as an emerging technique for the management of the poor.

<sup>16</sup> Snell, K. D. M, *Church and Chapel in the North Midlands: Religious Observance in the Century* (Leicester 1991), 39.



their expression in district nursing.<sup>17</sup> Some scholars have expressed different views about the relationship between religious doctrines and the social issues of the day, arguing that, under the influence of capitalism, religious thinking and values were directed by the fundamental importance of the political economy.<sup>18</sup>

Whatever their motivation and resources, however, the religious institutions certainly influenced society's capacity to nurture health values and to care for the sick and dying. Religious teaching encouraged the poor to lead a life of sobriety, hard work and Christian endeavour, to sustain personal esteem, and fulfil family and community obligations.<sup>19</sup> The rich and 'not so poor' were exhorted to celebrate their blessings by responding to the needs of the poor, and this many people did through organised voluntarism.<sup>20</sup> Others responded to a 'calling' to provide ministry, pastoral care and nursing to those in distress.<sup>21</sup> This type of district nursing functioned within a proselytising framework built on a moral foundation.<sup>22</sup> Towards the end of the nineteenth century, whilst not rejecting religious and moral values, district nursing began to adopt and develop a secular, science-based holistic approach which addressed the intertwined needs of body, mind and spirit.<sup>23</sup>

Of course, the developing relationship between religious society and home-based care was not exclusively a British one. In France, for example, similar relationships existed, as is shown by Jones' case study on the hospital-based 'Daughters of Charity', founded in France in 1633 by Saints Vincent de Paul and Louis de Marillac, priests of the Roman Catholic Church. The service emanated from a principle of pastoral devotion, and functioned on a process of selection, training and supervision. In 1638, St Vincent de Paul recognised the need to separate the religious and nursing vocations and decided to establish 'uncloistered sisters' to perform the visiting nurse role.<sup>24</sup> Jones also records that by 1789 the visiting nurse role had widened in scope to include the rudiments of clinical

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<sup>17</sup> Snell. *Church and Chapel*, 2-5, 15-16, 23; Simmons, J, 'A Victorian social worker: Joseph Dare and the Leicester Domestic Mission', *Transactions of the Leicester Archaeological and Historical Society*, Vol. XLV1, 1970 -1.

<sup>18</sup> Weber, M, 'The Protestant ethic and the spirit of capitalism', cited in Tawney, R. H, *Religion and Rise of Capitalism* (Middlesex 1969), xi.

<sup>19</sup> Perkin, H, *The Origins of Modern English Society 1780 - 1880* (London 1969), 356.

<sup>20</sup> Prochaska, F. K, *Women and Philanthropy Nineteenth Century England* (Oxford 1980), 8.

<sup>21</sup> Jones 'Sisters of Charity', *passim*; Prochaska, *The Voluntary Impulse*, 44 - 8.

<sup>22</sup> Jones. 'Sisters of Charity', 339 - 48; Bradshaw, A, *The Nurse Apprentice, 1860 - 1977* (Aldershot 2001), 2-3.

<sup>23</sup> Stocks, *100 Years of District Nursing*, 95 - 96; Craven, *Guide to District Nurses*, *passim*.

<sup>24</sup> Merry and Irven, *District Nursing*, 2.



decision making, functional autonomy, sapiential authority and executive control - a move that came into conflict with the medical man's perception of the nursing role.<sup>25</sup>

As the problems associated with the care of the sick assumed the same complexity and urgency as those of pastoral care and religious instruction, the position of nursing gained strength and was seen as a separate strand of church ministry. Concern for the nursing needs of the sick poor was manifested in other European countries; for example, Pastor Fliedner of Kaiserswerth in Germany founded the Deaconess System of pastoral care and sick-visiting in the early nineteenth century.<sup>26</sup> Accounts by Baly and Craven, supported by others, suggest that in many ways Europe served as a model for home nursing in Britain.<sup>27</sup> Compared with the situation in Europe, Britain seemed to have suffered an apparent loss of impetus in the provision of sick-nursing in the homes of the poor following the far-reaching religious upheavals of the sixteenth century.<sup>28</sup> In addition, tensions between medicine, ministry and politics tended to obscure the position of nursing.<sup>29</sup>

To some extent, the State acknowledged its responsibilities to the destitute, both the sick and the able-bodied, through the enactment of the 1601 Poor Law, but the needs of the sick and disabled poor passed unrecognised. It was a situation upon which the Bishop of Exeter reflected some three centuries later :

[he did] 'not suppose that Cardinal Wolsey realised what he was doing when he induced King Henry V 111<sup>th</sup> to do away with the monastic institutions in England.. From that time onwards the poor in every Parish had been crying out for medical attention and the service of good nurses'.<sup>30</sup>

<sup>25</sup> Jones, 'Sisters of Charity'.

<sup>26</sup> Baly, QNI, 4; Craven, 126-127.

<sup>27</sup> Dingwall, R. Rafferty, A. M and Webster, C, *An Introduction to the Social History of Nursing* (London 1988), 28, reference to Elizabeth Fry's visits to Europe to study systems of sick care in the home; Abel-Smith, B, *History of Nursing*, 18, it is claimed that the reform of nursing in Britain owed much to the Kaiserswerth scheme.

<sup>28</sup> Craven, M. *History and Guide to Derby* (London 1994), 36 – 8; Kendall, J and Knapp, M, *The Voluntary Sector in the UK* (Manchester 1996), 31 here the effect of the dissolution of the monasteries is seen as a significant loss of education, health care and welfare, which gave rise to the general secularisation of life and the filling of the vacuum, by local rich citizens; Dingwall, Rafferty and Webster, *Social History of Nursing*, 7-8.

<sup>29</sup> Inkster, I.' Marginal men: Aspects of the social role of the medical community in Sheffield 1790 – 1850', in Woodward, J and Richards, D, eds., *Health Care and Popular Medicine in Nineteenth Century England* (London 1977), 128 – 163; Pereira Gray, D. J. *The Royal College of General Practitioners (RCGP) – Forty Years on 1952 – 1992* (London 1993), 35; Witz, A. *Professions and Patriarchy* (London 1992), 129; Rafferty, A. M, *The Politics of Nursing Knowledge* (London 1996), 9 – 22.

<sup>30</sup> Devon Records Office 367M/B48 Devonshire District Nursing Association Meeting 24<sup>th</sup> April 1928 Annual Report. Address by The Rev. the Earl of Devon News Paper Report (unnamed and dated); Davison, A. W, *Derby: It's Rise and Progress* (Derby 1906), 23 –40 also observes the effects of the dissolution of the monasteries on the sick and poor in Derby.



The nursing input to the homes of the sick poor at this time would have taken many forms. From the seventeenth century, parish nurses, usually able-bodied paupers who were often illiterate and with no preparation for the role, cared for the sick pauper at home. Over two centuries later, the Poor Law (Amendment) Act 1834 introduced the workhouse and the workhouse infirmary, though trained and literate nurses were still not widely available.<sup>31</sup> Some scholars have highlighted the limitations of the Poor Law in that, although it offered a limited measure of support, in other ways it was viewed by the poor as harsh and punitive.<sup>32</sup> For instance, Thompson quotes the comments of a Leicester pauper appearing before magistrates – ‘I would rather go to gaol than return [to the Union]’.<sup>33</sup> It must be pointed out, however, that, as Prochaska asserts, charitable activities and voluntarism could also be perceived by the recipients as degrading, and as an insensitive, thinly disguised form of middle class self-interest through which power and status were confirmed.<sup>34</sup>

The voluntary infirmary movement developed alongside Poor Law provision as a prominent feature of eighteenth century British society through which facilities for medical education and research were secured in association with treatment and care. In the Midlands, voluntary hospitals were founded in Nottingham in 1743, Northampton in 1744, Leicester in 1771, Derby in 1810, and Stafford in 1865. Frizelle gives a comprehensive account of the history of the Leicester Infirmary (Royal status 1912), and describes this period in the history of secular health and welfare developments as a feature of the religious revival and the influence of evangelists such as Charles Wesley.<sup>35</sup> He also emphasised the Leicester Infirmary’s key role as a training establishment for both nurses and doctors. Rafferty, and Summers, however, see the developing voluntary hospital movement from another perspective as one of a ‘crusade’ against domiciliary nursing which promoted the career profile of hospital nursing.<sup>36</sup>

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<sup>31</sup> White, R, *Social Change and the Development of the Nursing Profession. A study of the Poor Law Nursing Service* (London 1978), 20; Abel-Smith, *History of Nursing*, 38 – 46.

<sup>32</sup> Snell, K. D. M, *Annals of the Labouring Poor. Social Change and Agrarian Society 1660 – 1900* (Cambridge 1985).

<sup>33</sup> Thompson, K. M, ‘The Leicester Poor Law Union 1896 – 1951. University of Leicester Ph.D. thesis, 1988, 136.

<sup>34</sup> Prochaska, F. K. ‘Philanthropy’ in Thompson, F. M. L ed., *The Cambridge Social History of Britain 1750 – 1950: Social Agencies and Institutions* (Cambridge 1990) Vol. 3, 357 – 93.

<sup>35</sup> Frizelle, E. R. *The Life and Times of the Royal Infirmary at Leicester (LRI): The Making of a Teaching Hospital 1766 – 1980* (Leicester 1988), 1.



### The secularisation of district nursing:

Several forms of home-care for the poor had emerged by the mid-nineteenth century. Probably the largest group of paid workers was the untrained nurse widely known as the handy woman. In rural areas, handy women were drawn from kindly and well-intentioned village women, and in the towns from the working class.<sup>37</sup> They helped relatives to care for the sick, lay out the dead, and to attend mothers at or after childbirth.<sup>38</sup> Private nurses, who either worked as independent practitioners or from an agency, were a significant group and were usually employed by the upper and middle classes as paid live-in servants in times of sickness. Nursing care continued to be provided by the religious orders and untrained paupers, who nursed their fellow inmates in the workhouse and often provided care for sick paupers in their own homes.<sup>39</sup> A number of initiatives from the mid-nineteenth century aimed to improve the standard of nursing care in the home (see Table 1).

As the process of urbanisation gathered momentum throughout the nineteenth century, various *ad hoc* experiments in organised benevolence came to fruition in Britain to respond to the gaps in health-care and welfare. The different time-scale and ways in which the nursing and welfare of the sick in their own homes took shape throughout this period must first be set against the prevailing ideologies, social change, an emerging scientific community and advances in medical knowledge and skill. Five key developments played an important role in this process. Firstly, in the 1830s-40s, the transition from the *laissez-faire* ethic, which had hitherto dominated public health provision, to a culture of organisation and administration reflected the country's expression of concern about poverty, and in particular the welfare of children. In the 1830s, the government took steps to improve the working conditions of children, followed four decades later by the expansion of state provision for education.<sup>40</sup> In addition, legislation, such as The Corporation Act of 1835 and the Public Health Act of 1848, enabled municipal authorities to become involved in the lives of people, and gave a fresh dimension to the State's

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<sup>36</sup> Rafferty, *Nursing Knowledge*, 3; Summers, A, 'The mysterious demise of Sarah Gamp. The Domiciliary Nurse and her detractors 1830 – 60', *Victorian Studies*, 1989, Vol 3, 365 – 86.

<sup>37</sup> Dingwall, Rafferty Webster, *Social History of Nursing*, 9- 13

<sup>38</sup> Aucott, S. R. 'Maternity and Child Welfare Movement in England and Wales, 1900 – 1948', University of Leicester M.Phil. thesis, 1993, 34 –38; Aucott, S.R. *Leicester's Maternity and Infant Welfare Services 1900 – 1948* (Leicester 1997), 24 – 25; Wells, M - retired district nurse (non-QN). Interview (1999).

<sup>39</sup> White, *Poor Law Nursing*, 10

<sup>40</sup> Thane, P, 'Government and society in England and Wales 1870 – 1914' in Thompson, *Social Agencies and Institutions*, 1 – 115.



**TABLE 1. DISTRICT NURSING – EARLY DEVELOPMENTS**

YEAR	ORGANISATION	ACHIEVEMENT
1828	General Society for Promoting District Visiting	Lay people from religious organisations who provided religious instruction and welfare to the needy.
1840	Elizabeth Fry's Institution of Nursing Sisters, London.	Supplied private trained nurses for the benefit of sick people with limited income.
1856	Mrs Bromhead's Nursing Institution, Lincoln.	Provided trained nurses for the sick in their own home in Lincoln.
1857	Ellen Ranyard's Domestic Female Bible Mission, London	Sold Bibles and gave domestic advice to the poor.
1859	William Rathbone, Liverpool, employed a hospital trained nurse – Mrs Robinson	To nurse his sick wife in her own home until her death; and afterwards to nurse the sick in their own homes, but the demands made upon her were too great.
1860	Florence Nightingale established a nurse training school at St Thomas' hospital, London.	Training for educated women to become nurses to teach and supervise other nurses; and to provide nursing care in the home.
1862	William Rathbone established a nurse-training scheme attached to Liverpool Royal Infirmary.	Supplied nurses to nurse the sick at home in Rathbone's area of Liverpool, for private work and to meet the needs of the hospital.
1863	William Rathbone established the Liverpool District Nursing Service	Provided trained nurses to care for the sick in their own home, and other nurses to work in private houses.
1866	Institute of Trained Nurses for the Town and County of Leicester.	Provided hospital-trained nurses to care for the sick poor in their own homes – modelled on Rathbone's scheme.
1868	William Rathbone, Member of Parliament for Liverpool	Involved in a project with the Order of St John of Jerusalem to promote district nursing in London.
1868	Ellen Ranyard's London Bible Women and Nurses Mission	Provided trained nurses to nurse the sick and give spiritual support to the sick poor in their own home.
1874	Mrs Dacre Craven (nee Florence Lees) founded the Metropolitan and National Nursing Association, London.	Established a local/national organisation primarily to provide trained nurses at the bedside of the sick in London. Produced first Guild Book for District Nurses and Home Nursing (1890).
1887	QNI, founded in London (Rathbone, Craven and Nightingale were the Driving force behind the inception of QNI)	A national scheme of affiliation, open to all towns and counties in the country, to provide trained district nurses to care for the sick poor in their own home.
1888	Mrs Malleon, Rural Nursing Association, West of England	Promoted the training of village nurse midwives for rural communities.
1892	Local Government Board Notification to all Boards of Guardians (Initiator Dr Rumsey)	Trained nurses styled 'District Nurses' to replace pauper nurses in the care of the sick in their own home.

Source: Author based on extensive reading of the literature



expression of concern about poverty and its implications for the nation's economy and welfare.<sup>41</sup>

Secondly, the work of district nurses was made more difficult by Victorian society's conflicting attitudes towards poverty.<sup>42</sup> On the one hand, some people subscribed to the philosophy of individualism, which regarded the poor as slothful and irresponsible and thus the cause of their own problems. On the other hand, there were those who subscribed to the philosophy of determinism based on a belief that the poor were made poor by external forces over which the individual had little or no control. Whatever the root of poverty, the district nurse had to attempt to ameliorate the causes and deal with its effects, and to respect and take into account all the distress that surrounded poverty and impoverishment, in particular the feelings associated with the state of being poor.<sup>43</sup> By the mid-nineteenth century religious and secular society was working alongside government to contribute to the welfare of the underprivileged. In addition to pastoral and caring roles, these organisations contributed to the management of the poor in an attempt to control disease and contain feelings of oppression.<sup>44</sup> For instance, in 1828 middle class women and occasionally respectable poor women were recruited by the Methodist church as District Visitors.<sup>45</sup> The visitors delivered their religious 'homilies with a basket of material necessities wrapped in domestic advice,' and it was out of this work, Prochaska argued, that many District Nursing Associations (DNA) grew.

Thirdly, the evolving process of establishing a systematic and scientific underpinning for clinical decision-making and education in medicine and the allied disciplines was making its mark.<sup>46</sup> For example, germ theory was in its early stages of development, and epidemiology

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<sup>41</sup> Royle, E, *Modern Britain. A Social History 1750 – 1985* (London 1988), 156 – 203; Stern, W. M, *Britain Yesterday and Today An Outline of Economic History from the Middle of the Eighteenth Century* (London 1966), 253.

<sup>42</sup> Rose, M. E, 'Poverty and self-help. Britain in the nineteenth and twentieth centuries' in Digby, A, Feinstein, C and Jenkins, D, eds., *New Directions in Economic and Social History* (Basingstoke 1992) Vol. 2, 149 – 62; Snell, *The Annals of the Labouring Poor*, 104 – 37; Chinn, C, *Poverty Amidst Prosperity. The Urban Poor in England 1834 – 1914* (Manchester 1995), 4 –7.; Oakleaf, Z. D, 'Poverty in Leicester at the turn of the century 1904 – 1912, University of Iowa Ph.D. thesis, 1982.

<sup>43</sup> Morris, P, *Power: A Philosophical Analysis* (Manchester 1987), 37 – 38; Loane, *The Queen's Poor*; Cohen, 'Loane, Nightingale and District Nursing'.

<sup>44</sup> Donnison, D, *The Politics of Poverty* (Oxford 1982).

<sup>45</sup> Prochaska, *The Voluntary Impulse*, 44.

<sup>46</sup> Waddington, I, *The Medical Profession in the Industrial Revolution* (Dublin 1984), *passim*. Holloway, S. W. F, *The Royal Pharmacological Society of Great Britain, 1841 - 1991*, *passim*; Youngson, A. J, *Medicine and Surgery in Early Victorian Britain* (London 1979), 12 –4; Donaldson, L. J, '125 Years of Public Health in the UK', *The Journal of the Royal Society for the Promotion of Health*, 121 (3), 2001, 126 – 151.



and microbiology were barely tested or articulated before the late nineteenth century, when Edward Jenner developed smallpox vaccine and Robert Koch identified the bacillus causing tuberculosis.<sup>47</sup> A more formalised approach to Public Health administration and practice evolved, and concepts of preventive medicine were cautiously influencing some spheres of clinical education and practice.<sup>48</sup> Behind these changes lay the prohibitive cost of traditional medicine; mistrust was rife and people did not believe that ‘medical men’ held the monopoly of the skills and knowledge of healing, with the result that self-medication and ‘quackery’ were deeply rooted.<sup>49</sup> The medical profession did not always hold the pre-eminence it was subsequently to achieve, and the sick poor lacked an effective advocate – a role gradually undertaken by district nursing.<sup>50</sup>

Fourthly, the voluntary hospital movement from the early eighteenth century aided advances in medical knowledge and skill. Although administered by the laity, the doctors took over the control of hospital admission policy in order to obtain patients of clinical interest.<sup>51</sup> The voluntary hospitals, however, from the mid nineteenth century offered a nurse training facility that was recognised and used by social reformers such as Elizabeth Fry in the 1840s, a system later formalised under the influence of Florence Nightingale at St Thomas’ Hospital, London in 1860.<sup>52</sup> As a result of her insight into the laws of hygiene and administration, Nightingale extended and honed the traditional domestic role of middle-class women into that of the nurse as a specialised form of health-care and welfare, whilst holding the firm belief that ‘not all women had the innate ability to nurse’.<sup>53</sup> The preparation of nurses included medical teaching, and eventually trained nurses supervised the probationer nurses on the wards. In spite of the limitations identified by Maggs, hospital-based nurse

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<sup>47</sup> Donaldson, ‘125 Years of Public Health’, 126 – 151.

<sup>48</sup> Stern, *Britain Yesterday and Today*, 229 – 270 with reference to the Public Health Act (1848) and the establishment of the General Board of Health; and the Public Health Act (1875) and the mandatory appointment of Medical Officer of Health; Mackintosh, J. M, *Topics in Public Health* (London 1985), 2- 4 argues the concept of social medicine; Jordan, T. E, ‘Historical Perspectives on Health: Assessment of National Progress in Public Health in England, 1832 – 1911’, *The Journal of The Royal Society for the promotion of Health*, 119, (2), 1999, 121- 9 .

<sup>49</sup> Holloway, S. W. F, *The Royal Pharmaceutical Society of Great Britain 1841 – 1991* (London 1991), 42 – 57; Porter, R, *Disease, Medicine and Society in England 1550 – 1860* (Cambridge 1987); Cartwright, F. F, *A Social History of Medicine* (London 1977).

<sup>50</sup> Blane, D, ‘Health professions’ in Scambler, G ed., *Sociology as Applied to Medicine* (London 1991), 221 – 35; Craven, *Guide to District Nurses*, 12; Nightingale, F. *Trained Nursing for the Sick Poor* (London, 1876), 6-7; Rafferty, A. M, *The Politics of Nursing Knowledge* (London 1996), 5 here it is argued that nurses provide an important source of mediation.

<sup>51</sup> Blane, ‘Health professions’, 221 - 35.

<sup>52</sup> Davies, C, ‘Where next for nursing history?’ *Nursing Times*, 76, 21, 920 – 2; Mortimer, B, ‘The history of nursing yesterday, today and tomorrow’, in Mortimer, B and McGann, S, eds., *New Directions in the History of Nursing* (London 2005), 1 – 15.



training provided a readily accessible foundation on which the specialist preparation for district nursing was built.<sup>54</sup>

Fifthly, following the emergence of multifarious occupational groups associated with healing and welfare, the issue of professionalisation arose, a reciprocal relationship between an occupation and society derived from the investment of trust, expectations and obligation.<sup>55</sup> The forces steering this process will be discussed in Chapter 3, but at this point it is important to note that several groups were either aspiring or emerging towards the autonomy of professional status during the early nineteenth century. The Medical Act of 1858 established the unification of medical practitioners into a single profession and gave statutory rights, whilst the State retained the ultimate control. On the one hand, the dominance of the medical profession frequently constrained the independent and reactive role of voluntary associations, whilst powerful gender and social class issues associated with the medical community tended to eclipse the essence and autonomy of district nursing.<sup>56</sup> On the other hand, however, the lack of coherence and standards in home-based nursing care attracted the attention of several groups and stirred them into action. Medical practitioners, religious sisterhoods and nursing pioneers all made efforts, for different reasons, to improve the state of home-based nursing.<sup>57</sup>

### Organisation and training:

An important feature of mid-to-late nineteenth century voluntarism in this country was the steady increase in the number of organisations and corporate bodies founded to provide nursing care in the home. These achievements were due largely to enterprising, enquiring 'gentlewomen' (not always nurses) such as Florence Dacre Craven, Agnes Jones, Elizabeth Fry and Florence Nightingale, who were far thinking and were fortunate in having the freedom and resources to be able to travel and consult widely.<sup>58</sup> The developing facility for nurse training within the voluntary hospitals from the early nineteenth century was also a major factor in the accomplishment of the goals that were taking shape in the minds and

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<sup>53</sup> Cohen, *'Loane, Nightingale and district nursing'*.

<sup>54</sup> Maggs, C, 'Nurse recruitment in four provincial hospitals', in Davies, C, ed., *'Rewriting Nursing History'* (London 1980), 18 – 40.

<sup>55</sup> Perkin, H, *The Rise of Professional Society in England since 1880* (London 1990).

<sup>56</sup> Inkster, 'Marginal men', 128 –146; Witz, *Professions and Patriarchy*, 129.

<sup>57</sup> Rafferty, *Politics of Nursing*, 1 – 22.

<sup>58</sup> Abel-Smith, *History of Nursing*, 18 – 9; Craven, *Guide to District Nurses*, preface.



aspirations of such women.<sup>59</sup> Formally-organised systems were developed to provide nursing in the home, three examples of which are worthy of exploration: the first emphasises the secular business approach; the second the influence of religious beliefs; and the third secular services divorced from proselytising and the ability to pay.

The secular business approach was closely associated with Elizabeth Fry, who founded the 'Institution of Nursing Sisters' in London in 1840, with the purpose of providing a private trained nursing service in the homes of the sick who could pay, and a free nursing service to offer visiting care for the poor. Fry earned the accolade of having established the first known institution of trained nurses to care for the sick in their own homes in Britain. Her work was inspired by the achievements she witnessed during her time with Pasteur Fliedner, in Germany.<sup>60</sup> The key principle of Fry's organisation was based on her philosophy that nurses caring for the sick in their own homes were to be more than 'good earnest women' - and should be a 'trained and organised body'.<sup>61</sup> The Institution was administered on similar ground rules to those applied to the management of a large household, with a strict code of conduct, a uniform, and free board and lodging 'to leave their minds untrammelled by too much consideration of personal profit'.<sup>62</sup> Rules were strict, high standards were demanded, and penalties were harsh and immediate, as the personal records of the Sisters maintained by the Institution show.<sup>63</sup> In addition to their private work, the Sisters were required to give their free time to 'the gratuitous nursing of the sick in the wretched districts' surrounding their Home.<sup>64</sup> But it would appear from Baly's account that the Institution of Nursing Sisters was unsure of its aims, nurses were inadequately trained, recruitment was poor, and there was a tension between services for money and those freely given to the poor, with the Sisters preferring the former.<sup>65</sup> Nevertheless, an important initiative had been taken which laid a foundation for others to consider: firstly, it was a move that distinguished evangelism from health-care whilst recognising the importance of both; secondly, it represented an important if small step forward towards the establishment of a corps of trained nurses; thirdly, selection and supervision safeguarded the interests of the nurse and offered protection to the public she

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<sup>59</sup> Abel-Smith, *History of Nursing*, 17 – 8 and 61 –62.

<sup>60</sup> WIHM, SA/QNI/W Anon, *Nursing Sisters' Institution* (undated), 3; Baly, *QNI*, 3 –6.

<sup>61</sup> Baly, *QNI*, 4 -5. It should be noted that nurse training at this time was unregulated and standards varied between hospitals.

<sup>62</sup> Baly, *QNI*, 4 -5.

<sup>63</sup> WIHM, SA/QNI/W.4. Records of the Institution of Nursing Sisters – Register of Nurses 1840-1855.

<sup>64</sup> Anon, *Nursing Sisters' Institution*.

<sup>65</sup> Baly, *QNI*, 4-5.



served; and fourthly, it responded to an unmet need to provide trained nursing care to the wealthy and ‘not so poor’ in their own homes.

The sharp contrast between the standards of Fry’s trained nurses and the ‘grim nursing situation in the Poor Law institutions’ was observed by Dr Rumsey, a prominent practising member of the Poor Law Medical Services, who argued in 1856, with considerable conviction, that the qualities for nursing the sick poor were unlikely to be found in the able-bodied pauper women. He expressed concern about the general lack of a ‘sufficiently numerous *corps of nurses*’,<sup>66</sup> and encouraged ‘a multiplication of Institutions of Nursing Sisters in every first class town’. But it was to be over three decades before the Local Government Board issued a General Order in 1892 to all Boards of Governors authorising the appointment of trained nurses ‘to be styled District Nurses’.<sup>67</sup> Social forces aligned to urbanisation impacted on health-care provision, in which disease was not the main determinant in defining an individual’s claim for treatment. The additional burden on the State arising from the increasingly controversial cost of welfarism resulted in cautious progress and occasional stagnation.<sup>68</sup>

A different, non-institutional approach, informed by strong religious principles, was adopted by Ellen Ranyard, an Anglican district visitor in 1857. The Ranyard Bible and Domestic Female Mission was founded in London to sell Bibles and to give advice on domestic issues at home and in Mothers’ Clubs organised by the Mission.<sup>69</sup> Ranyard’s ‘Bible Women’ were recruited from all Christian denominations and social classes; they were trained, paid and supervised, and generally regarded as the ‘first corps of paid social workers in England’.<sup>70</sup> Ranyard, like St Vincent de Paul and Elizabeth Fry, eventually seemed to recognise that the needs of the sick were just as pressing as welfare, spiritual solace, and religious teaching, but the need for nursing was initially eclipsed by evangelical priorities and social work. Ranyard also consulted widely both at home and abroad, and in 1868 she recruited and trained her first ‘Bible Nurses’ at the London hospitals. The nurses also received regular Bible instruction. Again, the administration of the organisation resembled that of a middle-class household but

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<sup>66</sup> White, *Poor Law Nursing*, 19 here Rumsey’s emphasis signified his regard for the importance of a cohesive body of trained nurses with a distinctive professional identity.

<sup>67</sup> White, *Poor Law Nursing*, 76. Reference to the first official endorsement of the title ‘District Nurse’.

<sup>68</sup> Symonds, A, ‘The social construction of public care: from community care to care by the state’, in Symonds and Kelly, *Construction of Community Care*, 18–32.

<sup>69</sup> Prochaska, F. K, ‘Body and Soul: Bible Nurses and the poor in Victorian London’, *The Bulletin of the Institute of Historical Research*, 60, 143, 1987, 336–348.

<sup>70</sup> Prochaska, *Women and Philanthropy*, 127.



the main differences between the Ranyard Bible Nurses and Fry's Institution of Nursing Sisters were twofold: firstly, Ranyard's exclusive role was with the sick poor; and secondly Fry laid down a strict rule 'not to interfere with, or influence in any way, a patient's religion'.<sup>71</sup> It was a rule that was to become one of the underlying principles of district nursing and one that set the Ranyard scheme apart from mainstream developments.

The third type of formally organised home nursing developed in the 1860s on a secular basis and represented a turning point for district nursing. By far the most important spearhead of change was William Rathbone, a Liverpool Quaker and ship owner, who, in 1861, expressed his intention to establish a district nursing service for the people in his locality.<sup>72</sup> Rathbone's district nursing service was founded on the belief that 'good nursing not only relieved suffering but restored morale and prevented pauperism by the timely return to work of the bread winner'.<sup>73</sup> The first obstacle he confronted was the absence of a pool of trained nurses. Persuaded by Florence Nightingale's belief that 'one of the chief uses of a hospital, though almost entirely neglected up to the present time, is to train nurses for nursing the sick at home', he established a nurse training school at the Liverpool Royal Infirmary amid considerable local goodwill.<sup>74</sup> His second challenge lay in the administration and facilitation of the nurses' work, for which purpose a lay committee was formed.<sup>75</sup> A third hurdle was the funding of the enterprise, for which he introduced a subscription scheme. His ambitions for Liverpool came to fruition in 1863, and thereafter others benefited from his visionary zeal. Rathbone is regarded as the father of modern district nursing. The service was widely acclaimed and copied, with Leicester being the third nursing service in the Country to adopt Rathbone's model in 1866 - a development that forms a significant part of this study.

### **Beyond the metropolis - district nursing in the provinces:**

Whilst the Liverpool experiment established the foundations of district nursing in 1863 as a systematic organisation for the relief of suffering in the homes of the poor, it also offered the potential of a new profession for women.<sup>76</sup> London and the Ranyard enterprise have all too

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<sup>71</sup> Baly, M. E, ed., *A New Approach to District Nursing* (London 1981), 281.

<sup>72</sup> Baly, *QNI*, 7, citing Rathbone, W, *Memoirs* (London, 1900) gives an account of his wife's illness and subsequent death and the events that led to his initiative in district nursing in Liverpool; Merry and Irven, *District Nursing*, 4-5.

<sup>73</sup> Baly, *QNI*, 280.

<sup>74</sup> Baly, *QNI*, 5; Abel-Smith, *History of Nursing*, 17 – 14 and 61.

<sup>75</sup> Baly, *QNI*, 5.

<sup>76</sup> Abel-Smith, *History of Nursing*, 1; Dingwall, Rafferty and Webster, *Social History of Nursing*, 1 - 13, 19, 35 and 95; Holloway, *Royal Pharmaceutical Society*, 58; Records Office of Leicester, Leicestershire and Rutland (ROLLR) L288 SRI, Haynes, B; *Working-class Life in Victorian Leicester*.



frequently been portrayed as the core of innovation in district nursing.<sup>77</sup> Whilst important developments undoubtedly took place in the capital in the nineteenth century, the endeavours of social reformers and philanthropists elsewhere were equally impressive. For example, during the latter part of the nineteenth century, secular organisations known as Trained Nurses Institutions were established in the provinces to secure and maintain an appropriate nursing force for the voluntary hospitals, the private sector, and the charity work of the district nursing service.<sup>78</sup> The Institutions were encouraged and influenced both by Florence Nightingale and by her associates, particularly those who accompanied her to the Crimean War. For instance, probably one of the first institutions to be formed in England was the Lincoln Institution for Trained Nurses, established in 1856, more than a decade before the Ranyard initiative. It became known as The Bromhead Nursing Institution, named after a nurse who had travelled with Florence Nightingale during the Crimean War (1854-56) and on whose initiative the Institution was founded.<sup>79</sup>

### Conclusion:

District nursing is a social phenomenon whose development was prompted by impoverishment and distress. It formed part of a complex process of continuity and change, in which the conscious efforts of district nurse leaders were in no small degree affected by changes in the wider context of society over which they had little or no control. The development of home-based care was not a linear movement but one of uneven progression and patchy provision. This research takes the irregularities as its starting point and projects the study of district nursing into a systematic stage. It was within this context that district nursing functioned both as a barometer of social change within a capitalist society, and as an agent of social change, claiming a specific place for women in society.

The fact that arrangements for the training and organisation of home-based nursing emerged on an *ad-hoc* basis proved to be the Achilles' heel of one of the most important developments in health-care and the emancipation of women in late nineteenth century Britain. Schemes lacked standardisation and regulation and independent practitioners performed a variety of home-based care services. Throughout the country, district nurses operated in small isolated

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*The Joseph Dare Reports* (Leicester 1991), 43 and 52 reflecting Dares abhorrence of working class appeal of 'quackery' using as an example the 'Wise Woman of Wing'.

<sup>77</sup> Prochaska, 'Bible Nurses'.

<sup>78</sup> Maggs, 'Nurse recruitment', 18 – 40; Anon, 'A History of the Nursing Sisters Institute' cited in Baly, *QNI*, 4.(London) 1930

<sup>79</sup> Bray, C., Grantham K and Wright, A, '*The Enemy in our Midst: The Story of Lincoln's Typhoid Epidemic 1905*' (Lincoln, 1987), 22.

voluntary agencies under the direction of influential members of the local church, medical and/or aristocratic communities. The nurses were often employed in a manner similar to servants, divorced from standard-setting and administrative functions within the organisation. Nevertheless, there seemed to develop considerable conformity between the voluntary sector organisations in matters of constitution that provided a basis for future development and change in district nursing.<sup>80</sup>

Beyond the metropolis there were many significant developments in district nursing from the mid-nineteenth century which have been largely neglected. This research provides a corrective, using Leicester as a case study and deploying historical analysis to show that voluntary sector developments in district nursing made a significant contribution to the health and welfare of urban Britain throughout the period 1866 to 1974.

To assess the context in which district nursing sought to establish its professional identity, Chapter 3 focuses on the structures, functions and relationships within the health-care professions between 1866 and 1974.

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<sup>80</sup>Prochaska, *Women and Philanthropy*, 103-113.



# 3

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## STRUCTURE, FUNCTIONS AND RELATIONSHIPS WITHIN THE HEALTH CARE PROFESSIONS 1866 - 1974

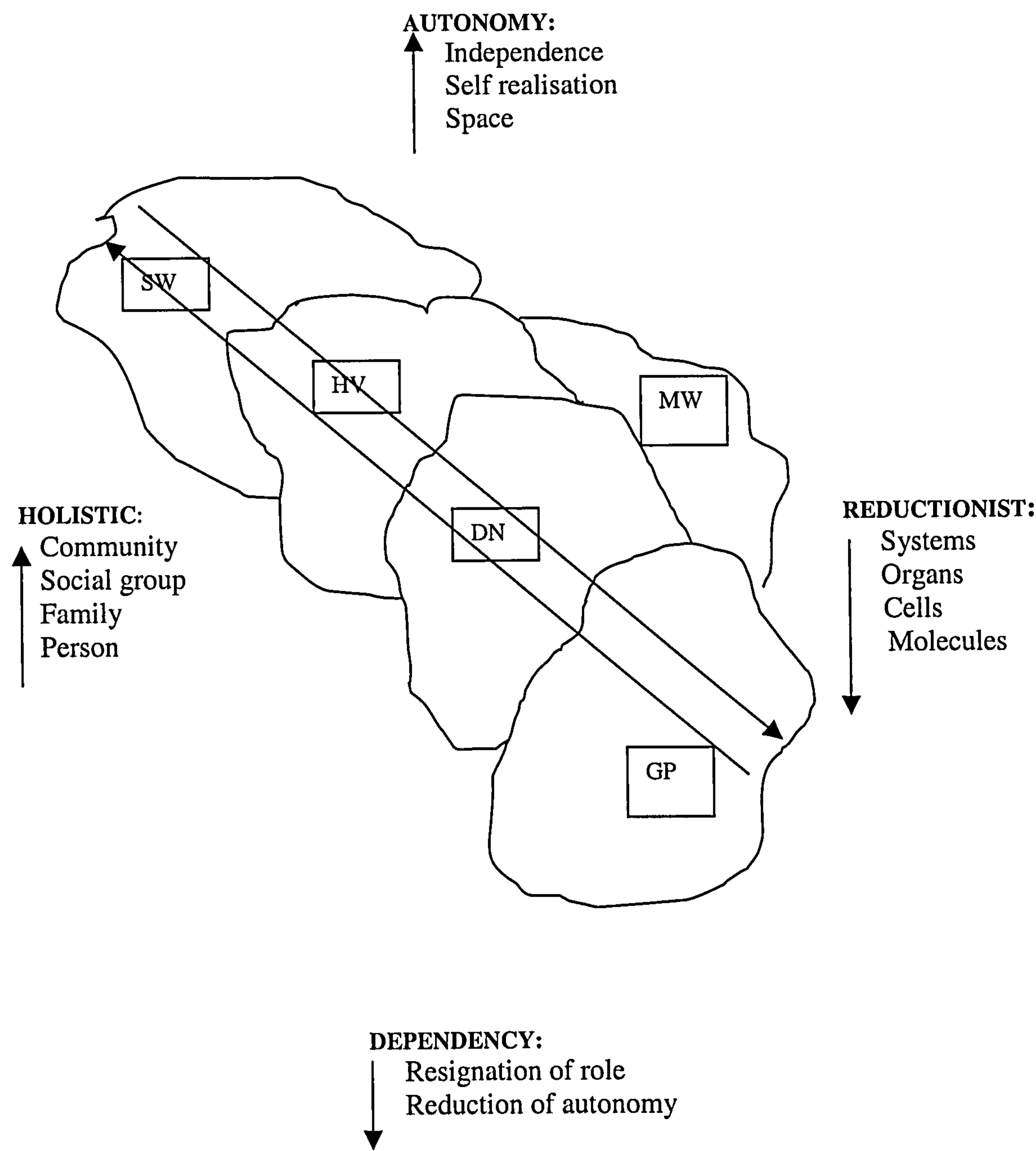
‘It is only by analysing the socially structured tensions within a profession that we can understand how the institutional framework emerged and changed from period to period’.

Waddington, I, ‘General Practitioners (GPs) and Consultants: the sociology of intraprofessional conflict’, in Woodward, J and Richards, D, eds., *Health Care and Popular Medicine in Nineteenth Century England* (London 1977), 164 – 95

The purpose of this chapter is to examine the development of the district nurse’s professional identity and role in relation to other roles in health-care and welfare during the period 1866 to 1974 and the implications for the district nurse's sphere of practice within a burgeoning medical and scientific community. The analysis will focus on the tensions that occurred within and between the professions against a background of shared purpose and in the face of external forces over which they had limited or no control.

The boundaries between professional groups rarely create watertight compartments. District nursing interacted directly in the course of its work with four main groups: the general medical practitioner (GP); the social worker (SW); the health visitor (HV); and the midwife (MW). The boundaries within which the five groups operated and through which they negotiated and established their distinctive identities are central to this study of district nursing. Their intra-and inter-boundary relationships are a critical feature of institutional solidarity - a resource, which can both secure and threaten the stability of a group and its accountability to society. For the purpose of this thesis, Figure 1, although constructed in 1983, is a relevant illustration of these relationships and the different styles of practice adopted by each group with the resulting impact on the recipients of care.

FIGURE 1: A DIAGRAMATIC ILLUSTRATION OF ROLE RELATIONSHIPS



**Key:**

HV- health visitor. SW-social worker  
DN-district nurse . GP -general practitioner. MW - midwife

Source: Adapted from English Nation Board for Nursing, Midwifery and Health Visiting (ENB) Joint Statement on the Development of Inter-professional Training (London 1983), 9 and 10.

The relationship between the different groups is presented on two axes: the holistic–autonomy axis represents a whole person approach where independence is of prime importance; the



reductionist–dependency axis represents one in which autonomy and independence are suspended in favour of control.<sup>1</sup> The schema illustrates movement between and within groups, as denoted by their irregular shaped boundaries and overlapping positions. All groups move fairly freely and to differing extents along the axes in response to the needs of their patients and other circumstances that dictate where movement occurs.

The early development of district nursing comprised a history that in many respects ran parallel to that of medicine and, in particular, general practice - a hybrid speciality within medicine that gradually established a separate identity and sphere of practice.<sup>2</sup> Like district nursing, general medical practice is often referred to as the ‘longest art’ and in the early days the GP was an untrained pioneer.<sup>3</sup> It was a relationship that was influenced by the dissimilar social contours in which medicine and district nursing were grounded; differences in social status between men and women, the level and type of education to which they were exposed and the relative autonomy they experienced created different life chances.<sup>4</sup> As a consequence, medicine became the dominant (male) partner with nursing (female) tending to become an adjunct of medical knowledge and skill, and the epitome of the female nurturing role.<sup>5</sup> From the mid-nineteenth century, the respective roles of the district nurse and GP were closely related through a primary obligation to relieve suffering and to repair physical and mental dysfunctional mechanisms. Whilst those roles were informed by similar reductionist-dependency principles, the approach to care was influenced by different perspectives and strategies. The intervention of doctors was imposed and sustained through surveillance and control within a relationship where the patient was often compliant and disengaged,<sup>6</sup> whereas the values underpinning district nursing required a whole-person approach and a relationship that engaged the patient<sup>7</sup> as an active partner in care.

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<sup>1</sup> Central Council for Education and Training in Social Work (CCETSW), Council for the Education and Training of Health Visitors (CETHV), Panel of Assessors for District Nurse Training (PADNT) and The Royal College of General Practitioners (RCGP), ‘Joint statement on the development of interprofessional education and training for members of the primary health care team’ (English National Board for Nursing, Midwifery and Health Visiting (ENB), (unpublished 1983), 4.

<sup>2</sup> Waddington, ‘GPs and Consultants’, 164 - 95.

<sup>3</sup> Lane, K, *The Longest Art* (London 1969).

<sup>4</sup> Stein, L, ‘The doctor-nurse game’ in Dingwall, R and McIntosh, J eds., *Readings in the Sociology of Nursing* (London 1978) 107 – 17; Mortimer, B, ‘The history of nursing: yesterday, today and tomorrow’, in Mortimer, B and McGann, S, eds., *New Directions in the History of Nursing* (London 2005), 1-17.

<sup>5</sup> MacKay, L, *Conflicts in Care* (London 1993).

<sup>6</sup> Illich, I, *Limits to Medicine: Medical Nemesis. The Expropriation of Health* (London 1976); Illich, I, *Disabling Professions* (London, 1977); Niemi, M. ‘Health experts and the politics of knowledge: Britain and Sweden 1900 – 1940’, University of Leicester Ph.D thesis, 1999, 9-11.

<sup>7</sup> ‘Patient’ in the context of district nursing includes the sick person and his/her supporters.



Nevertheless, district nursing was particularly vulnerable to the domination of doctors and their insistence that district nursing operated under medical referral and clinical control.<sup>8</sup> It was a position that was often unhelpful to the patient and created conflict and additional responsibility for the district nurse, particularly in the first half of the twentieth century when GPs tended to move out of the poorer districts to the more prosperous ones for more lucrative financial rewards.<sup>9</sup> The introduction of the National Health Service (NHS) in 1948 did little to harmonise the working relationship between the GP and district nurse when they continued to be divided by different administrative structures. During the latter part of the twentieth century, however, a more creative partnership evolved with the concept of social medicine providing a common ground.<sup>10</sup>

By comparison, social work (SW), which evolved as a response to social need and to provide advocacy for the disadvantaged citizen in the mid-nineteenth century, began to establish a separate identity as a somewhat ambiguous speciality in the twentieth century. In some respects SW shared its early background with that of district nursing through the Victorian visiting societies.<sup>11</sup> SW, however, developed independently of medicine and gradually became informed by a different, more individualistic and liberal ideology which focused on people as citizens with rights and responsibilities and not as objects of health-care strategies.<sup>12</sup> It was a fragmented service, which mushroomed in response to social need but lacked systematic training and accreditation until the 1960s. SW was practised as an empowering process through which individuals were enabled to engage with an understanding of their situation to bring about change.<sup>13</sup> In the 1970s, however, radical SW found that the individualistic casework approach, which targeted change in the individual, was difficult to justify in comparison with community social work, which located problems at the structural

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<sup>8</sup> Wellcome Institute for the History of Medicine (WIHM) Supplementary Archives (SA)/Queen's Nursing Institute (QNI C3/5. Minutes of Council and Committees (1910) Nursing Committee Minutes of special meetings and reports of conferences. 2-5.

<sup>9</sup> Lowe, R. *The Welfare State in Britain since 1945* (Basingstoke 1999), 168.

<sup>10</sup> Macintosh, J. M, *Topics in Public Health* (London 1965), 52 – 54.

<sup>11</sup> Prochaska, F. K, 'Philanthropy', in Thompson, F. M. L, *The Cambridge Social History of Britain 1750 – 1950: Social Agencies and Institutions* (Cambridge 1990), Vol 13, 357 – 93.

<sup>12</sup> Stainton, T. 'Rights and rhetoric of practice: contradictions for practitioners', in Symonds, A and Kelly, A, eds., *The Social Construction of Community Care* (London 1998), 135 – 44; Bruno, F.J. *Trends in Social Work as reflected in the proceedings of the National Conference of Social Work 1874-1946* (New York 1948), Foreword with reference to the English system of social work, passim; Day, P. R. *Social Work and Social Control* (London 1981), 72-4.

<sup>13</sup> Clarke, S. 'Community developments and health professionals', in Symonds, and Kelly, eds., *Community Care*, 125 – 34.



and societal level of change.<sup>14</sup> It is therefore easy to understand why social work began to move on a different plane from nursing and other medically based disciplines.

Health visiting (HV), unlike district nursing, evolved as a hybrid of the sanitary and social domains of health-care and welfare and was imposed as a mechanism of public health surveillance and instruction to the poor from the late nineteenth century.<sup>15</sup> As a consequence, although health visiting originated as a voluntary organisation, like district nursing, HVs were closely related to the role of the medical officer of health (MOH). The position of health visiting from its inception in the late nineteenth century was distinctly different from that of district nursing in two very significant ways. Firstly HVs were not required to be qualified nurses or midwives but were recruited, as McEwen describes, from two categories of women – ‘ladies of position, and working women belonging to the class of those they would endeavour to influence’. Secondly, McEwen states that the HVs’ remit was not to nurse the sick but to ‘popularise sanitary knowledge, and to alleviate people physically, socially, morally and religiously’ by inspecting the homes and workplaces of the poor, and by offering individual or group teaching. In 1919, however, because of the growing importance of maternal and child health for the nation, coincidental with the Nurses Registration Act, the newly created Ministry of Health specified minimum standards of entry to HV training, one criterion being the possession of a nursing qualification.<sup>16</sup> Following the establishment of this requirement, HV was adopted as a specialist branch within the nursing profession, probably for reasons of convenience.<sup>17</sup> Throughout its history, however, for a number of reasons, HV has existed in a conflict ridden and uncertain relationship with both district nursing and SW.<sup>18</sup> Foremost among these uncertainties was the structural and vulnerable position of HV, whose role arguably straddled those of district nursing and social work; HV distanced itself from the perceived low status of the former,<sup>19</sup> while expressing an allegiance to the latter which was not always reciprocated.

<sup>14</sup> Pinkney, S. ‘Anti-oppressive theory and practice in social work’ in Davies, C, Finlay, L and Bullman, A eds., *Changing Practice in Health and Social Care* (London 2000) 121 –30.

<sup>15</sup> McEwen, M. *Health Visiting* (London 1962), 19 –30.

<sup>16</sup> McEwen, *Health Visiting*, 19 – 30.

<sup>17</sup> Kelly, A, Mabbett, G and Thomé, R, ‘Professions and community nursing’, in Symonds and Kelly, *Community Care*, 157 – 75; McEwen, *Health Visiting*, 3 – 4.

<sup>18</sup> Wilkie, E. *The History of the Council for the Education and Training of Health Visitors (CETHV) 1962 – 1975* (London 1979), 3, 49, 53 here reference is made to the significance of Margo Jeffrey’s article (New Society, 1965) rather aptly entitled ‘The uncertain health visitor’, there were divisions both in the ranks of health visiting and between health visiting and other health care and welfare professions; Batley, N. *The History of the CETHV: The Middle Years 1975-80* (London 1983), 7 –8.

<sup>19</sup> Royal College of Nursing (RCN)/ Edinburgh Archives (EA), RCN 6, Public Health Section (PHS), May 1929/66 membership restricted to those who came under the definition of the ‘Ministry of Health



Midwifery is another strand of health-care whose strong links with medicine stemmed from shared aspects of the obstetric role but with an emphasis on health and normal physiological functions within a holistic perspective. By the turn of the century, statutory safeguards were being introduced but in rural communities the midwife's role was combined with that of the much maligned, relatively untrained village nurse - the incumbent being designated as village nurse-midwife.<sup>20</sup> Nevertheless, because of the close association between midwifery and district nursing (and HV in triple-duty appointments) in rural communities, Fox, with perhaps some justification, claimed that developments in district nursing were made at local level through the relatively more powerful position of midwifery.

The relationships both between and within these occupational groupings were not static, and by the early twentieth century the different occupations, in an almost amoeba-like fashion, began to adapt and create new postures or divisions of labour to meet the changing needs of society.<sup>21</sup> The following diagram (Figure 2), although produced in 1980, has relevance for this thesis in that it provides an overview of the complexity of a relationship that was further aggravated by increasing specialisation. Overlapping elements, however, brought not only the advantage of providing a complementary response to health-care and welfare, but the disadvantage of creating a potential core of tension and conflict that became a battleground for demarcation and boundary disputes, which frequently resulted in confusion for the client. SW are not assigned to a particular area of health-care in the diagram because they held an overall obligation to all the different groups as a facilitator of social well-being. Both the overlap, and, in some situations, the actual movement between occupational groups raise questions about the widely held belief in the neat delineation of territory and the preservation

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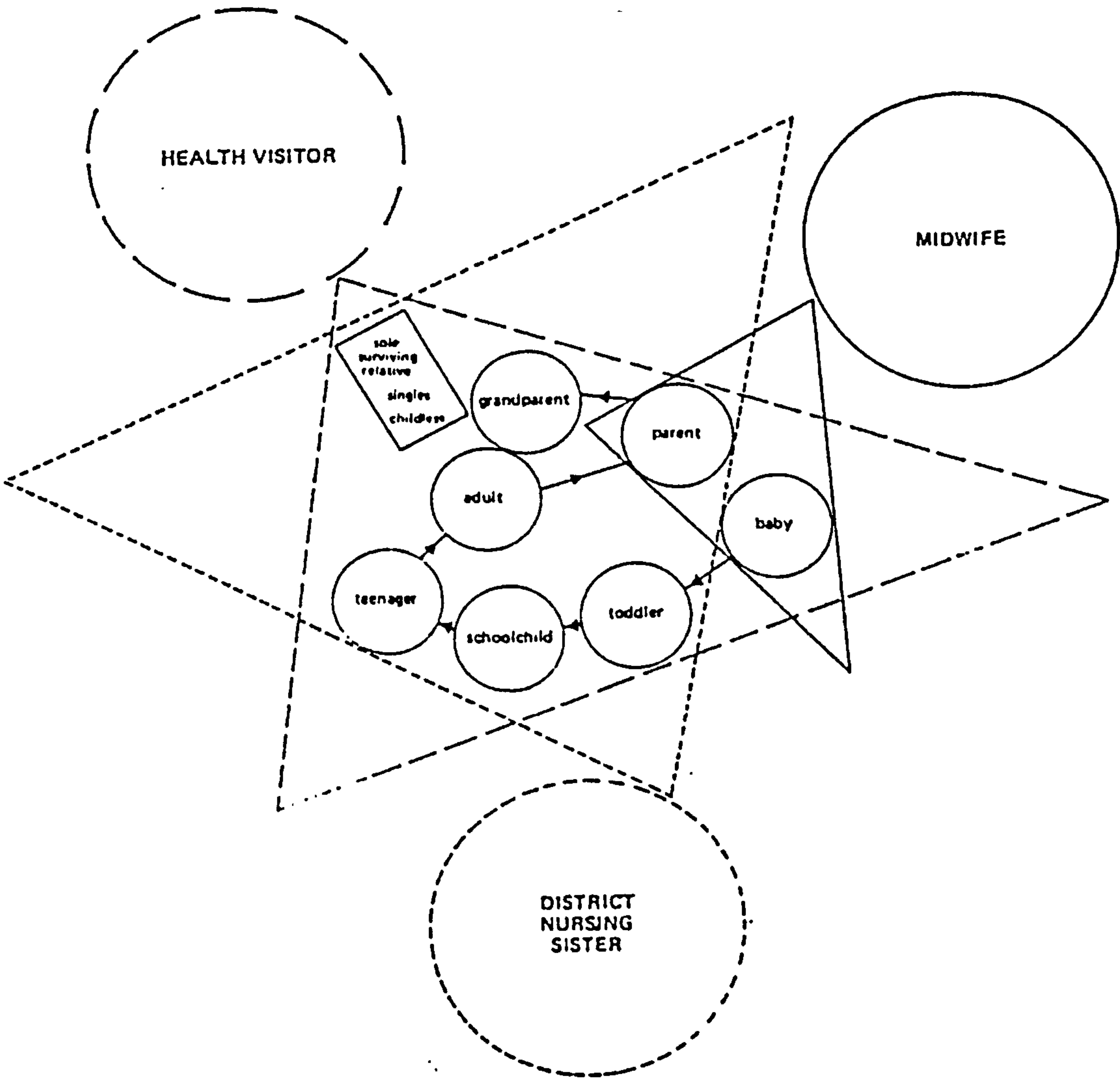
Service' i.e., HVs who excluded district nurses on several other counts e.g., the non-preventive nature of their work, low salary - cheap labour status, and domestic servant image of living in a Home; RCN 85 (8) 4 July 1929, 90 (3) 29 August, 95 (2) 5 October 1929 and 107 (14) 7 November 1929 Re: Draft Circular Local Government (Qualifications of MOH and HV) Regulations Act 1929 - QNI proposals for combined district nurse-HV qualifications not accepted, see also, Wellcome Institute for the History of Medicine (WIHM) Supplementary Archives (SA)/ QNI C.3/13 – 15, Minutes of QNI Council and Committees proposing closer links with HV; Cawthorn, M. HV Oral History (1999) – distinguished between HV (educators) and district nursing (practical worker) an attitude which undervalued the intellectual capacity associated with practical work.

<sup>20</sup> Fox, E. N. 'District Nursing and the work of District Nursing Associations (DNA) in England and Wales, 1900 – 48', University of London Ph.D. thesis, 1993), 40 – 51, NB in urban settings the practice of midwifery and district nursing were separate specialised functions.

<sup>21</sup> ENB, *Joint Statement*, passim; Wilkie, *CETHV*, 3



FIGURE 2: BOUNDARIES OF CARE



Source: Royal College of Nursing, *Primary Health Care Nursing. A Team Approach*. (London 1980), 20.

of intellectual boundaries.<sup>22</sup> Moore argued that patient care is a composite process of interconnected roles and not one that can be limited by ‘jurisdictional boundaries’.<sup>23</sup> He claimed that the twentieth century challenges to traditional orthodoxy had rightly redefined the meaning of boundaries and clinical jurisdiction and brought new knowledge and skills to complementary specialities.

Clearly, the construction of professional boundaries, and the definition of roles and functions with particular reference to district nursing did not occur in a vacuum but in relation to

<sup>22</sup> Spicer, J. E, ‘District nursing: its focus through a comparative analysis of nursing problems’, University of Surrey Ph. D. thesis, 1993, *passim*.  
<sup>23</sup> Moore, W. E, *The Professions: Roles and Rules* (New York 1970).

economic and social change, autonomy and professional identity, and political and organisational change.

### **Economic and social change:**

The town has existed from medieval times as a clearly defined geographical and social feature. Industrialisation was not the prerogative of the Victorian era; even in the mid-eighteenth century Britain held a reputation as a wealthy commercial country with a large industrial output.<sup>24</sup> Further urbanisation, however, was an integral part of the process of industrial and technical change which increased in pace until, by the mid-nineteenth century, Britain had been transformed into a predominantly urban society with considerable upheaval as a result.<sup>25</sup> As the twentieth century approached, the government and the medical profession were at a loss to know how to combat the human distress created by this upheaval and its disastrous effects on the health of the expanding population. Indeed, it is claimed that medical science at this time contributed little to the overall amelioration of social ills.<sup>26</sup> Environmentalist structural approaches were applied to improve the infrastructures of the towns but it was left to the local religious organisations, philanthropists and social reformers to provide for the vulnerable and sick poor.<sup>27</sup>

Three inter-related problems lay at the heart of urban society throughout the mid-nineteenth and twentieth centuries: migration processes; poverty and impoverishment; and social stratification. Specific problems will be analysed in relation to district nursing in forthcoming chapters but it is felt appropriate to give a brief summary here of the context in which the mission of district nursing flourished and professional development occurred.

The continuing process of migration from rural to urban communities as well as inter-urban and intra-urban mobility reflected the magnetic effect of work opportunities despite the human cost and social dislocation. Consequently, the influx of people affected the provision of housing and schools, and health-care and welfare services well into the twentieth century,

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<sup>24</sup> Crowther, A, 'Health Care and Poor Relief in Provincial England', in Ole, P. G, Cunninham, A and Jütte, R. *Health Care and Poor Relief in 18<sup>th</sup> and 19<sup>th</sup> Century Northern Europe* (Aldershot 2002), 203 – 19.

<sup>25</sup> Dyos, H. J. 'Exploring the urban past', in Cannadine, D and Reeder, D, eds., *Essays in Urban History* (Cambridge 1982) 1 - 46; Waddington, 'GPs and Consultants', ix; Perkin, H. *The Origins of Modern English Society 1780-1880* (London 1969), preface.

<sup>26</sup> Luckin, B and Mooney, G, 'Urban history and historical epidemiology: The case of London 1860 – 1920', *Urban History*, 24, 2, 1997, 37 – 55.

<sup>27</sup> Weber, A. F, *The Growth of Cities in the Nineteenth Century* (New York 1963).



and placed huge demands on district nursing.<sup>28</sup> The process of geographical mobility was a central feature of urbanisation and one that changed communities, people and places.<sup>29</sup> The tripartite relationship between housing, ill health and poverty represented a vicious triangle of deprivation that threatened personal integrity, community solidarity and the quality of human capital on which the economy depended.<sup>30</sup>

The overcrowded and unsanitary conditions, in which the poor people lived during the mid-nineteenth and early twentieth century, were the workplaces of district nurses. The break-up of communities in the process of urbanisation represented the erosion of crucial networks through the disruption of close family and neighbourhood relationships by which individuals were sustained during a crisis - a human interactive capacity into which district nursing made a primary contribution to care and health teaching.<sup>31</sup> As new communities were formed in the towns, however, the core values of social solidarity re-emerged in the unsanitary communal courtyards behind the houses where children played and women socialised; here, people created channels of information and self-help, and established norms and sanctions.<sup>32</sup>

From the early 1830s the rich migrated to the suburbs,<sup>33</sup> and the poor were left languishing in the cities; it was not until nearly a century later that the poor in significant numbers were rehoused on council estates away from the city centre.<sup>34</sup> Nash examines the change of scene in Leicester in the 1960s when attempts were made to revitalise inner city areas through the development of high rise, high density accommodation, which incorporated community facilities for both the indigenous population and the influx of commonwealth citizens. The

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<sup>28</sup> Pahl, R.E, Flynn, R and Buck, N. H. *Structures and Processes of Urban Life – Aspects of Modern Sociology* (New York 1983); Rodger, R. *Housing in Urban Britain, 1780 – 1914* (Cambridge 1995); The Hygiene Committee of the Women's Group on Public Welfare. *Our Towns a Close-Up* (Oxford 1943).

<sup>29</sup> Cooper, H, Aber, S, Fee, L and Ginn, J, *The Influence of Social Support and Social Capital on Health* (London 1999), passim – noting the 'elusive concept of health', which for this study is taken to mean, not merely the absence of disease; Ostrom. E 'Social Capital: fad or a fundamental concept?' in Dasgupta, P and Serageldin, I, eds., *Social Capital a Multifaceted Approach* (Washington DC 2000), 172 –214 she asserts that health is an asset that is drawn on to achieve other goals; Mackintosh, J. M, *Topics in Public Health*, (London 1985), 3 , infers a triangle of interaction; Organisation for Economic Co-operation and Development (OECD), *The Well-being of Nations. The Role of Human and Social Capital* (Paris 2001), 26, 28 and 32 contends that human capital impacts on all aspects of human health and well being.

<sup>30</sup> Mackintosh, *Topics in Public Health*, 3; Rodger; *Urban Housing*, 2- 3 and passim.

<sup>31</sup> OECD, *The Well-being of Nations*, 40 – 6.

<sup>32</sup> Rodger, R, *Urban Housing in 1780 - 1914*, 34.

<sup>33</sup> Pritchard, R. M. *Housing and Spatial Structure of a City* (Cambridge 1976), 44 –6; Brown, A. E. *The Growth of Leicester* (Leicester 1972), 7.

<sup>34</sup> Nash, D, and Reeder, D, eds., *Leicester in the Twentieth Century* (Leicester 1993), 135 – 40.



problems associated with early urbanisation reappeared as poverty, crime, poor health and social isolation manifested themselves again.<sup>35</sup>

Throughout the period of this study, the practical, social and emotional implications of various crises in housing were some of the most constantly challenging problems facing a district nurse, whose mission included the prevention of cross infection, the promotion of health, and the comfort and care of the dying.<sup>36</sup> Insufficient and inadequate housing could not be attributed to a single factor but was the product of the cumulative effects of high rents, low incomes, substandard environmental circumstances and social disruption that undermined the health and life-chances of the poor.<sup>37</sup> Hospital admission, until the late 1940s, was not always a desirable or feasible option for the sick, and the homes in which some people remained were not only a challenge to the district nurse and her skill in responding to the distressed mind and a feverish, often contagious, body but also a potential threat to the health of the nurse.<sup>38</sup>

Poverty and impoverishment, therefore, were endemic features with which the district nurse had to contend. For instance, family life and support units were often disrupted and destabilised by poverty, financial insecurity, overcrowding and role-conflicts, with profound implications for health.<sup>39</sup> The situation of the poor was further aggravated by Victorian perceptions of poverty and by attitudes that emphasised the culpability of the poor for their own plight. This had a negative effect on policy decision making and resource allocation both at central and at local government level.<sup>40</sup> Indeed Nightingale delivered a homily of mixed messages that illustrated the ambivalence of society's attitude towards the poor when she saw the district nurse as;

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<sup>35</sup> Bulmer, M, 'The underclass, empowerment and public policy', in Bulmer, M, Lewis, J and Piachaud, D, eds., *The Goals of Social Policy* (London 1989), 245 – 57; Fitzpatrick, R. M, 'Society and changing patterns of disease', in Scambler, G, ed., *Sociology as applied to Medicine* (London 1991), 3 – 17.

<sup>36</sup> Sweet, H and Ferguson, R. 'District nursing history', in Lawson, S, Cantrell, J and Harris, J, eds., *District Nursing. Providing Care in a Supportive Context* (London 2000), 81 – 97.

<sup>37</sup> Elliott, M, *Victorian Leicester* (Surrey 1979), passim.

<sup>38</sup> Haynes, B. *Working-class life in Victorian Leicester. The Joseph Dare Reports* (Leicester 1991), 22 – 4, Dare saw district nursing as having a liberating effect on the poor and able to 'confer incalculable blessings' on the individual and his family; Pascall, G, 'Health', in Marsh, D. C, ed., *Introducing Social Policy* (London 1979), 141 – 64.

<sup>39</sup> Rodger, *Urban Housing*, 44.

<sup>40</sup> Rowntree, B, Seebohn, *Poverty: A Study of Town Life* (London 1899), 117 – 8, distinguished between primary poverty (insufficient income) and secondary poverty (mismanaged income); Snell, F. D. M. *Annals of the Labouring Poor 1660 – 1900* (Cambridge 1985), 104 – 37; Chinn, C. *Poverty Amidst Prosperity. The Urban Poor in England 1834 – 1914* (Manchester 1995), passim; Townsend, P. *Poverty in the United Kingdom* (Harmondsworth 1979), 249 – 51; Rose, M. F. 'Poverty and self-help. Britain in the nineteenth and twentieth century', in Digby, A, Feinstein, C and Jenkins, D. eds., *New directions in Economic and Social History* (Basingstoke 1992) Vol 11, 149.



‘teaching the disorderly how to live in imperfect dwellings’ and ...  
 ‘the great civilizer of the poor ... nursing them out of ill health into  
 good health, out of drink into self control ... all without preaching,  
 without patronising – as friends in sympathy.’<sup>41</sup>

In addition to the physical, social and environmental reality of being poor, the feeling of being poor was a universal experience of exclusion, powerlessness and disadvantage, as old skills became redundant and working practices changed.<sup>42</sup> Poverty is a dynamic and often negative energy force within the social structure; its relationship with society is one by which the poor are not only perceived to be different but are discriminated against.<sup>43</sup> Such feelings and attitudes cause apprehension and strengthen group solidarity, which often results in the rejection of external intervention and widespread attempts at concealment.<sup>44</sup>

The reality and experience of poverty in terms of human distress lies at the heart of district nursing. Figure 3 illustrates the contributory factors in this situation, and shows how all aspects were pervaded by the reality of poverty, the attitudes and feelings evoked by personal perceptions and external forces, and the skills that were brought to bear on the problem. The district nursing role was shaped by this matrix of impoverishment and, indeed, the mantle of poverty arguably obscured its professional status and the true value which should have been ascribed to the work. The mission of district nursing was to preserve the integrity of the sick and empower them by enhancing their knowledge base and problem solving skills within a supportive context.

A range of approaches was attempted by the state, as well as by voluntary associations and charitable organisations, to tackle the problem of poverty from the late nineteenth century, and efforts even accelerated at the beginning of the twentieth century because of the serious

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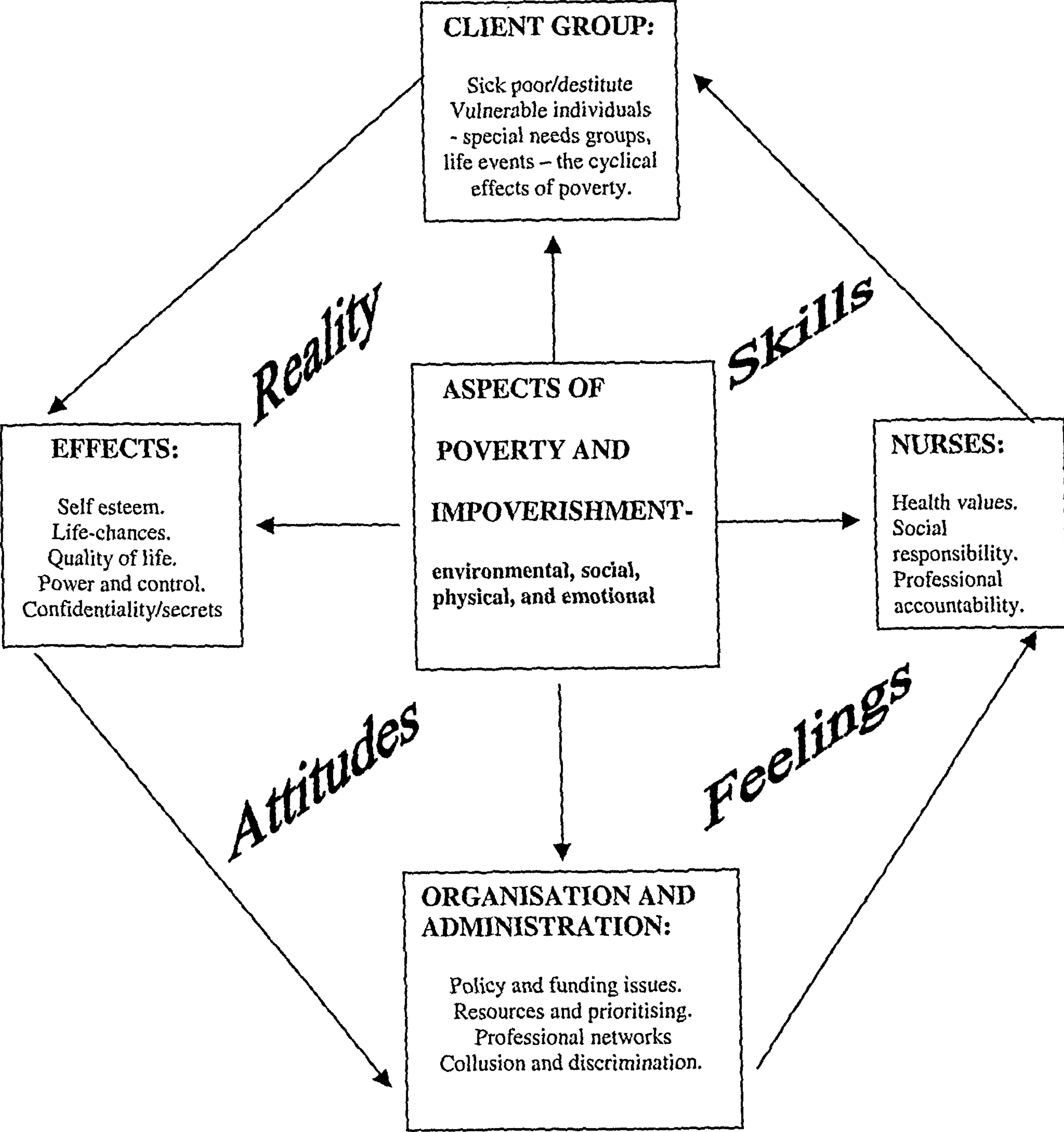
<sup>41</sup> Nightingale, F. ‘Letter to the Duke of Westminster, December 1868’, cited in Merry, E. J and Irven I. D, *District Nursing* (London 1948), viii; Nightingale, F. ‘Introduction to the history and progress of district nursing’ cited in Baly, M. E, *A History of the Queen’s Nursing Institute (QNI)* (London 1987), 8.

<sup>42</sup> Stern, W. M, *Britain Yesterday and Today. An Outline of Economic History from the Middle of the Eighteenth Century* (London 1966), 66 – 86.

<sup>43</sup> Donnison, D. *The Politics of Poverty* (Oxford 1982), 226 – 28.

<sup>44</sup> Hardy, A. *Epidemic streets* (Oxford 1993), 131 – 4.

FIG 3: POVERTY AND IMPOVERISHMENT



Source: Author’s extensive reading, oral histories and personal testimonies of Leicester district nurses (1998 – 2002)



threat to the nation of the sub-standard health of its citizens.<sup>45</sup> By the end of the Second World War in 1945, a different vision emerged and a new approach was adopted. Social distress was reconceptualised and a shift was made away from placating the poor to that of addressing the whole issue of poverty - and a new battle against 'want', 'disease', ignorance' squalor' and idleness began under the umbrella of a state welfare system.<sup>46</sup> A legitimate question to ask would be "What was new for district nursing?"<sup>47</sup>

Throughout the study there is evidence of the changing position of women in society and their role within the workplace, and the impact it had on the work of the district nurse. Because of the nature of its episodic visiting pattern, district nursing relied on the presence of a 'kin-keeper' within the sick person's family group.<sup>48</sup> For many, however, this essential help was unavailable, as women were increasingly forced to work outside their traditional domestic role in the quest for relief from poverty, to fill gaps in the war-time labour market, and sometimes also from a desire for self-fulfilment.<sup>49</sup> District nurses, HV and SW could all be found tackling the same problems in their separate ways. By the 1960s, however, it became widely recognised that no one profession could necessarily meet 'the complex needs of many patients' and the principle of inter-professional teamwork was developed.<sup>50</sup>

Social mobility, with more complex class-based relationships, was another feature of mid-to-late nineteenth and early twentieth century urbanisation.<sup>51</sup> For instance, the emergence of a middle class – the 'self-made man' – from the early nineteenth century brought 'fresh life' to the political-economic arena of the city, and replaced or augmented the traditional role of patriarchal 'city fathers'.<sup>52</sup> The involvement of these self-made men and women in the

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<sup>45</sup> MacGonigle, G, C, M, *Poverty and Public Health* (London 1936), 25 – 45; Niemi, 'Health, experts and knowledge', 71 – 2.

<sup>46</sup> Lowe, *The Welfare State*, 150.

<sup>47</sup> Baly, M. E. ed., *A New Approach to District Nursing* (London 1981), 0 – 7; Allsop, J. 'What do we mean by the Welfare State?' in Gaffin, J, ed., *The Nurse and the Welfare State* (Aylesbury 1981), 20 – 31.

<sup>48</sup> Cook, L, 'Demography and social change', in Lawton, Cantrell and Harris, *District Nursing – a Supportive Context*, 35 – 48; Hareven, J. T. *Family Time and Industrial Time* (Cambridge 1982), 105 – 6, the concept of 'kin-keeper(s)' refers to women within a large family group who retain their role throughout life as helpers, arbiters and pacifiers – a role that is seen to become more pivotal with age.

<sup>49</sup> Nash and Reeder, *Twentieth Century Leicester*, Chapter 2.

<sup>50</sup> Sherrington, C. A, 'The National Society for the Prevention of Cruelty to Children (NSPCC) in transition 1884 – 1983. A study of organisational survival', London School of Economics and Political Sciences Ph.D thesis, 1984; Starky, P, 'The Medical Officer of Health (MOH), the Social Worker and the problem family. The case of Family Service Units' *Society for the History of Medicine*, 11, 3, 1998, 421 – 43; Moss, J. Leicester MOH Report (1969).

<sup>51</sup> Perkin, *Modern English Society*, 176 – 95.

<sup>52</sup> Esping-Anderson, G, ed., *Changing Class – Stratification and Mobility in Post Industrial Societies* (London 1993); Freer, D, 'The dynasty builders of Victorian Leicester', *Transactions of the*



welfare of workers and their inspirational participation in the management and funding of district nursing services constituted a long-term investment for the sick and needy.<sup>53</sup> A hierarchy of social groupings based on the classification of people by type of employment was a product of the nineteenth century population census.<sup>54</sup> The status of the professions and related groups, however, was ambiguous; for instance, nursing was consigned to the domestic order - and this remained unchanged until 1921, when the first official reference was made to the 'nursing profession'.<sup>55</sup> New techniques and roles in the manufacturing, retailing and commercial sectors of the economy produced specialist skills and knowledge which in turn generated a different social hierarchy, changed the distribution of wealth, and produced new social roles and new health problems.<sup>56</sup> Levine provided a model of social class and social stratification in the form of a class typography matrix to show the increasing plurality of roles, levels of authority and range of skills within the socio-economic domain of work.<sup>57</sup> The matrix arguably conceptualised the divisions within vocationally orientated occupations and their organisation, including district nursing, thereby offering a more useful tool than the traditional hierarchy for health service planning and the identification of medico-social risk factors. Health in the workplace has long been associated with the pro-active role of district nursing.<sup>58</sup>

The state of industrial relations also had an effect on family life and health. Individual workers were not able to match their employer's bargaining power to improve their terms and conditions of employment, and so by the mid-nineteenth century, a network of trade unions was gaining strength and was providing help in negotiations at a local level.<sup>59</sup> In addition to remuneration and trade disputes, health risks and danger in the workplace became a priority

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*Archaeological and History Society*, 53, 1977 – 8, 42 – 54, also see reference to Ellis, I. C, *Records of Nineteenth Century Leicester* (privately printed), 14 – Collin Ellis' preface to his mother's book.

<sup>53</sup> Stocks, M, *A Hundred Years of District Nursing* (London 1960); Prochaska, 'Philanthropy', 357 – 93.

<sup>54</sup> General Register Office, *1951 Census for England and Wales; Classifications of Occupations* (London 1951), Introduction.

<sup>55</sup> Davies, C, 'Making sense of the Census in Britain and USA. The changing occupational classification and position of nurses', *The Sociological Review*, 28, 3 1980, 581 – 609.

<sup>56</sup> Perkin, H, *The Origins of Modern English Society 1780 – 1880* (London 1969), 176 – 95; Donaldson, R. J and Donaldson, L. J. *Essential Community Medicine* (Lancaster 1983), 79 – 82; Records Office for Leicester, Leicestershire and Rutland (ROLLR) 20D. 72 Medical Officer of Health (MOH) Annual Health Report (AR), (1900), 11, here the MOH identified the health impediment of 'hurry' and the consequent vicious circle of maladies that give rise to multiple pharmacology.

<sup>57</sup> Levine, R. F. *Social Class and Social Stratification* (Lanham 1998), 150.

<sup>58</sup> Charley, I. H, *The Birth of Industrial Nursing* (London 1978), 47 – 89; Prochaska, 'Philanthropy', 72 – 6; Merry and Irvén, *District Nursing*, 48; McEwen, M, *Health Visiting* (London 1959), 350.

<sup>59</sup> Stern, *Britain Yesterday and Today*, 99, 102, 106, 112-113.



for trade unionists, environmentalists, social reformers and politicians.<sup>60</sup> The trade unions and working men's clubs provided educational opportunities, leisure facilities and welfare schemes to which the employee, or the district nurse on the family's behalf, could apply for support in times of adversity.<sup>61</sup>

### **Autonomy and professional identity:**

The professions are generally recognised as a phenomenon of industrial society, that evolved and developed from the early-nineteenth century under conditions of social and economic change, resulting in the redistribution of wealth and new social roles, creating new health problems and aggravating old ones.<sup>62</sup> The long-standing essence of a profession was that of a 'calling' or vocation, in which human need, 'self-mastery' and 'distinctive autonomy' were paramount.<sup>63</sup> The main requirements were the possession of a body of knowledge and skills, selection by merit as adjudged by peers, community sanctioned authority, and a regulatory code of ethics.<sup>64</sup>

The professions were viewed with some ambivalence; although the term 'professional' was generally applied to various privileged groups, they were not all regarded with equal status. Status within the professional hierarchy was awarded according to rather dubious and controversial criteria. For example, from the 1960s Etzioni and others sought to draw a distinction between 'semi-professions' and the 'true' professions of the church, medicine and the law on the basis that the former possessed lesser knowledge, had a shorter period of training and enjoyed fewer rights and privileges.<sup>65</sup> Furthermore the 'semi' or 'sub' professions were deemed subordinate to the true professions in the management of patient care; and the relationship between district nursing and general practice could be construed as one such example. A division of labour between medicine and nursing existed, however, within the complex sphere of direct patient care, where the juxtaposed, yet often blurred, distinction between medical diagnosis and prescription, and nursing assessment and care, had the

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<sup>60</sup> Stern, *Britain Yesterday and Today*, 87 – 128.

<sup>61</sup> ROLLR, L36; Taylor, J. Working Men's Clubs' From self-help to glamour 1860 – 1972', *History Workshop Pamphlet No. 7*. (Oxford 1972), Introduction. ROLLR, L367; Tremlett, G. *Clubmen: History of the Working Men's Club and Institute Union* (Leicester 1987) passim.

<sup>62</sup> Corfield, P, *Power and Professions* (London 1995), 2; Perkin, *Modern English Society*, 176 – 95; Donaldson, and Donaldson, *Community Medicine*, 79 - 82

<sup>63</sup> Cogan, M. L, 'Towards a definition of *Profession*', *Harvard Educational Review*, 23, 1953, 30 – 50. Moore , W. E, *The Professions; Roles and Rules* (New York 1970), 3; Perkin, H, *The Rise of Professional Society since 1880* (London 1999), 4; Perkin, *Professional Society*, xiii; Greenwood, E, 'Attributes of a Profession', in Etzioni, A, *The Semi Professions and their organisation* (New York 1969), v.

<sup>65</sup> Etzioni, *Semi-Professions*, v; Moore, *Roles and Rules*, 174 – 177



potential to create ambiguity and instability for the professional role.<sup>66</sup> On the whole, an almost arbitrary approach was applied to distinguishing the professional constructs that differentiate the largely male-dominated 'true' professions from the concentration of women in 'sub-professions'; a situation that could be construed as reflecting more complicated gender issues.<sup>67</sup> Whilst it was certainly true, however, that the doctor controlled the process of diagnosing disease, prescribing medical treatment and the delegation of specific aspects of this process to others, it was still the responsibility of the district nurse to assess, plan, prescribe, implement and evaluate nursing care in response to the effects of disease and the experience of being ill.<sup>68</sup> Indeed experience showed that a district nurse could still be held accountable for any harm caused to a patient even when a doctor had ordered the treatment. From the very inception of the Queen Victoria's Jubilee Institute for Nurses (now known as the Queen's Nursing Institute (QNI) in 1887, the principle was established that a district nurse could not be absolved from making her own assessment of the situation and the action she had taken, be it acts of omission as well as of commission.<sup>69</sup> Moore developed the concept of 'centrifugal specialisation', and clarified the issue of accountability by his belief that 'centrifugal' roles possessed a degree of specialisation beyond the control of the 'principal' professions. He cited as examples nursing and pharmacy, arguing that, whilst in some circumstances they operated under the instruction of the doctor, they were always professionally accountable for their own standards of care and practice.<sup>70</sup>

From a political perspective, the professions were regarded as contributing to 'a new kind of post-industrial society', which emanated from the increasing superiority of formal knowledge as a tool for economic development and problem solving that was marginal to the 'main divisions of class, status, power and interest.'<sup>71</sup> Furthermore, external controls invested by the state and the sanctioning powers of the sponsoring economic elite gave rise to a perception of professional autonomy that was more 'technical than absolute'.<sup>72</sup> By contrast, the internal dynamics of a profession provided a challenging, if not threatening, source of power through

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<sup>66</sup> Spicer, 'District nursing: Analysis of problems'

<sup>67</sup> Simpson, R.L and Simpson, I. D. 'Women and bureaucracy in the semi-professions', in Etzioni, *The Semi-Professions*, 5.

<sup>68</sup> Field, D, 'The social definition of illness', and Tuckett, D, 'Doctors and society' in Tuckett, D, ed., *An Introduction to Medical Sociology* (1976), 334 – 97.

<sup>69</sup> WIHM, WY 100, 1889, C89g, Craven, Dacre, *A Guide to District Nurses and Home Nursing* (London 1890), passim; Stocks, *100 Years of District Nursing*, passim.

<sup>70</sup> Moore, *Roles and Rules*.

<sup>71</sup> Brint, S, *In an Age of Experts. The Changing Role of Professionals in Politics and Public Life* (New Jersey 1944), 3; Elliott, P, *The Sociology of the Professions* (London, 1972), 144.

<sup>72</sup> Cogan, 'Definition of Profession', 33 – 50.



the creation of ‘communities of interest’ within a community.<sup>73</sup> Professional communities were grounded in a common identity and a sense of obligation and loyalty, through which they generated specific networks of support. Whilst such welding experiences were a positive force for growth and empowerment, unresolved conflict within a group had the potential to endanger its internal stability and external image, as will be shown later in relation to the QNI. Likewise, group solidarity sometimes resulted in negative segregation, an isolating effect that diminished freedom and eroded the power of other groups.

An important stage for all aspiring health professions was reached in 1885, when legislation ensured for all branches of medicine the protection of a statutory designation and powers of self-regulation through the creation of a single General Medical Council (GMC) and a Medical Register with a single point of entry (see Figure 4).<sup>74</sup> Developments in medicine, however, were strengthened by the founding of the powerful British Medical Association in 1832, whose belief in medicine as a profession was unshakeable; and for 53 years ‘the profession’ continued to flourish without regulation other than the jurisdictions of the Corporations.<sup>75</sup>

Nevertheless, it is worthy of note that in 1875 the Metropolitan and National District Nursing Association (MNDNA) had been formed to co-ordinate the position of district nursing and counter the ‘dangers of amateur treatment of the sick’.<sup>76</sup> In 1887, the MNDNA formed the nucleus of the newly founded QNI. The QNI had a major impact both at home and abroad. It established three important benchmarks that laid down the ground rules for its own approach to the regulation of district nursing: centralised control of standards of training and practice through accreditation and supervision; local autonomy to respond to local need; and an authentic voice and vanguard for development.<sup>77</sup> The broader profession of nursing did not

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<sup>73</sup> Goode, W.J., ‘Community within a Community; the Professions’, *American Sociological Review*, 22, 1957, 194-200.

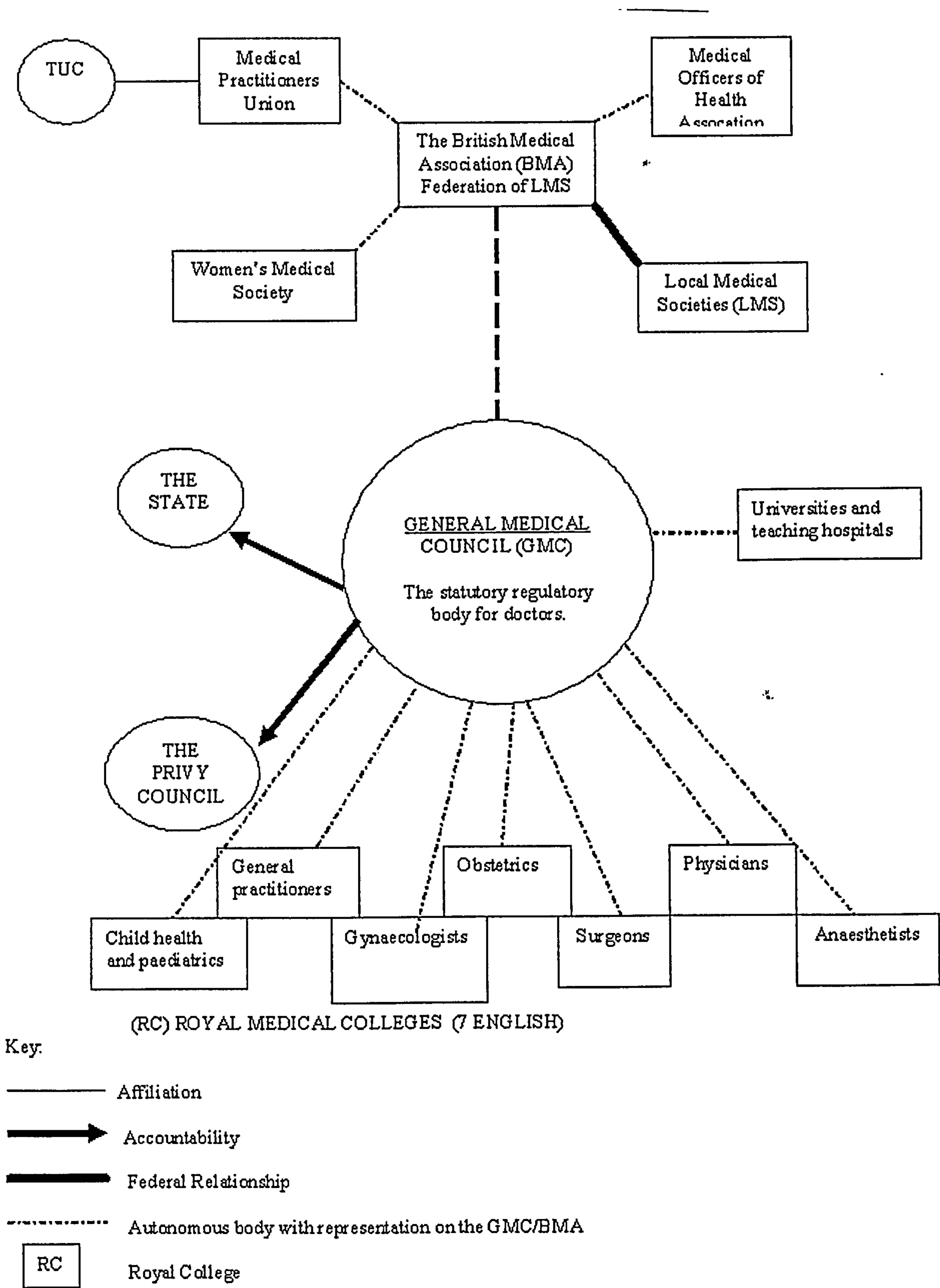
<sup>74</sup> Porter, R, *The Greatest Benefit to Mankind. A Medical History of Humanity from Antiquity to the present* (London 1997), 355 – 6; Stacey, M, *Regulating British Medicine. The General Medical Council (GMC)* (Chichester 1992); Waddington, I. *The Medical Profession in the Industrial Revolution* (Dublin 1984), 113-15.

<sup>75</sup> Muirhead Little, E, *History of the British Medical Association (BMA) 1832 – 1932* (London 1932), Vol. 1, 5; Grey-Turner, E, *History of the BMA 1932 – 1981* (London 1982), Vol. 2, here an account is given of the influence of the BMA in contemporary medical practice.

<sup>76</sup> Stocks, *100 Years of District Nursing*, 43 – 8 citing the important work under taken by the MNDNA in its survey of district nursing in London (1875) and the identification of the dangers of amateur treatment of the sick.

<sup>77</sup> Stocks, *100 Years of District Nursing*, passim; Lin, R, *Angels of Mercy: District Nursing in South Australia* (Norwood, South Australia 1993), 10 - 15.

FIG 4: PROFESSIONAL NETWORKS AND MEDICAL ELITES



Source: Author's consultation and extensive reading.



achieve ground rules of this type until nearly thirty years later – a period described as ‘the thirty years war’.<sup>78</sup>

The College of Nursing was founded in 1916 to establish a register of trained nurses, and three years later the General Nursing Council (GNC) was established in statute by the enactment of the Nurses Registration Act (1919). The GNC, with an almost exclusive investment in hospital-based nurse training for the qualification of State Registered Nurse (SRN), was charged with the duty to maintain a professional register of trained nurses and to lay down rules for training and professional discipline (see Figure 5). The GNC became a powerful body within the profession, and the women involved, of whom a high proportion were matrons and tutors from leading hospitals, used this power as much to discriminate against men as to advance the profession, with the result that men were assigned to a supplementary part of the register until 1946 and excluded from membership of the Royal College of Nursing until 1960.<sup>79</sup> In the same way, district nursing was discriminated against by the RCN, which gave priority to hospital nursing with the resultant neglect of nursing in the home.<sup>80</sup>

In contrast to the GMC, the GNC provided multiple entry points to cater for the largely medically determined specialities within nursing, but it failed to secure statutory protection for the title of Nurse. Furthermore, integration between pre-registration general medicine and post-registration clinical specialities was achieved through a network of august corporations known as the Royal Colleges, whose role advanced the art and science of each speciality – a strength that nursing failed to grasp.<sup>81</sup> The 1919 Nurses Registration Act did not fully achieve the aspirations of a substantial voice within the profession and its supporters. It is perhaps not surprising, therefore, that Dingwall and others regard the GNC as a ‘study in failure’.<sup>82</sup> The lack of critical analysis of the statutory position and functioning of the GNC is regrettable, in

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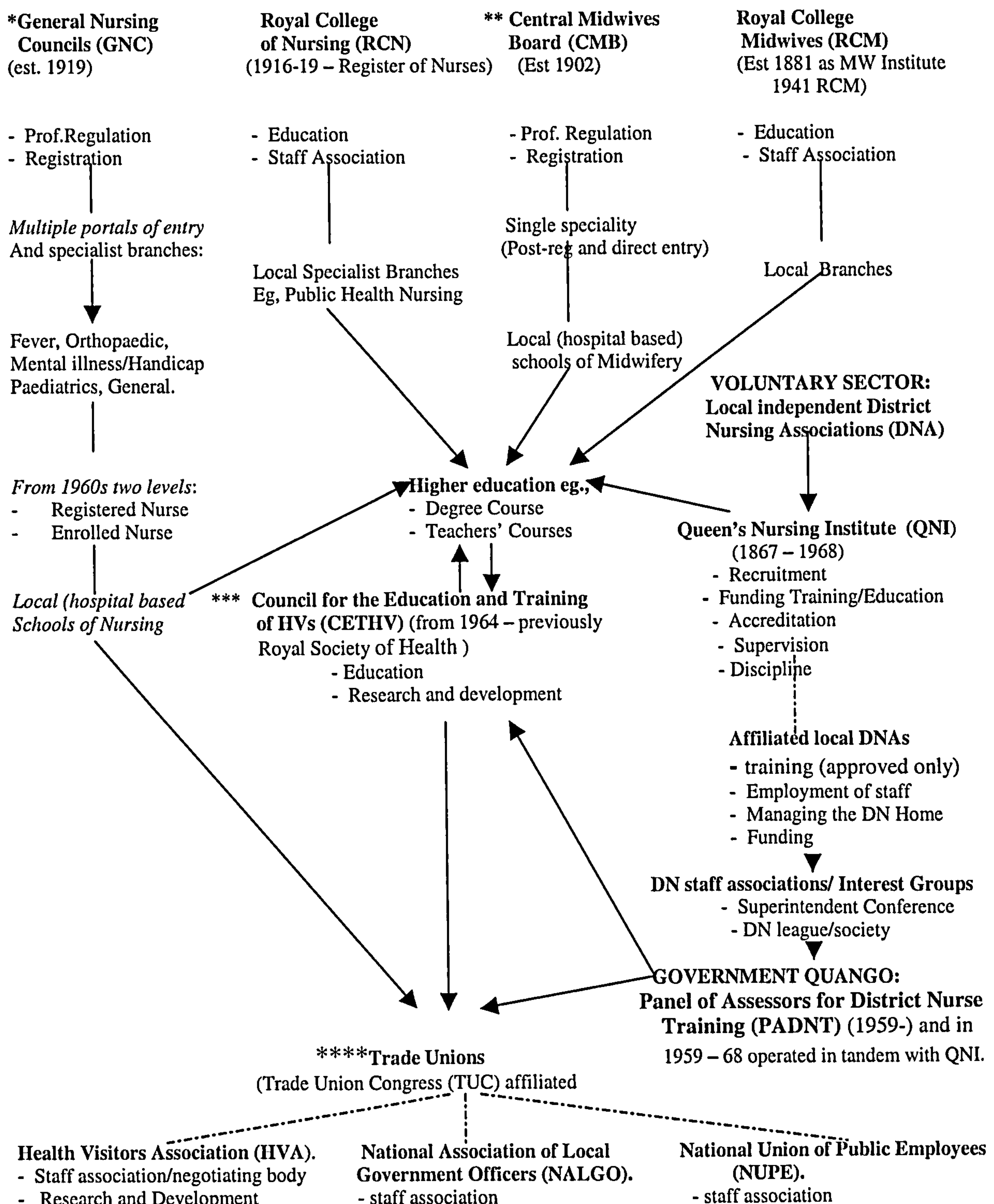
<sup>78</sup> Witz, A, *Professions and Patriarchy* (London 1992), 73 and 128 – 66.

<sup>79</sup> Abel-Smith, B, *A History of the Nursing Profession* (London 1977), 99 – 114, the issues associated with The Nurses Registration Act 1919; Greene, J, ‘Men in nursing and the Royal College of Nursing’, *History of Nursing Journal*, 4, 1992/93, 3 – 9.

<sup>80</sup> Davies, C, ‘Four events in nursing history – a new look’, *Nursing Times*, Occasional Paper 2, June 1978, 69 – 71.

<sup>81</sup> Stacey, *The GMC*, 14, 17 – 18 and 73; Porter, *A Medical History*, 198 – College of Physicians founded 1518, 288 – 9 the Company (later College) of Surgeons founded in 1745 were the first two Colleges (later Royal), 499 Royal College of Psychiatrists founded in 1971 was one of the last Colleges to be established.

<sup>82</sup> Dingwall, R, Rafferty, A. M and Webster, C, *An Introduction to the Social History of Nursing* (London 1988), 95.

**FIG. 5: PROFESSIONAL NETWORKS IN NURSING****KEY:**

\* Statutory responsibility for nurse training leading to Registration or Enrolment and the regulation /discipline of Registered and Enrolled Nurses.

\*\* Statutory responsibility for midwifery education; the regulation/discipline of State Certified Midwives (SCM).

\*\*\* Statutory responsibility for the education and training of HVs.

\*\*\*\* Although midwives, health visitors and district nurses could be represented by their own specialist organisations, many chose to belong to the RCN and trade unions.

----- Affiliation arrangements.

————> Networks.

Source: Author from extensive reading and consultation.



that such a study could have shed new light on the struggle for full professional status by district nursing.

From the 1930s, a number of factors, including legislative controls, improvements in conditions of service, and competition, led to an acute shortage of nurses which affected all branches of the profession and made it difficult to sustain an optimum level of care in the hospitals and in the district nursing service.<sup>83</sup> The analysis of QNI data in Chapter 4 will illustrate the extent to which the GNC adjusted entry requirements and individual hospitals instituted pre-nursing initiatives to capture the elementary school leaving population and augment shortages. By the end of the Second World War, the situation was dire and managers were focusing more on the organisation of their nursing staff than on the exact needs of patients. Responses to the shortage of nurses were dependent on an arbitrary distinction between ‘basic nursing’ and ‘technical nursing’, from which evolved the ambiguous concept of a nursing hierarchy and ‘non-nursing’ duties.<sup>84</sup> It was not until the 1960s that the nursing profession responded sufficiently to what was arguably the second ‘black period’ in nursing history, and one that had far-reaching effects.<sup>85</sup> District nursing, with its royal allegiance through the QNI, remained relatively distanced from the political mainstream until the 1950s, the significance of which, especially in terms of its confused identity and changing professional role, comprises a main focus of this study in Chapters 6 and 7.

Whilst to have an occupation designated as a profession was highly regarded, conversely the power and authority of the professions and their privileged access to secrets was sometimes abhorrent to some scholars and philosophers, who regarded the relationship as disabling rather than enabling.<sup>86</sup> The principal responsibilities of the GMC and GNC were two-fold: firstly, to protect the vulnerability of the public when served by a registered practitioner; and secondly, to uphold public trust and confidence in the profession.<sup>87</sup> The GMC, GNC and Central

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<sup>83</sup> Abel-Smith, *Nursing Profession*, 114 – 29 and 176 – 90.

<sup>84</sup> Baly, M. E, *Nursing and Social Change* (Bath 1980), Appendix 1. ‘Some Nursing Reports’, with particular reference to the Report of the Wood Committee of Inquiry (Majority Report), 1947.

<sup>85</sup> Baly, *Nursing and Social Change*, 329 – 45 and Nursing Research Report; Abel-Smith, *The Nursing Profession*, 1 – 16; Bradshaw, A, *The Nurse Apprentice, 1860 – 1977* (Aldershot 2002), 18 and 21 - both Abel-Smith and Bradshaw refer to the first black period as represented by Charles Dicken’s fictional character, Sairey Gamp in his novel *Martin Chuzzlewit*.

<sup>86</sup> Moore, *Roles and Rules*, 3; Illich, *Disabling Professions*, passim; Fitzpatrick, R. M ‘Society and changing patterns of disease’ in Scambler, *Sociology*, 3 – 17.

<sup>87</sup> Waddington, ‘GPs and Consultants’, 164 – 95; Bendall, E and Raybold, M. E, *A History of the General Nursing Council for England and Wales* (London 1970); Pyne, H *Professional Discipline in Nursing: Theory and Practice* (London 1981), 2-6 – From 1919 a registered practitioner in nursing was titled State Registered Nurse (SRN) with adjustments for speciality branches, such as State Registered Sick



Midwives Board (CMB), formed in 1902, determined the standard of entry to the profession by prescribing a specific body of knowledge and skills, setting criteria of accreditation and authorising entry to the professional register. Maintenance of the professional register involved the investigation of cases of alleged professional misconduct and, if proven, possible removal from the Register.

In addition, professional associations and trade unions such as the British Medical Association, the Health Visitors' Association, and the Royal College of Nursing were established to safeguard and promote the professional and political interests of the practitioner. For doctors, a third type of professional support was set up at local level in the form of a Local Medical Society linked to the British Medical Association.<sup>88</sup> The complexity of this network is diagrammatically illustrated at Figures 4 and 5.

### **Political and organisational change:**

The QNI, which had done so much to establish the professional credentials of district nursing, at a later stage appeared to some to become a significant cause of the eclipse of the district nursing role. Research by Fox, a political scientist, identified both stabilising and de-stabilising factors in the approach adopted by the QNI since its existence in 1887.<sup>89</sup> Several de-stabilising factors, she claimed, exposed the vulnerability of the QNI as an organisation. Her findings implied that political ineptitude, the absence of both critical self-evaluation and a systematic assessment of unmet need, and lack of role definition created tension between skill adaptation and specialisation.

Political ineptitude by the QNI arguably stemmed from a position Fox saw as 'ineffectual intransigence' and self-induced isolation from the main stream of health-care at national and local level. It was a stance that persisted in the face of considerable evidence of the shortfall of nurses nationally and the implications for district nursing coverage across the country.<sup>90</sup> In

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Children's Nurse (RSCN), after the Second World War a second level of practitioner who worked under the direction of the Registered Nurses was introduced titled State Enrolled Nurse (SEN).

<sup>88</sup> Vaughan, P, *The Doctors' Commons. A Short History of the British Medical Association* (London 1959); Clinical Sciences Library (CSL); Special Collection, University of Leicester, 'Leicester Medical Society (LMS) Minutes and Reports', see also LMS, *The Library Catalogue and a History of the Library* (LMS 1990), 214.

<sup>88</sup> Witz, *Professions and Patriarchy*, 73 – 83 and 166.

<sup>89</sup> Fox, 'DNAs', 352-356.

<sup>90</sup> Baly, *Social change*, Appendix 1 cited: Crawford, Earl. Chairman. 'An inquiry into the shortage of nurses, trained and untrained, for the nursing of the sick in general and special hospitals.' *The Lancet Commission* (1930), 427 – 8, Athlone, Earl. Chairman, 'Inter-departmental Committee on nursing



the 1930s, there was serious concern about the staffing of the hospitals, with only 45% of trained nurses holding hospital posts; 26% were in private nursing and a mere 18% of trained nurses chose public health and district nursing.<sup>91</sup> Furthermore, Abel-Smith drew attention to the abuse taking place within district nursing, in that untrained nurses were still employed as district nurses by some agencies.<sup>92</sup> Aware of this situation, the RCN, with representation from the QNI, led a deputation to the Minister of Health in 1935, with the purpose of claiming the funding necessary to ensure adequate district nursing provision.<sup>93</sup> The QNI adopted what seems to be an almost contradictory stance by focusing exclusively on the district nurse's role in the care of the sick, rather than seeking to legitimise its position in the realm of prevention. Given the declared mission of district nursing, reflected in the maxim 'the district nurse nurses as she teaches and teaches as she nurses',<sup>94</sup> prevention was ideologically and practically central to the role of the district nurse.<sup>95</sup>

Because of the perceived elitist and intransigent stance taken by the QNI, hostility began to appear.<sup>96</sup> As consultations on the NHS proceeded throughout the 1940s, the RCN challenged the suitability of voluntary schemes for the status and security of nurses amidst concern that 'the QNI did not fully represent the provinces' (many DNAs having opted out of affiliation with the QNI).<sup>97</sup> Another major weakness in the system was the lack of a district nursing voice equivalent to that of the MOH in local health politics of public health, hospital and GP services. In the view of McIntosh, the absence of such a role for district nursing increased its political marginality and contributed to the insecurity attributed to some managers when the locus of control changed with the introduction of the NHS in 1948.<sup>98</sup>

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services' (1938), 429 – 30, Horder, Lord, Chairman. 'Nursing Re-construction Committee' (1942-3), 430 –4, Wood, Sir. R, Chairman. 'Working party on the recruitment and training of nurses' (Majority Report) (1947), 435 – 6 and Platt, Sir, H, Chairman. 'A reform of nursing education' (1964), 438 –441

<sup>91</sup> Abel-Smith, *Nursing Profession*, 154 – 5, cites the results from a questionnaire distributed by the GNC in 1937.

<sup>92</sup> Abel-Smith, *The Nursing Profession*, 127.

<sup>93</sup> Morton, P, 'Developments in the organisation of primary health care 1900 – 1977', University of Nottingham M.Phil thesis, 1978.

<sup>94</sup> A maxim frequently included on QNI examination paper for analysis and discussion.

<sup>95</sup> WIHM SA/QNI Minutes of Council and Committee meetings. Roll of Queen's Nurses; Craven, Guide for District Nurses, *passim*.

<sup>96</sup> Dingwall, Rafferty and Webster, *History of Nursing*, 202 – 3.

<sup>97</sup> Fox, 'DNAs', 325.

<sup>98</sup> McIntosh, J. B, 'District nursing: A case of political marginality', in White, R, *Political Issues in Nursing. Past, Present and Future*, (Chichester 1985), Vol.1, 19 – 44.45 – 66.



Although lack of critical self-evaluation and assessment of unmet need was arguably not unique to district nursing but was common to all health-care and welfare professions in the nineteenth to mid-twentieth centuries, nevertheless, as Fox argues, a lack of substantive data weakened the position of the QNI and undermined its ability to negotiate. In addition, its isolation from the mainstream and its increasingly fringe role as a voluntary organisation made the QNI extremely vulnerable. Evaluative practices were variously affected by organisational, intellectual and attitudinal elements influenced by changing traditions, values and goals within district nursing. Furthermore, the lack of a qualitative approach to the identification of need in district nursing was arguably influenced by the pre-1950 public health administrative tradition rooted in surveillance, inspection, control and direction. An example of this value system and its mechanistic quantitative approach can be observed in the first 'rough estimate' of district nursing provision in England and Wales made by the QNI in 1926, which revealed that 75% of the population was served by one nurse to 10,000 population.<sup>99</sup> A subsequent quantitative survey in 1934 showed some improvement towards the QNI's objective of full district nursing coverage: in England, the service was available to 96% of the population and, in Wales, 87%.<sup>100</sup> In the absence of a systematic qualitative analysis of the district nursing service, the survey left many questions unanswered, and this seemingly encouraging position masked the realities of a shortfall in some urban areas, where an estimated 759 more nurses were needed, plus an additional 739 for the administrative counties.

Subsequent mapping exercises took place from 1937, with further missed opportunities to make a qualitative assessment of the nature of the unmet need. In 1937, the survey found that 98% of Britain was provided with a district nursing service (the whole of Scotland and Ireland were covered by affiliated associations), but failed to identify what percentage of that service was provided by district nurses who were specifically trained.<sup>101</sup> By the 1950s, it was revealed that only 50% of the SRNs employed in the district nursing service were district nurse trained – a situation primarily created by the undervaluing of district nursing by employing authorities and the lack of clarity and priority given to the specialised training needs for district nursing by members of the nursing profession who advised the employers. As a result, there was a confusion between 'basic' and 'technical' nursing that resulted in arbitrary decisions about skill-mix and divisions of labour. At the same time, the cost of

<sup>99</sup> ROLLR, DE 665/40 QNI, *Survey of District Nursing in England and Wales* (London 1934).

<sup>100</sup> QNI, *Survey*, 6.

<sup>101</sup> Merry and Irven, *District Nursing*, 1; Political and Economic Planning (PEP), *Report on the British Health Services* (London 1937), 174 – 5.



training and affiliation to the QNI was prohibitive and membership was irksome to LHAs, particularly in the 1960s, when the prevailing attitude was one of self-assertion and the rejection of control. In addition, as changes were made to the GNC syllabus for general nursing at this time, there was an increasing lack of appreciation of the need for extra training to develop specific skills relevant to district nursing.<sup>102</sup> Instead of being seen as providing a more appropriate preparation for hospital practice and strengthening the foundation for post registration roles and specialist training, these changes were used to diminish the district nurse training.<sup>103</sup>

The situation only served to demonstrate the limited understanding within the professions of the true nature and value of district nursing. Merry and Irven's textbook for district nursing and the QNI manual, published in 1948 and 1954 respectively, with the emphasis on procedure rather than principle, did little to clarify or enhance the position of district nursing.<sup>104</sup> Furthermore, nursing textbooks used by district nurses were written by hospital tutors, and were similarly rooted in procedure rather than principle, while the doctors' contribution to the nursing literature only served to limit the boundaries of nursing knowledge by restrictive, pre-digested use of medical knowledge and scientific discovery.<sup>105</sup>

Arguably, the first and most important problem for district nursing was the QNI's portrayal of district nurse training as the *adaptation* of hospital techniques and methods. It is clear from Nightingale's perception and Craven's early guidelines that district nursing was a specialised area of non-institutional nursing, and that, whilst the foundation was laid on hospital training, the role of the nurse outside the institution required a different dimension of theoretical underpinning, and practical and inter-personal skills development. It is not surprising that Fox claimed, with some justification, that Webster's over-simplified account 'obscures district nursing's distinctive history, professional identity and social characteristics'.<sup>106</sup> Neither is it unusual to find district nursing eclipsed by hospital nursing in publications by other disciplines aiming to take a *gestalt* view of nursing.<sup>107</sup>

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<sup>102</sup> Gibson, S. R. 'A history of the Panel of Assessors for District Nurse Training (PADNT) 1959 – 1983, University of Surrey Ph. D. thesis, 1993, 94 and 98; McEwen, *Health Visiting*, 27 referred to the GNC syllabus emphasis on human behaviour in the family and society; personal and community health and the place of the nurse in teaching.

<sup>103</sup> Davies, C, 'Past and present nursing education', *Nursing Times*, 76, 39, 1980, 1703 – 7.

<sup>104</sup> Merry and Irven, *District Nursing; QNI, Outline of District Nursing Techniques* (London 1954).

<sup>105</sup> Bradshaw, *The Nurse Apprentice*, 29 – 38.

<sup>106</sup> Webster, C, *The Health Services Since the War* (London 1988) , 96.

<sup>107</sup> Carr –Saunders, A.M. and Wilson, P.A, *The Professions* (Oxford 1933), 117 –121; Katz, F. E, 'Nurses', in Etzioni, ed., *Semi-Professions*, 54 –81.



Because the behavioural and social sciences were not part of the district nursing repertoire until the mid-1960s, the QNI did not possess the language, investigative skills and concepts to illuminate the distinctive features of district nursing – medical reductionism was restrictive and inadequate.<sup>108</sup> Other problems experienced by the QNI were largely due to outside forces such as those affecting recruitment prior to and after the Second World War, and the competition for nursing created by the attractions of other professions and new opportunities within industry and commerce.<sup>109</sup> By the 1950s, Abel-Smith claimed there was little evidence of a shortage of recruits but rather that increasing demands were exceeding supply. He also drew attention to the impact of war when demands were increased; trained nurses opted to work with wounded service-men in preference to the civilian population, particularly the chronically sick and those suffering from tuberculosis or mental illness. Indeed, only 9% of newly trained nurses chose to work with the latter groups. The implications for district nursing are obvious.

The position of the QNI must also be set against the ‘hidden’ nature of district nursing within the home. There was an apparent lack of appreciation by the professions and society in general of the knowledge and range of skills possessed by district nurses, and the potential of their contribution to both individuals in distress and to the socio-economic life of the community. The situation was not one confined to this country; in South Australia, district nursing was assessed as ‘the Cinderella of all charities – neither fully appreciated nor understood’.<sup>110</sup>

In Leicester, local authors also fell into the trap of omitting or undervaluing the presence of district nursing. In 1927, Emily Fortey’s publication on ‘Women’s work as Citizens’ in Leicester failed to position district nursing on the socio-political map of Leicester.<sup>111</sup> Her account addressed the significance of women’s work in relation to their ‘concern with the physical and spiritual basis of life and the development of the race’, and the achievement of

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<sup>108</sup> Prochaska, F, *The Voluntary Impulse – Philanthropy in Modern Britain* (London 1988), preface; Eyden, J. L. M and Marsh D. C ‘Social policy and administration: The field of study’, in Marsh D. C, *Introducing Social Policy* (London 1979), 1 – 23; Jones, K, Brown, J and Bradshaw, W, *Issues in Social Policy* (London 1984), Introduction and 25 – 33; Bulmer, M, Lewis, J and Piachaud, D eds., *The Goals of Social Policy* (London 1989), 64 – 83; Sandler, *Sociology*, introduction by Margot Jeffreys.

<sup>109</sup> Abel-Smith, *Nursing Profession*, 151 – 90.

<sup>110</sup> Lin, *Angels of Mercy*, 70 and 101

<sup>111</sup> Fortey, E, ‘Women’s work as citizens’, in ROLLR L914.2, Howes, C, *Leicester Civic, Industrial, Institutional Social Life* (Leicester 1927), 250 – 9.



political and economic equality of the sexes. When she referred to each of the women listed below she noted their claim to fame and the importance of their voluntary work as indicated:

Mrs Bernard Ellis, President of the Leicester Health Society  
 Mrs Cooper, Member of the Leicester Board of Guardians.  
 Mrs Paget, associated with Bond Street Maternity Hospital since its foundation.  
 Miss Stafford, held office in The Girls' Social Guild.  
 Mrs Bond, Justice of the Peace  
 Miss Cephlan, Member of Leicester Arts and Technical Colleges Committee.

All these women were also prime movers in the establishment of a district nursing service in Leicester yet no mention was made of this.<sup>112</sup> Even the latest commentators on the history of health-care systems fail to give due regard to district nursing in Leicester. Harrison in 1999 made a brief reference to district nursing but only as part of the NHS,<sup>113</sup> and Welshman in 2000 gave some recognition to district nursing but failed to grasp the essence of its contribution.<sup>114</sup> Such experiences reinforced an image of district nursing as a Cinderella-like group hidden from history, a position arguably shared with women in general, particularly within a capitalist society and urban communities.<sup>115</sup> It might be argued, therefore, that in many respects the transition of district nursing was influenced as much by women's history as by its tenacious journey as a profession.

Nevertheless, district nursing itself cannot be absolved from responsibility for its eclipse or misrepresentation in the professional literature and the public arena. District nursing was frequently criticised for its self-effacing attitudes and reticent behaviour, as commentators in the late nineteenth and first half of the twentieth centuries looked for a higher profile being adopted by an 'invaluable' movement.<sup>116</sup> This accusation is to some extent confirmed by a history of district nursing written by the Leicester District Nursing Association (LDNA). Whilst presenting an interesting outline case-study of voluntarism in miniature, the publication is devoid of any reference to the skill-development of district nurses and the influence of the socio-economic context in which the history of district nursing was laid and from which the process of transition took place. The strength of the brief historical review produced by the LDNA lies in the implicit rather than explicit recognition of three key

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<sup>112</sup> Leicester District Nursing Association (LDNA), *A History of the LDNA 1887 – 1953* (Leicester 1953).

<sup>113</sup> Harrison, C, *In Sickness and in Health 1900 – 50* (Leicester 1999).

<sup>114</sup> Welshman, J, *Municipal Medicine in the twentieth Century* (Oxford 2000).

<sup>115</sup> Rowbotham, S, *Hidden History: 300 Years of Women's Oppression and the Fight Against it* (London 1977) , viv.

<sup>116</sup> PEP, *British Health Services*, 174 – 180; Haynes, *Joseph Dare Reports*, 52.



achievements: the construction of a profession; the development of a service; and the translocation of a culture of voluntarism to statutory control.

### **A hard lesson learned – survival, demise or regeneration?**

Documented evidence associated with the pre-NHS debates found that civil servants formed the impression that district nursing was ‘not a specialism at all in the sense of other nursing-related occupations’; furthermore, they believed that trained nurses were thrown away on the old and the chronically sick’; as a consequence the QNI’s submission for all district nurses to hold a HV qualification was disregarded.<sup>117</sup>

It was thus in a climate of conflict and antagonism, increasing state supremacy and the bureaucratisation of health and welfare that the government set up a committee in 1953 under the chairmanship of Sir Frederick Armer, a civil servant, to ‘consider what training is required for registered and enrolled nurses in district nursing.....and the means by which such training should be undertaken’.<sup>118</sup> Stocks records that the QNI had minimal representation on the Armer committee and was effectively sidelined by the proposals in the majority report which followed. The report led to the setting up of the Panel of Assessors for District Nurse Training (PADNT), controlled by the government, and a significant reduction in the length of district nurse training.<sup>119</sup> As a result of this development, district nursing faced a crisis of identity and loss of professional status. The experience and outcome of the Armer Committee was in sharp contrast to the quality and integrity of subsequent enquiries into social work and health visiting, in which their training needs and their management were interpreted from a proper study of role and function in relation to population needs.<sup>120</sup> Those rigorous enquiries were led by academics who were well informed in the social and political sciences, and their methods enabled full participation by the profession. The outcome was the establishment of two autonomous statutory bodies - one for health visiting and the other for social work – with a lengthening of their training. District nursing had no such independent body or statutory definition of its training needs.

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<sup>117</sup> WIHM Supplementary Records/QNI H13/17/2 QNI Council’s submission of evidence to the Interdepartmental Committee on Social Insurance and Allied Services followed by a meeting with Committee members on 8 July 1947 when QNI reaffirmed the importance of the scheme before the Minister of Health for district nurses to take a nine month course combined HV/district nurse course.

<sup>118</sup> Fox, ‘DNAs’, 324 – 32 and 355; Gibson, ‘PADNT’, 80 – 1; Stocks, *100 Years of District Nursing*, 171 – 82

<sup>119</sup> Lowe, R, *The Welfare State in Britain 1945* (Basingstoke 1999), 41 – 3 here, Lowe examines three types of political power, which illuminate the experience of district nursing, namely, the power to control the political agenda; the power to pre-shape ideas; and the power to manipulate face to face interaction.



In the middle of all this turmoil, a conceptual shift was taking place, influenced by the growing significance of social and behavioural sciences and a re-conceptualisation of nursing away from reductionism towards holism,<sup>121</sup> following the theory and practice which was developing in America from the late 1950s. The American nurses put the patient at the centre of their nursing....

The nurse enters imaginatively and sensitively into the lives of the people she serves in order to understand their health needs, determine their perception of their need, reconcile the differences between the two sets of perceptions and institute appropriate nursing measures in interaction with the recipients of her service'.<sup>122</sup>

District nursing in Britain began to produce its own scholars and forge links with other academic disciplines. From the 1950s, the promotion of an experimental combined course for HV and district nurses created new opportunities for a wider and more appropriate learning experience and, by the end of the decade, many joint courses were accredited at undergraduate level. In spite of being sidelined, the QNI itself did not abandon the initial training of DNs. Instead, it adopted a much more constructive approach. For the next fourteen years, the QNI worked with the PADNT, and at the same time turned its attention to the development of research into the practice of district nursing by funding academic positions in higher education and research projects. As the number of degree programmes continued to grow throughout the 1960s and 1970s, the research interest of academic disciplines was aroused.<sup>123</sup>

A major contribution to the development of research was made by Hockey, one time QNI Inspector.<sup>124</sup> Her research during the 1960s and 1970s focused on the efficacy of the district nursing service and its practices.<sup>125</sup> The general picture that emerged was disappointing, with district nursing not playing the part it could, or should. Problems were claimed to be caused

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<sup>120</sup> Wilkie, *CETHV*, 1-3, outlines the establishment of the CETHV and the CCESW.

<sup>121</sup> Brown, E. L. *Newer Dimensions of Patient Care* (New York 1965).

<sup>122</sup> Shetland, M. L., 'Teaching and Learning in Nursing'. *American Journal of Nursing*; (1965). 9. 112.

<sup>123</sup> Gibson, 'PADNT', 1993, 196 –99, 211, 410 – 434; Wilkie, *CETHV*, citing Brocklington, *A University Course in Nursing*, (1969); Baly, M. E. *Nursing and Social Change*, 321; Merry and Irvén, *District Nursing*, 33 and 39; Field, D, *Nursing the Dying* (London 1989), a Leicester study with particular reference to district nursing 94 – 108.

<sup>124</sup> Hockey, L and Mcleod Clark, J, *Research for Nursing* (Aylesbury 1979).

<sup>125</sup> Hockey, L, *Feeling the Pulse* (London 1966); RCN, *Report of a Working Party on The Future of Public Health Nursing* (London 1969), an enquiry that led to the recommendation of an integrated preventive and therapeutic nursing service; Hockey, L, and Potter, A, *Co-operation in Patient Care* (London 1970); Hockey, L, *Use or abuse? A study of the SEN in the local authority nurse services* (London 1972), the study highlighted inconsistencies in the deployment of SENs in the district nursing service – the study was aptly titled.



by out of date management, poor communication, and lack of knowledge of the service's potential on the part of others; one of the most disturbing features, particularly at a time of nurse shortage, was the waste of professional skill through under- or misemployment.

The 1970s spawned a range of research initiatives, albeit mostly small scale. At this time district nursing was said to be 'more extensively researched than most other areas' of nursing, but research in other fields also made a contribution to district nursing.<sup>126</sup> A new focus pursued the question 'What do district nurses do?' rather than 'What do district nurses need to know?'<sup>127</sup> A number of studies approached the assessment and evaluation of the unique features and complexity of district nursing.<sup>128</sup> The work-study by McIntosh challenged commonly held perceptions of the work of the district nurse as 'technical procedures and some chat'.<sup>129</sup>

Later studies undertaken by Spicer, Kendrick and Griffiths also reflected district nursing as a speciality grounded in the 'critical selection and application of the principles of judicious, safe and holistic practice, constructed into a programme of care relevant to different social, human and environmental conditions'. In addition, Spicer and Griffiths recognised the significance of the 'invisibility' factor and the potential weakness of a situation where the person who is likely to know *all* is the patient.<sup>130</sup> The studies, along with McIntosh, identified intricate patterns of communication as the nurse moved from initiating and sustaining to a relationship of mutual trust and esteem as a partner in care with the patient. The conclusions reinforced beliefs about the inadequacies of the district nurse training due to an impoverished role definition and the limited ability of GPs and other professionals to understand the full extent of the contribution to be made by the district nurse.

In the 1960s, a re-organisation of working practices occurred, resulting in the attachment of district nurses and HVs to GP practices. This new arrangement had the potential to increase

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<sup>126</sup> Kratz, C. R, *Care of the Long Term Sick in the Community*, (London 1978), 98; Stockwell, F, *The Unpopular Patient*, (London 1972).

<sup>127</sup> Brown, *Dimensions of Patient Care*.

<sup>128</sup> McIntosh, J. B. *Work Study of District Nursing Staff* (Scottish Health Services Studies No 37, Edinburgh 1976); Kenrick, M, 'Research based practice on the district; a study to test whether research findings can influence district nursing practice', University of Liverpool D.Phil thesis, 1995; Griffiths, J, 'An ethnographic study of district nursing work', University of Liverpool Ph.D. thesis, 1996; Spicer, 'Analysis of nursing problems'; Walker, J. M. 'The management of elderly patients with pain: a community nursing perspective', Dorset Institute, Ph.D. thesis, 1989.

<sup>129</sup> Macintosh, *Work Study of District Nursing Staff*, 32.

<sup>130</sup> Griffiths, 'An ethnographic study of district nursing', 120 – 5.



isolation from the peer group and create a new alliance between the district nurse and the GP. By the conclusion of this study in 1974, 80% of district nurses were working in attachment schemes of this type.<sup>131</sup> Whilst this arrangement was in danger of generating a conflict of interest between employer, employee and the practice team, theoretically it also provided new avenues through which district nurses could expand and fully utilise the true scope of their professional role.

Almost simultaneously with re-organisation in the practice, separate functional management was gradually discontinued in favour of multidisciplinary management teams, in which the district nurse manager could either be a HV or a district nurse. The principle underpinning this strategy was that of sapiential authority. Again, this development could either pose a further threat to group solidarity or provide new opportunities and career development for district nurses and an equalisation of status between the hitherto disparate professions.<sup>132</sup>

At national level, the PADNT was wooed by the Council for the Education and Training of Health Visitors (CETHV) as a potential partner but their respective professional organisations were more cautious,<sup>133</sup> and eventually the setting up of Royal Commission on Nursing in 1972<sup>134</sup> scuttled the proposal. The Royal Commission presented an opportunity for district nurses to benefit from a comprehensive and progressive system of nurse education grounded in the specialist health needs of contemporary society and those of the patients to whom district nurses provided care in their own homes and the community. Would district nursing grasp the full potential of the future?

## CONCLUSIONS:

The effects of industrialisation were far reaching. On the one hand it promoted urbanisation and bureaucratic systems. On the other hand, for some individuals and groups, the reality was oppressive and exploitative. Urban life was an experience caught between discrimination and

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<sup>131</sup> McIntosh, J. B and Dingwall, R, 'Teamwork in theory and practice' in McIntosh, J. B and Dingwall, R. eds. *Readings in the Sociology of Nursing* (London 1978), 118 –34; Pointon. G. retired Leicester QN. Interview (1999); Gibson, 'PADNT', 275. 'Attachment schemes' refers to the replacement of 'geographical patch' to 'GP practice' for district nurses, HV and MW whilst remaining in contract of employment to the local authority, see also Abei, R. A, 'Nursing attachments to GP; A Department of Health and Social Security (DHSS) Report' (1969), cited in Wilkie, *CETHV*, 57.

<sup>132</sup> Mayston, L. (Chairman), Report of the Working Party on Management Structure in Local Authority Services (DHSS, SHHD, WO, London 1969).

<sup>133</sup> Wilkie, *CETHV*, 105.

<sup>134</sup> Baly, *A New Approach to District Nursing*, 283-4; Davies, C and Beach, A, *Interpreting Professional Self-Regulation* (London 2000), 2 – 34.

humiliation on the one axis and privilege and self-esteem on the other. District nursing was caught up in this culture. After the second world war rapid and far reaching developments occurred in the structure and delivery of health care within a continually changing society.

Deep-seated structural weakness affected the position and development of district nursing. Firstly, the division within district nursing between QNI affiliated and non-affiliated local DNAs associations weakened what might have otherwise been a strong negotiating position. Secondly, boundaries between the different health care professions symbolised both their distinctive spheres of practice and governing ideology, and the interaction of class and gender; the resulting reality was often the negative effects of interprofessional conflict. Thirdly, the district nursing service operated outside the main strands of the increasingly dominant hospital and public health services; this resulted in a lack of recognition and endorsement of the training needs and professional development requirements of district nurses.

Parallel to the class system a hierarchical professional society evolved whose status did not rely on market forces but on a discrete body of specialist knowledge and skills, autonomy and control. The professions provided a range of expertise directed towards the relief of spiritual, mental, physical and social impoverishment. The situation of district nursing as a profession is ambiguous but the theory of centrifugal professional status, which embraces the concepts of direct and indirect independence, and professional accountability, reflects the ethos of district nursing and is therefore accepted as a benchmark for this research.

The QNI was a leading force in the professionalisation of district nursing; the standards set by the QNI for the training and practice of Queen's Nurses, who provided skilled nursing care in the homes of sick, dying and indigent people, laid a foundation for future regeneration. Chapter 4 pursues a deeper understanding of this inheritance by analysing the biographical characteristics and career rhythms of Queen's Nurses.



## 4

## QUEEN'S NURSES: BIOGRAPHICAL CHARACTERISTICS AND CAREER RHYTHMS

'The early pioneer Queen's Nurses were all highly qualified professional women, intelligent, physically strong and spiritually inspired to serve mankind without fear of fatigue or greed of gain..... It would be interesting to compile an accurate survey of their social background.'

Stocks, M, *A Hundred Years of District Nursing* (1960)<sup>1</sup>

Mary Stocks threw down the gauntlet for an evaluation of her impression of the social characteristics of Queen's Nurses (QNs) as she reached the end of her account of one hundred years of district nursing, a period that bridged the mid-nineteenth to the twentieth century. Against a background of evolving urbanisation in which poverty was a key characteristic these remarkable women were recruited into district nursing. Her study concentrates almost exclusively on the development of the Queen's Nursing Institute (QNI) and the regulations it laid down to distinguish the QNs from the general body of district nurses. Boundaries between the two groups were preserved by the establishment of a Roll of QNs, entry onto which was controlled with considerable rigour. Although it was an autonomous voluntary organisation, the QNI operated within a network of inter-connecting branches of health-care systems, through which specific spheres of practice, accountability and codes of practice were resolved.

The purpose of this chapter is to respond to Stocks' challenge by analysing the biographical characteristics and career rhythms of QNs whose names were entered on the QNI Roll and to present a profile of the district nurses within the QN sub-set. As has been indicated in Chapter 1, because of the wealth of information contained on the Roll, the focus of this research was limited to the data available for every tenth year between 1910 and 1960, and for 1968 when the Roll closed. The analysis of this unique collection of 3555 records makes an original contribution to the district nursing literature by giving shape and meaning to a diverse community of interests and a specific aspect of women's history and social change

<sup>1</sup> Stocks, M, *A Hundred Years of District Nursing* (London 1960), 89.



from the close of the Victorian era in 1901 and on through the first three quarters of the twentieth century, during a time of unprecedented change.<sup>2</sup> Hobsbawm argues that ‘what every generation brings is much more striking than its similarity to what has gone before’.<sup>3</sup> The research focuses on the changing profile and contribution of several generations of QNs, with observations about the divisions and professional tensions in district nursing as a whole during the transition from individual support to collective welfarism. In this respect, the study offers an alternative perspective to the alleged invisibility and marginalised position of the district nursing community.<sup>4</sup>

The archival evidence on which the research was based was drawn from QNI records deposited with the Wellcome Institute for the History of Medicine (WIHM) (see Appendix 1).<sup>5</sup> The Roll of QNs which opened in 1890 and closed in 1968 was a composite record of the life events and professional development of QNs. The record for each QN included biographical data and a detailed profile of the nurse’s career from birth to completion of district nursing service by resignation, retirement or death. The records were produced by the QNI from the nurses’ application forms, training records, feedback from the QNI Inspectors’ visits to the affiliated district nursing associations (DNA), and reports received from the DNAs in which the nurses were employed. The process was co-ordinated by the QNI Council, which comprised well-connected men and women representatives from the aristocracy, church, medical profession and politics. From its inception, the position of general secretary was held by a QN of renowned reputation, but it was several years before QNs themselves were invited to become members in any significant numbers. Designated committees were accountable to Council for specialist aspects of its remit, and a QNI Inspector serviced the professional committees, such as Education and Nursing, thus providing continuity from the field through the committees to Council (see Appendix 2).

The number of cases analysed for each tenth year reveals the growth in QNs over that period, as shown at Table 1. As can be seen from the table there were two main peaks of recruitment: in 1920 after the first world war, when recruitment was variously influenced by the introduction of statutory health and social insurance benefits, a higher focus on the health of

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<sup>2</sup> Prochaska, F, *Royal Bounty: The Making of a Welfare Monarchy* (London 1995), 67 – 135.

<sup>3</sup> Hobsbawm, E, *On History* (London 1997), 26.

<sup>4</sup> Dingwall, R, Rafferty, A. M and Webster, C, *An Introduction to the Social History of Nursing* (London 1988), 198; McIntosh, J, B, ‘District nursing: a case of political marginality’, in White, R, ed., *Political Issues in Nursing. Past, Present and Future* (Salisbury, 1985) Vol. 1, 45 –66.

<sup>5</sup> Appendix 1: Wellcome Institute for the History of Medicine (WIHM) Supplementary Archives (SA) J. 3/16 – J. 6/12 Queen’s Nursing Institute (QNI) Roll of Queen’s Nurses (QNs)



TABLE 1: ENTRIES ON ROLL OF QNs (Britain) - SELECTED YEARS 1910 - 68

RECORDS:	CASES ANALYSED:		GROWTH IN NUMBER OF QNs:	
	Number of cases	% of total cases	Growth in number	% increase
Year of enrolment	n =	%	n =	%
1910	312	8.8		
1920	377	10.6	65	21.0
1930	439	12.3	62	16.5
1940	497	14.0	58	13.2
1950	589	16.6	92	18.5
1960	630	17.7	41	7.0
1968	711	20.0	81	13.0
TOTAL	3555	100.0	399	127.8%

Source: See Appendix 1

women and children, and the statutory control of nurse education introduced by the Nurses Registration Act (1919); and in 1950, following the introduction of the National Health Service (NHS) and a statutory obligation to provide district nursing cover across all sectors of society, although the specific training for district nursing was not mandatory. The smaller increase in 1960 could have been the effect of the Armer Committee’s investigation into district nurse training in 1952 and the subsequent establishment of the Panel of Assessors for District Nurse Training (PADNT), a Ministry of Health controlled system of training which offered a shorter course without the added expense of an affiliation contract (see Chapter 3). The healthier increase in 1968 probably reflects the fact that it was the last opportunity to gain the prestigious QN qualification ahead of the closure of the QNI Roll.

The QNI, established in 1887, opened the Roll of QNs in 1890. Entry was by accreditation or special dispensation, and endorsed by the issue of a certificate and an official uniform. The award of the QNI certificate of competence was determined by three processes: firstly, continuous assessment, carried out by the superintendent of an approved training home of an affiliated association;<sup>6</sup> secondly, a practical assessment conducted by a QNI visiting examiner at the end of the course; and thirdly, the QNI national written assessment based on the following syllabus and criteria of assessment.

<sup>6</sup> ‘Contract of Affiliation’, a voluntary arrangement between the QNI and a local district nursing association (DNA). The DNA paid an annual fee and was required to observe the conditions laid down by the QNI to secure a uniform standard of training and practice, and an adequate supply of QNs.



**SYLLABUS (Summary)**

District nursing – practice and principles.  
 Sociology – family, poverty, welfare.  
 Psychology –human development and motivation - defects and treatments.  
 Public health – government (local and central), law and vital statistics  
 Overcrowding, housing defects, hygiene and personal health needs.  
 Industrial health, injuries and diseases – links with health personnel.  
 Nutrition, deficiency diseases allergies and requirements related to ageing.  
 Common diseases – prevention, treatment, palliative care  
 Contagious disease – TB and VD and regulations, education, treatment.  
 Tutorials – integrating theory with practice.  
 Personal appearance, life-style, personal professional development.  
 Written work.

**ASSESSMENT CRITERIA (Summary)**

Skills, techniques, safety and rehabilitation.  
 Approach to patients, family, community.

Holistic health assessment/interaction  
 Recognising statutory constraints and opportunities for health and welfare.  
 Powers of observation and resourcefulness, prevention of cross-infection.

Knowledge and use of social services.  
 Co-operation with colleagues and others, recognising religious/cultural influences.  
 Record keeping. Use of charts and message papers in the home.  
 Case reporting; maintenance and use of equipment.  
 Management of care, staff and district.  
 Inter-personal skills, temperament, health status and powers of discretion.  
 Intellect, professional knowledge and skill.

Source: Merry and Irven, *District Nursing*, 36 – 7. WIML, SA/QNI Roll of QNs

The issue of a wardrobe of distinctive uniform - predominantly light and dark blue in colour, edged with a plaited two-tone cord of the same colours - was symbolic of the status and function of QNs. A brassard and a badge bearing the Queen's monogram were adopted. The badge was struck in three metals: bronze for the rank and file QNs; silver for superintendents; and gold for distinguished service; it was worn round the neck on a two-tone blue ribbon or cord. The emblems remained unchanged until the QNI ceased to award them in 1968, but the style of the hat, dress and coat changed from time to time, within the limits of function and propriety, to fit in with contemporary fashion. Because the QN lived her private life as well as her professional life in the public domain, uniform for the QN was a symbol of an elitist sub-set of district nursing, and the means by which this special group created its identity and communicated its professional values.<sup>7</sup> Other important symbols were the black Gladstone nursing bag and the official name-plate, which distinguished the nurse's house and the Nurses' Home from other dwellings in the area.<sup>8</sup>

<sup>7</sup> Watkins, P, G, 'Women in the work force in non-traditional jobs', in Lester P. M. *Images that Injure: Pictorial Stereotypes in the Media* (London 1996), 69 – 85; Savage, J, *Nurses, Gender and Sexuality* (London 1987), 63 – 87.

<sup>8</sup> Pointon, G, retired Leicester QN. Interview (1998), recalled the outrage when new nameplates were issued with the designation 'District Nurse' and not 'Queen's Nurse'.



Following qualification, a QN was tied by an ‘agreement’ with the QNI to work for one year as a QN “where directed”. Failure to fulfil the agreement incurred a fine, which might be waived under special circumstances. The data suggests that QNs most frequently broke their agreement through home commitments, marriage or ill health, but occasionally they did so as an act of rebellion against the strict code of practice imposed by the QNI. Inspection and supervision were key principles of the QNI. They were the means by which the QNI’s boundaries and standards of practice were monitored - all QNs, regardless of rank, being inspected annually by a QNI Inspector.<sup>9</sup> A full assessment of the process is included in Chapter 6 but it is clear from the QNI database that there were two possible outcomes of this process: commendation and a recommendation for promotion, or censure and a decision to remove a nurse’s name from the Roll of the QNI. QNs employed by a non-affiliated district were suspended from membership and when they changed employment back to an approved area they were required to pay a re-entry fee. The evidence suggests that many chose not to do this but continued to practise under the designation of ‘Ex-QN’.

The research data comprises the records of a sub-set designated ‘QNs’, which represents only one facet of a complex movement collectively known as district nursing, as shown in the reproduction of Fox’s analysis at Table 2. Fox’s data shows that the district nursing community affiliated to the QNI was increasing in strength and numbers: QNs (column c) were one of the largest cohorts; the minimally trained Village Nurse Midwives (VNMW) (column d) formed a significant proportion of the workforce, and ‘other nurses’ (column e) covered all those who were not specifically trained as district nurses, including hospital trained nurses, whether State Registered (SRN) or State Enrolled (SEN), and other staff who were prepared to varying standards.<sup>10</sup> The growth of ‘other nurses’ is highly significant. The QN was the flagship of the QNI.

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<sup>9</sup> QNI Inspector, a paid officer with a QN qualification and a wide experience in district nursing.

<sup>10</sup> SRN and SEN see Chapter 3, others would include assistants without a nursing qualification.

**TABLE 2: DNA AFFILIATIONS: QNs AND NURSES IN POST (England and Wales) 1902 - 47.**

YEAR	DNAs:	CNAs:	QNs:	VNMW:	Others:	Totals:
	(a)	(b)	(c)	(d)	(e)	(columns c, d and e)
			%	%	%	
1902*	348	9				NA
1905	440	13				NA
1910	610	23	48.8	33.8	17.4	2677
1915	627	27	44.2	34.9	21.0	3531**
1920	715	36	28.5	51.5	18.9	4377
1925	738	42	31.0	51.4	17.7	5120
1930	865	43	35.7	50.1	14.2	5733
1935***	1038	46	42.1	45.6	12.3	6375
1940	1413	47	46.9	39.1	14.0	7122
1945	1603	49	49.3	38.2	12.5	6726
1947*	1731	50	46.1		53.9	7439

Key:  
\* First and last years for which figures are available  
\*\* Includes QNs on war work  
\*\*\* Possible influence of the (failed) 1934 Domiciliary Service (private member's) Bill.  
DNAs - District Nursing Associations  
CNAs - County Nursing Associations  
VN/MW - Village Nurses Midwives.  
Source: Fox, E, 'An honourable calling or a despised occupation. Licensed midwifery and its relationship with district nursing before 1948', *The Society for the Social History of Medicine*, 1981, 237 - 59, Table 1.

The research data has been analysed along three main themes: professional socialisation and education; careers and conflicts; and QNI welfarism within a culture of managerial accountability. Within each theme the tension between personal, parenting and professional obligations is reflected as an integral force that has both negative and positive effects along with other pressures on district nurses.<sup>11</sup>

**Professional socialisation and education**

The organising concept of professional socialisation is an amalgam of the explicit and implicit influences of the home, the school, the course leading to a professional qualification, and the workplace, in the building of a body of expertise. For QNs the end product of appropriate professional socialisation is responsive, proactive and flexible human capital, which is distinguished here from the mechanistic and reactive effect of indoctrination. In 1874, Mrs Dacre Craven (née Florence Lees), secretary to the Metropolitan and National Nursing Association (MNNA), appeared to be working on a basis consistent with this concept when she defined the unique range of responsibilities undertaken by the district nurse



and the attributes necessary for safe practice as ‘a higher education and higher grade of woman than for hospital nursing, or even hospital superintendent’, reinforced by ‘special training attributes for entry to district nursing’.<sup>12</sup> These criteria, publicly supported by Nightingale in 1876, became the benchmarks for admission to the QNI roll.<sup>13</sup> Rafferty, over one hundred years later, emphasises the ‘pivotal’ position of education in the development of professional expertise, culture and politics and as a ‘powerful vehicle’ for socialisation and the transmission of values.<sup>14</sup> Blane also accepts the concept of professional socialisation as a process through which knowledge and skills are acquired, and attitudes and values are inculcated.<sup>15</sup>

Until 1950 there is no mention in the data of any male QNs even though some types of nursing had become open to men, especially after 1919 when a supplementary part of the register was established by the General Nursing Council (GNC) for male nurses. It was not until after the Second World War that men could qualify as QNs and they always constituted a minority group - never more than 10%. Initially this was mainly because of reservations concerning unchaperoned male nurses attending patients within the isolation of their own homes, but later it resulted from self-selection, in that men were likely to be more attracted to the profession of medicine itself, or those professions ancillary to medicine. The effect of this predominantly female profession influenced the culture and practice of district nursing, because, as women, district nurses were expected to play a similar role in the professional domain as they did at home. The development of district nursing might have been different if men had been afforded equality of opportunity from the outset.

Blane regards selection as the first stage of professional socialisation, a process which turns a lay person into a member of a particular profession.<sup>16</sup> QNs were recruited from a wide range of educational backgrounds: for example, Mary Jones was brought up and educated in an orphanage; Alice Monroe attended a board school; Margaret Atkinson, a council elementary

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<sup>11</sup> Masson, M, *A Pictorial History of Nursing* (Twickenham 1985), 11.

<sup>12</sup> WIHM, WY 100, 1889, C89g, Craven, D, *A Guide to District Nurses and Home Nursing* (London 1890).

<sup>13</sup> Merry E. J and Irvén, I. D, *District Nursing* (London 1948), 33 - 4. Informal observation made by a retired QNI Inspector – “QNs were selected from the hospital Gold Medallists” – the highest accolade awarded by a hospital to a nurse on completion of her training for exemplary behaviour and excellence in theory and practice.

<sup>14</sup> Rafferty, A. M. *The Politics of Nursing Knowledge* (London 1996), Introduction.

<sup>15</sup> Blane, D, ‘Health professions’, in Scambler, G, ed., *Sociology as applied to Medicine* (London 1991), 221 – 35.

<sup>16</sup> Blane, ‘Health professions’ 221 - 35.



school and later a grammar school; Daisy Black, Cheltenham Ladies College; and Jean Fraser, an Edinburgh preparatory school, followed by Melrose Academy and university.<sup>17</sup> It is evident from the figures (Table 3), however, that increasing numbers were drawn from a grammar school and university background from 1940 onwards. Ambitious nursing reformers

**TABLE 3: QNS - TYPE OF EDUCATION - SELECTED YEARS 1910 - 68**

YEAR of QNI enrolment and number:	1910 N = 312	1920 N = 377	1930 N = 439	1940 N = 497	1950 N = 589	1960 N = 630	1968 N = 711
TYPE:	%	%	%	%	%	%	%
University	0.0	0.0	0.0	0.4	0.3	0.3	0.3
College/Institute	6.4	4.5	5.9	7.3	4.6	3.5	5.6
Grammar	20.5	24.1	21.4	29.8	33.3	36.5	30.5
Religious/Charity	13.1	16.2	18.2	15.7	12.2	9.8	9.7
Private	24.4	15.6	5.5	3.0	1.9	1.4	0.8
Elementary	24.4	35.8	44.9	42.9	36.0	24.3	22.9
Other	0.6	0.5	0.0	0.0	4.4	0.5	2.1
NK	10.6	3.2	4.1	1.0	7.3	23.7	7.9
Missing records	0.0	0.0	0.0	0.0	0.0	0.0	20.1
TOTAL	100.0	100.0	100.0	100.2	100.0	100.0	100.0

Source: See Appendix 1.

reformers, by attracting educated women into nursing, sought firstly to raise the status of nursing, secondly to improve the standard of nursing care, and thirdly to prise the control of nursing from the traditional medical and administrative strongholds – a struggle that can be observed in the Leicester district nursing service (see Chapter 6).<sup>18</sup> The consistent though small percentage of people who proceeded to University from 1940 onwards was undoubtedly due to changes in education policy, and attitudes towards women’s work and social status. By contrast, the academic level of those recruited from religious and private sectors, which included private tutors, governesses, and establishments supported by endowments, was generally non-quantifiable, and the decline in this form of education reflects the shift towards an expanding state provision. Elementary type education was received by one third to one quarter of the sub-set, peaking in 1930 when almost half of QNs who enrolled were educated at that level. The significance of this trend was arguably associated with the critical shortage of nurses in the 1930s. The crisis was accompanied by concerns about the calibre of probationers entering nursing, though only in 1962 did the GNC

<sup>17</sup> These and other references to individuals are drawn from the QNI data base unless otherwise noted.  
<sup>18</sup> Simnett, A, ‘The pursuit of respectability: women and the nursing profession, 1860 – 1900’, in White, Political Issues in Nursing, Vol. 2, 1 – 24.



set a minimum educational level of entry to nurse training, based on school leaving qualifications or an entrance test in literacy, numeracy and comprehension. The changes were largely welcomed by the profession and clearly led to a significant reduction in the recruitment of people who had left school without qualifications (see Table 4).<sup>19</sup> There was a tension, however, between service managers and professionally motivated nurses which undoubtedly lay at the heart of the struggles to raise the status of nursing, as attested by the conflict surrounding nurse registration and the internal disunity in district nursing examined in Chapter 3.

TABLE 4: QNs - SCHOOL LEAVING AWARDS 1960 and 1968

YEAR of QNI enrolment and number:	1960 N = 630	1968 N = 711
AWARDS:	%	%
<b>Higher Level:-</b>	5.1	6.9
Higher School Certificate		
GCE A Level		
Senior Cambridge Certificate		
Matriculation		
<b>Ordinary School Certificate:-</b>	23.7	26.6
School Certificate		
GCE O Level		
Royal Society of Arts (RSA)		
Junior Cambridge Certificate		
<b>Local Certificates:-</b>	5.9	9.8
Primary/National		
Commercial		
Intermediate		
<b>Vocational</b>	0.3	0.7
<b>Other</b>	0.0	0.4
<b>None</b>	50.9	33.1
<b>NK</b>	1.3	2.3
<b>Records missing</b>	2.8	20.3
<b>TOTAL</b>	100.0	100.0

Source: See Appendix 1.

The academic ability of QNs is also evidenced by the range of language abilities shown (Table 5), although, bearing in mind the presence of overseas recruits to QN (see Tables 9 and 14), the ‘foreign’ language could arguably have been the mother tongue and English the second language.

<sup>19</sup> Bendall E. R. D and Raybould, E, *History of the General Nursing Council for England and Wales (GNC) 1919 – 1969* (London 1969), 108 – 9.

**TABLE 5: QNs - LANGUAGE SKILLS - SELECTED YEARS 1910 - 68**

YEAR of QN enrolment and number:	1910 N = 312	1920 N = 377	1930 N = 439	1940 N = 497	1950 N = 589	1960 N = 630	1968 N = 711
LANGUAGE:	%	%	%	%	%	%	%
Dutch	1.3	0.3	0.5	0.0	0.3	0.6	0.3
French	11.9	4.8	5.0	8.5	12.4	11.6	13.8
Gaelic, Irish, Welsh	7.1	5.8	5.0	9.7	7.1	4.4	2.5
German	3.2	1.1	0.2	1.0	2.2	2.7	2.3
Italian	0.3	0.0	0.5	0.0	1.0	0.2	0.0
Latin, Hebrew	0.3	0.3	0.2	0.2	1.4	0.2	1.0
Spanish	0.0	0.0	0.0	1.0	0.2	1.0	1.1
Other	0.3	0.3	0.5	0.2	1.7	2.7	3.2

Source: See Appendix 1

The findings of this research concur with Abel-Smith's comparative study of the differences in educational attainment between nurses, teachers and shorthand typists and secretaries, in that nursing in general was not only recruiting from 'better-educated women but a higher proportion of such women'.<sup>20</sup>

Hockey, in her study of district nursing in 1966, also raised questions about the disparity between the lack of educational qualifications and the significant number of nurses who attended grammar schools.<sup>21</sup> Hockey's hypothesis that a large number of nurses did not finish their education due to family or financial difficulties is supported by the extensive data drawn from QNI records, although her conclusions were drawn from a disparate group of nurses, both those with and those without a district nursing qualification.

The 'class' of women from which QNs were recruited was significant. As self-reliant practitioners, isolated from their peers in domestic settings, they needed to be accurate in observation, documentation and decision-making, to negotiate their position in the home and community networks, to relate to other agents as equals, to function within an extended nursing role, and to be the eyes and the ears of the doctor.<sup>22</sup> A brief look at the qualitative data provided by the QNI Inspectors' annual appraisal of QNs supports this conclusion, but further research would provide a fuller picture.<sup>23</sup> Social class had a positive correlation with

<sup>20</sup> Abel-Smith, B, *A History of the Nursing Profession* (London 1977), 266 – 9.

<sup>21</sup> Hockey, L, *Feeling the Pulse* (London 1966), 32.

<sup>22</sup> Nightingale, F, Letter to The Times 14 April 1876, cited in Baly, M. E, *A History of the Queen's Nursing Institute (QNI) 1887 – 1987* (London 1987); Cohen, S, 'Miss Loane, Florence Nightingale, and district nursing in late Victorian Britain', *Nursing History Review*, 1997, 83 – 103; Oral histories and personal testimonies of Leicester district nurses analysed as part of this research confirm this definition and expectation of the district nurse.

<sup>23</sup> Source Appendix 1.



the level of educational background, academic achievement and social competence. In accordance with established practice, the occupation of the QN’s father was used as an indicator of social class and occupations were categorised with reference to the General Register Office Classifications (see Table 6).<sup>24</sup>

**TABLE 6: QNs - SOCIAL CLASS - SELECTED YEARS 1910 - 50**

YEAR of QNI enrolment:	1910 N = 312	1920 N = 377	1930 N = 439	1940 N = 497	1950 N = 589
	%	%	%	%	%
SOCIAL CLASSIFICATION:					
Professional	9.6	5.3	3.2	2.8	5.4
Intermediate	59.3	57.8	51.9	54.4	42.4
Skilled	28.2	32.9	39.2	31.5	21.9
Partly Skilled	1.3	3.2	3.9	8.1	3.4
Unskilled	0.0	0.0	0.7	0.6	0.5
No occupation	1.6	0.0	0.0	0.0	0.0
NK, deceased, retired	0.0	0.8	1.1	2.8	26.3
TOTAL	100.0	100.0	100.0	100.0	100.0

Categories based on the Classifications of Occupations, *The General Register Office* (London 1951)  
Source: See Appendix 1.

QNs were predominately drawn from upper and middle class backgrounds, whilst, in contrast, Simnett’s comparative study of nursing student recruits at two contrasting institutions revealed that in the twentieth century ‘nursing was not such a solidly middle class occupation’.<sup>25</sup> The influence of social class, in which values and attitudes were frequently informally caught rather than formally taught, made an important contribution to district nursing, and the middle class women’s commitment to service and their powers of command were the cornerstone of Queen’s Nursing. The observed increasing diversity of fathers’ occupations merits further investigation in relation to Levine’s typography of social stratification referred to in Chapter 3. The inclusion of the father’s occupation in the QN’s personal record was discontinued after 1950 when married women began to be admitted to the profession and information about fathers became inappropriate. Hockey’s 1966 study, however, gave an added dimension to the social class of district nurses insofar as the social class of the husbands of district nurses suggested a similar distribution (see Table 7).

<sup>24</sup> General Register Office, *Census for England and Wales 1951; Classifications of Occupations* (London 1951), Introduction.  
<sup>25</sup> Simnett, ‘The pursuit of respectability’.

TABLE 7: DISTRICT NURSES’ SOCIAL CLASS 1960s

SOCIAL CLASSIFICATION:	DISTRICT NURSE SAMPLE (N = 87)      %	PROFESSIONS/OCCUPATIONS:
1	6.9	Judge, clergy, university lecturer, Surveyor, solicitor, chemist.
2	73.0	Nurses, civil service, police
3	16.0	Stonemason, silversmith, Carpenter, builder
4	2.3	Coal miner, painter sprayer
5	2.3	Iron and steel workers.

Source: Hockey, L, *Feeling the Pulse* (London 1966), 31, Table 31.

Religious affiliations made a particular contribution by accustoming nurses to the integration of caring and ministry. Arguably, religious affiliation was also a factor associated with the father’s occupation and therefore reinforced social class values and beliefs, particularly with the growth of non-conformism and its attraction for the new self-made middle class (see Chapter 3). The distribution of religious allegiance reflects Perkin’s description of religious society as a sandwich, with the Anglican and Roman Catholic churches representing the top and bottom layers and the non-conformists the filling (see Table 8).<sup>26</sup>

TABLE 8: QNs – RELIGIOUS AFFILIATION - SELECTED YEARS 1910 - 68

YEAR of QNI enrolment and number:	1910 N = 312	1920 N = 377	1930 N = 439	1940 N = 497	1950 N = 589	1960 N = 630	1968 N = 711
	%	%	%	%	%	%	%
DENOMINATIONS:							
Anglican communion	55.8	52.0	58.1	56.5	52.3	54.3	50.8
Roman Catholic	12.5	11.9	14.8	13.7	14.6	16.5	18.6
Non Conformist	31.1	35.8	26.9	26.8	28.7	23.8	12.1
Other Faiths	0.6	0.3	0.2	0.6	2.5	1.3	0.8
No Religion	0.0	0.0	0.0	0.2	0.2	0.0	0.4
NK	0.0	0.0	0.0	2.2	1.7	4.1	17.3
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Classified in consultation with clergy of the Anglican and non-conformist denominations.  
Source: See Appendix 1

The categorisation of some forty-six different religious affiliations was a challenge that was not exclusive to this study. A similarly complicated structure devised by the QNI Council was allegedly abandoned in favour of the simple classification of ‘Protestant’ or ‘Roman Catholic’ but the records suggest that this change of policy was not implemented.<sup>27</sup>

<sup>26</sup> Perkin, H. *The Origins of Modern English Society 1780-1880* (London 1969), 33 – 4.  
<sup>27</sup> Stocks, *100 Years of District Nursing*, 85 – 6.



Throughout women’s history and its association with charitable endeavours there has existed a strong affinity between vocationalism and the ministry of the church (see Chapter 2). Bradshaw argued that nurses were perceived by the public in a special way as ‘quasi-religious’ and held in high esteem because nursing was not regarded as ‘a job’.<sup>28</sup> Even in the 1960s, one study to which Bradshaw referred reflected the findings summarised at Table 8 above, namely that comparatively few nurses admitted to being without religious affiliation. Religion was arguably one of the factors that determined the type of education experienced by QNs, with between 10% and 18% having attended a convent, charity, or church supported institution (see Table 3). Religion, in many instances, was also culturally based, in that it was associated with the individual’s country of origin; for instance, the highest proportion of the convent-educated QNs came from Ireland, and other religions gained prominence from the 1950s onwards, as society became increasingly multicultural.

The country of origin and/or nationality was an aspect of personal identity that the QNI recorded from the 1960s, when the influx of people recruited from overseas to work in the health service reached considerable proportions (see Table 9). The long-standing role of the

**TABLE 9: QNs COUNTRY OF ORIGIN/NATIONALITY 1960 AND 1968**

YEAR and NUMBER of QNI enrolments:	1960 N = 630	1968 N = 711
	%	%
COUNTRY/NATIONALITY		
Great Britain/British	82.4	77.4
Irish	4.8	6.9
European	2.2	1.4
Caribbean	5.4	2.8
Africa	3.8	2.5
Far East	1.1	1.8
Australia/New Zealand	0.5	0.4
North/South America	0.3	0.4
NK	0.2	0.6
Missing records	0.0	5.8
TOTAL	100.8	100.0

Source: See Appendix 1.

QNI as part of a two-way international community and its strong links with the Commonwealth inevitably influenced custom and practice in district nursing. Most QNs were born in Britain or in Commonwealth countries and were therefore designated British by

<sup>28</sup> Bradshaw, A, *The Nurse Apprentice 1860 - 1977*, 197, 233 – 4.

country of origin. The two categories are not necessarily compatible in terms of the socialising effect of culture, but the data provides an impression of the rich mixture of the background of QNs.

Hockey’s survey of 685 candidates undertaking district nurse training in 1962 – 3, however, showed that on average overseas students achieved a lower standard in the QNI examinations than the UK student; she speculated that this was due to language difficulties and the complexity of UK legislation.<sup>29</sup> Another possible reason for lower standards was identified by Shkimba and Flynn who found that home-sickness and culture shock had a severe effect on trainee-nurses coming from the Caribbean.<sup>30</sup>

In terms of experience and training, the period between the end of school and entry to nurse training was spent in a variety of ways. As can be seen from Table 10, prior to hospital

**TABLE 10: QNs PRE-NURSING EMPLOYMENT - SELECTED YEARS 1910 - 68**

YEAR of QNI enrolment::	1910 N = 312	1920 N = 377	1930 N = 439	1940 N = 497	1950 N = 589	1960 N = 630	1968 N = 711
TYPE OF EMPLOYMENT:							
Actor/Artist/Author/Photographer/Student	1.3	0.3	1.1	2.0	2.9	5.7	6.2
Agriculture/Horticulture	0.0	0.3	0.0	0.4	0.5	1.1	0.8
At Home'/Companion/Housekeeper/Matron	4.2	1.9	1.8	1.4	1.5	2.1	1.1
Civil Service/Banking/Business Proprietor	1.3	0.5	0.2	0.2	0.8	1.7	1.4
Domestic/ Chauffeur/Porter/Ambulance Driver	0.6	1.1	1.4	0.2	1.0	1.4	0.4
Dressmaker/Milliner/Embroiderer	2.9	3.2	3.4	2.2	0.8	1.1	0.6
Factory/Bakery/Laundry/Laboratory	1.3	1.3	1.8	1.8	2.5	4.0	3.0
H M Forces	0.0	0.0	0.0	0.0	3.6	1.6	1.8
Governess/Nannie/Nursery/Children's Nurse	7.7	6.1	3.4	4.0	3.1	7.5	3.5
Hairdresser/Beautician/other trades	0.0	0.0	0.0	0.2	0.5	0.5	0.6
Law/Medicine/Pharmacy/Veterinary/Church	1.0	0.8	0.9	0.4	1.4	2.9	1.8
Nursing (trained) including MW/HV/DN	0.3	0.0	0.0	0.4	6.6	0.1	0.4
Nursing cadet/probationer/attendants/orderly	1.3	0.8	0.0	0.4	1.2	3.7	1.4
Office/book keeping/telephony	4.5	4.5	8.7	12.5	14.8	19.4	20.3
Retail/Service Industry	2.9	2.1	5.2	5.2	4.6	5.4	6.3
Social Worker/Sick visitor/ VAD/VSO	0.0	0.3	0.1	0.2	1.0	0.5	0.1
Teaching/Library	5.1	5.3	3.2	1.0	2.0	1.9	2.5
None	65.7	71.6	68.8	67.0	50.4	39.2	45.1
NK	0.0	0.0	0.0	0.6	0.8	0.2	2.7
TOTALS	100.0	100.1	100.0	100.1	100.0	100.0	100.0

Source: See Appendix 1.

<sup>29</sup> Hockey, L, ‘QNI Survey of District Nurse Training in England and Wales 1962 –3’ (Unpublished 1964), 22.

<sup>30</sup> Shkimba, M, and Flynn, K, ‘In England we did nursing’. Caribbean and British nurses in Great Britain and Canada, 1950-1970’, Mortimer, B and McCann, S, eds., *New Directions in the History of Nursing* (London 2005), 141- 150.



training a high percentage of recruits stayed at home participating in domestic routines and family businesses - a trend that changed considerably over the years. Others were engaged in a variety of forms of employment either from choice or, in some instances, as a substitute for nursing because of its negative image of hard work, menial tasks and self-denial.<sup>31</sup> The status of pre-nursing occupations reflected a similar picture to that of the upper and middle class origins of the fathers of QNs. Women’s work, and to some extent men’s too, began to operate within a more flexible mode which created new opportunities, choice, and fulfilment, with the potential to re-vitalise nursing by replacing the stranglehold of apprenticeship, control and ritual by reasoning and principle – the essential ingredients of district nursing.<sup>32</sup> An interesting feature of Table 10 is the range of work experience undertaken by some people prior to nurse training. The quality of these posts as opportunities for learning and personal development was variable; certainly hospitals and other caring environments were popular venues in which nurses acquired and transferred practical skills and knowledge, but it was often through a process of repetition rather than progression. Cadet and probationer schemes helped to bridge the gap for early school leavers between school and entry to nurse-training, and by the 1930s many schemes were addressing the educational gap also through courses of further education. Table 11 examines this pattern more closely in relation to nursing posts

**TABLE 11: QNs PRE- NURSE TRAINING POSTS - SELECTED YEARS 1910 – 68**

TYPE OF NURSING EXPERIENCE:	Cadet (Pre nursing posts)	Hospital specialties - Training/service:	Other - Training/service:	Midwifery training - Training/service:	TOTAL %:	SAMPLE N = 3550
YEAR of QNI enrolment	%	%	%	%	%	No
1910	13.5	13.5	8.7	1.6	23.4	312
1920	0.0	6.9	4.8	2.9	11.7	377
1930	4.1	11.2	4.3	4.3	19.8	439
1940	13.9	12.5	2.6	0.6	29.0	497
1950	6.5	10.0	5.9	0.0	22.4	589
1960	14.8	5.1	2.1	0.5	21.9	630
1968	21.5	4.1	6.0	0.1	31.6	711

Source: See Appendix 1.

<sup>31</sup> Dickens, M, *One Pair of Feet* (Aylesbury 1942); Savage, *Nurses, Gender and Sexuality*, passim.; Simnett, ‘The pursuit of respectability’, in White, 1- 24

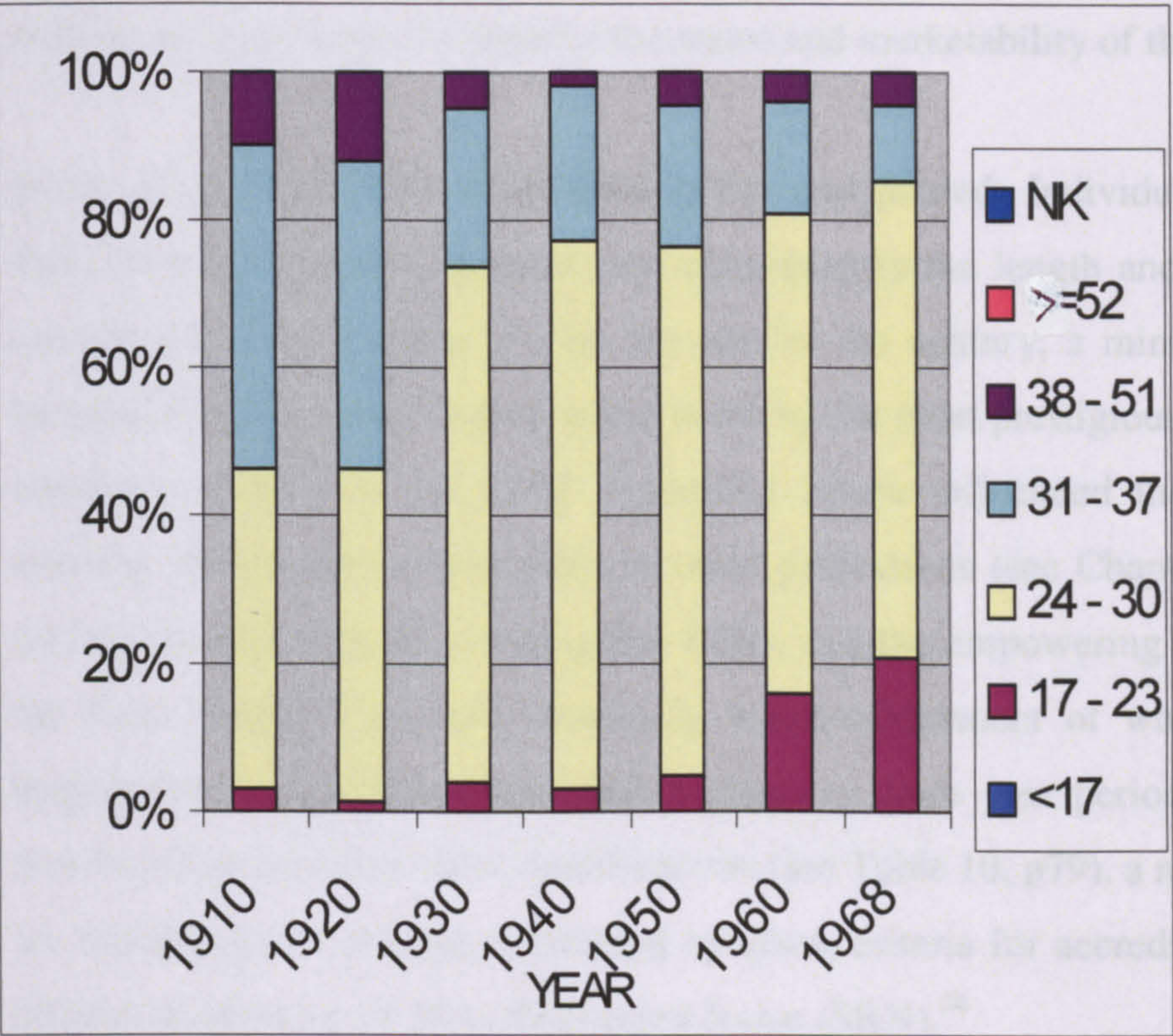
<sup>32</sup> Bradshaw, *The Nurse Apprentice*, passim; GNC, Research Unit, ‘Report on modular scheme of training’ (Unpublished 1976) following changes in the syllabus in the 1960s, it was reported that the twelve weeks ‘community’ option was least the popular option of four possible choices.



held prior to QN training. Specialist training was most commonly undertaken at fever hospitals, sanatoria and children’s hospitals where the age and level of education was frequently lower than for general training – a form of proving ground where many nurses continued to work after gaining their certificate.

Midwifery, with its independence from nursing and higher status following legislative controls in 1902, was an attractive option for women.<sup>33</sup> The position of midwifery is further illustrated by Figure 1, which shows that, whilst a few women undertook their midwifery training at a comparatively early age, the majority of women qualified following general nurse-training; joint courses were frequently offered by the QNI, with financial support and leave of absence (LOA) providing encouragement to district nurses to undertake midwifery-training (see Tables 26 and 27, and later discussion).

**FIG. 1: QNS AGE AT COMPLETION OF MIDWIFERY TRAINING  
SELECTED YEARS 1910 - 68**



Source: See Appendix 1.

The exclusion of men from midwifery was reviewed in the late 1960s and early 1970s in relation to their human rights and expectations of unrestricted career development and

<sup>33</sup> Donaldson, R. J and Donaldson, L. J, *Essential Community Medicine* (Lancaster 1984), 290 – the Midwives Act 1902 established the profession of Midwifery with protection to the title ‘Midwife’.



vocational fulfilment on merit rather than gender – a situation that was undoubtedly helped by anti-discriminatory legislation in the form of the Sex Discrimination Act (1965).

Hospital training in general nursing was, however, the first stage in the process of professional socialisation and the acquisition of knowledge and skills for use in domestic settings. It was a stage in which Florence Lees had little faith at the time.<sup>34</sup> Hospital training was often seen as too autocratic, ritualistic and lacking in the scientific basis for the practice of district nursing. Nevertheless, it provided easy access to an appropriate environment for the attainment of practical skills and routines, albeit overshadowed by the priority given to medical education and research. For some QNs, entry to general nurse training resulted in a positive experience of professional socialisation, but for others the process was one of simple indoctrination. A perpetual student population was a bonus for the service-providers because it gave a stable pool of cheap labour from which to staff hospitals and resource other clinical areas. Meanwhile, the chasing of qualifications and the 'touristy' pattern of employment arguably offered QNs an escape from professional responsibility as well as an opportunity to improve the status and marketability of their nursing skills.<sup>35</sup>

In the nineteenth century nurse training was unregulated. Individual hospitals trained to meet their own specific requirements, and consequently the length and quality of training varied considerably (see Chapter 5). By the turn of the century, a minimum period of two years hospital training was accepted as the norm by the most prestigious hospitals, and became the standard of entry to the QNI. Numerous forces influenced the general development of nursing: the changes taking place in other professions (see Chapter 3); pressure from nurse reformers (including the *avant-garde* QNI); and the empowering political climate following the First World War, with increasing acknowledgement of women's rights. The Nurses Registration Act (1919) established a statutory three year period of general training, with remission for previous nurse qualifications (see Table 10, p79), a minimum age of twenty one for registration as a nurse, a national syllabus, criteria for accreditation/registration, and the official designation of State Registered Nurse (SRN).<sup>36</sup>

<sup>34</sup> Baly, M. E, *A History of the Queen's Nursing Institute (QNI) 1887 – 1987* (London 1987), 13.

<sup>35</sup> Pape, R, 'Touristry: a type of occupational mobility', in Dingwall, R and McIntosh, J, *Readings in the Sociology of Nursing* (London 1978), 53 – 66.

<sup>36</sup> Bendal and Raybould, *GNC*, passim - even after implementation of the Act some hospitals were accepting girls as young as fifteen and a half years. Bendall claimed that the Admiralty refused the GNC permission to use RN as the intended official abbreviation.

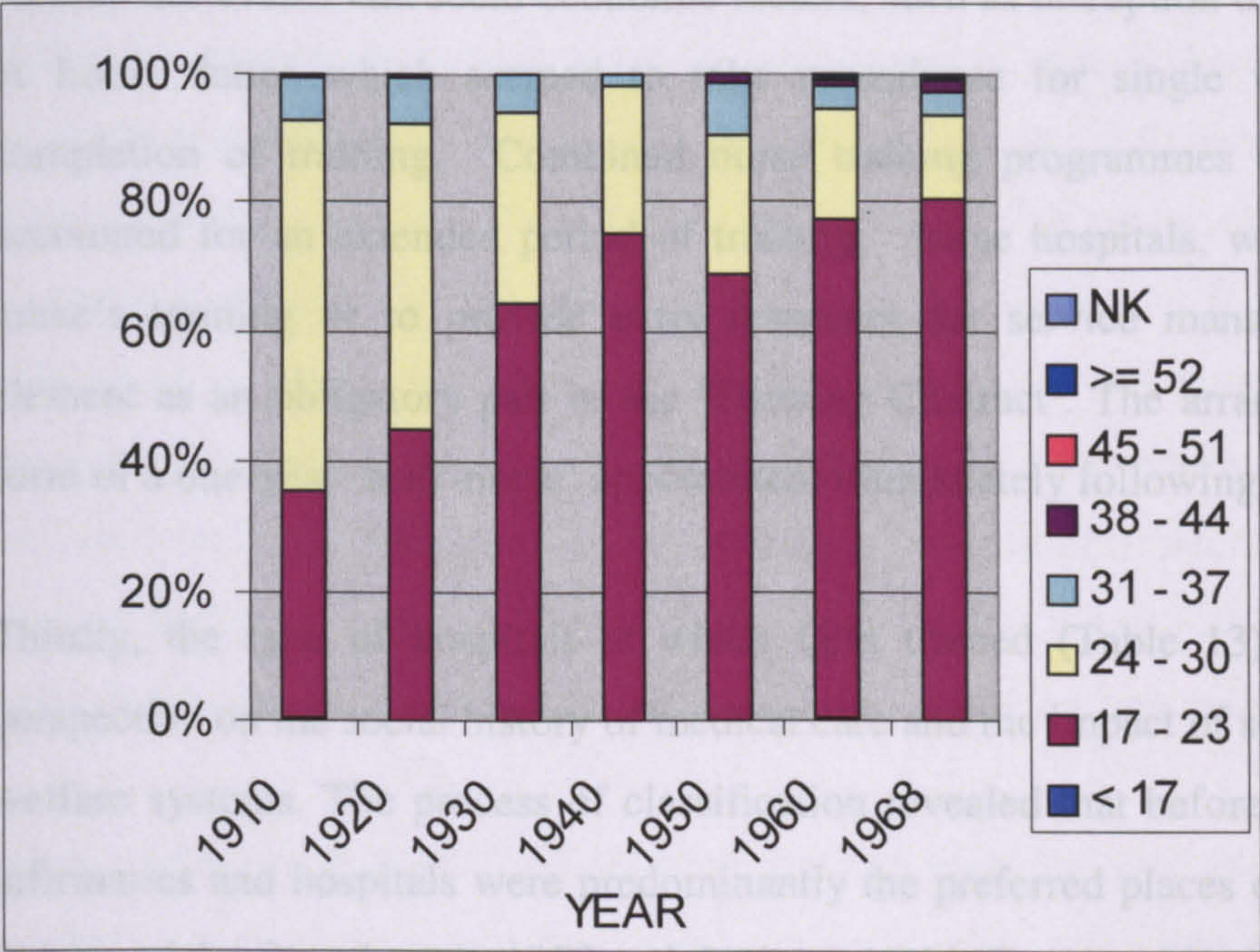


Three aspects of nurse training will be examined in relation to the professional socialisation of QN: the age of entry to general training; the length of hospital training; and the type of hospital in which training was undertaken.

FIGURE 2: QNs LENGTH OF GENERAL NURSE TRAINING - SELECTED YEARS

Firstly, the age of entry to hospital training (Figure 2) was closely related to pre-nursing experience and type of education in that most people either progressed direct from school into nursing or chose to follow a more circuitous route via an alternative career. Women between the ages of 17 and 23 provided the main source of recruitment, but in the 1950s an increase in the number of entrants from older age groups can be observed. Abel-Smith noted similar trends in England and Wales.<sup>37</sup> The increase in entrants from the older age groups was a trend influenced by second career people such as ex-service personnel and those who changed to nursing from commerce, teaching and other occupations (see Table 10, p79). Nursing was arguably increasing in respectability and able to withstand competition from other occupations.

**FIG 2: QNs AGE OF ENTRY TO GENERAL NURSE TRAINING - SELECTED YEARS 1910 - 68**



Source: See Appendix 1.

Secondly, the length of training (Table 12) suggests that a small but increasing minority of QNs completed less than the statutory three years general nurse training for a variety of

<sup>37</sup> Abel-Smith, *History of Nursing*, 264, Table 13.



reasons, including the unregulated pre-1919 conditions, eligibility for remission on account of previous training, and the one year post-Second World War intensive short course for men

**TABLE 12 : QNs LENGTH OF GENERAL NURSE TRAINING - SELECTED YEARS 1910 – 68**

Year of QNI Enrolment:	Years of nurse training:				NK %	N =
	<3 %	3 < 5 %	5 < 7 %	<= 7 %		
1910	4.8	91.7	3.5	0.0	0.0	312
1920	0.5	94.4	4.8	0.3	0.0	377
1930	1.4	94.8	3.4	0.5	0.0	439
1940	1.0	97.8	1.2	0.0	0.0	496
1950	9.0	88.3	2.5	0.0	0.0	589
1960	8.3	88.3	3.5	0.0	0.0	630
1968	6.9	88.6	1.3	0.4	2.8	711

Source: See Appendix 1.

with service nursing experience. By contrast a number of QNs exceeded the minimum three year training requirement. The data indicates that, in some circumstances, this was due to various life events and socio-economic factors, such as disruption of training due to ill health or home duties which seemed to take precedence for single women and delayed the completion of training. Combined nurse training programmes and degree courses also accounted for an extended period of training. Some hospitals, whether to consolidate the nurse’s training or to provide extra resources for service managers, imposed a service element as an obligatory part of the ‘Training Contract’. The arrangement usually took the form of a one-year ‘staff-nurse’ appointment immediately following qualification.

Thirdly, the type of hospitals at which QNs trained (Table 13) reflected an interesting perspective on the social history of medical care and the impact of social policy on health and welfare systems. The process of classification revealed that before 1930 the elite voluntary infirmaries and hospitals were predominantly the preferred places of training. Following the demise of the Poor Law in 1929 and the increased influence of local authority developments, the general municipal hospitals assumed greater importance in the training of nurses. In the early days too, the workhouse and ‘Union’ institutions had played a small but significant part in the training of nurses, but after 1930 they gradually disappeared. In addition, military hospitals provided a training resource from the end of the Second World War as more women were attracted to the services.

TABLE 13: NURSE TRAINING OF QNS – TYPE OF HOSPITAL - SELECTED YEARS 1910 – 68

YEAR and NUMBER of QNI enrolments:	1910 n = 312	1920 n =377	1930 n = 439	1940 n = 496	1950 n = 589	1960 n = 625	1968 n = 711
TYPE OF HOSPITAL:	%	%	%	%	%	%	%
General/Infirmary	94.6	98.2	95.0	95.2	97.5	92.1	92.1
Workhouse/Union	2.9	3.7	2.7	0.0	0.2	0.0	0.0
Combined General/Specialist	2.6	2.7	2.3	3.6	1.5	1.1	1.3
Religious	0.0	0.0	0.0	1.2	0.7	0.5	0.1
Military	0.0	0.0	0.0	0.0	0.2	1.1	2.4
Schools of Nursing	0.0	0.0	0.0	0.0	0.0	0.2	2.7
Higher Ed: Degree/Integrated	0.0	0.0	0.0	0.0	0.0	0.0	1.4
TOTALS	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: See Appendix 1.

The practice of combining fever, tuberculosis, children’s and women’s specialities with general training seemed to peak during the Second World War – the relevance for QNs is more fully examined in connection with post registration experience as identified in Tables 17 and 18 to follow. The creation of Schools of Nursing in 1960 was a change introduced by the GNC to reduce the number of small ineffectual and uneconomic hospital-based training schools by replacing them with consortia centred on the School. This change provided a wider generic learning experience and a counterweight against parochialism and the influence of medical-institutional values, and thus had a positive influence on the development of district nursing - although there was a long way to go.<sup>38</sup> A period of intense academic interest in nursing emerged in the 1960s, particularly following the Robins Report into Higher Education in 1963, with its more inclusive philosophy and planned expansion.<sup>39</sup> Wilkie records the enthusiasm of Professor Brocklington of Manchester University in 1969 for a common academic focus across the medical and caring professions and for the benefits that accrued from an integrated degree course.<sup>40</sup> Thereafter a range of degree courses in nursing and relevant academic disciplines with a nursing option became widely accepted.

QN’s choice of location for both their general nurse training and midwifery training (see Tables 14 and 15) is of particular interest in terms of the elites and hierarchies in nursing, as

<sup>38</sup> Gott, M, *Learning Nursing* (London 1984).

<sup>39</sup> Wilkie, E, *The History of the Council for the Education and Training of Health Visitors* (CETHV) 1962 – 1975 (London 1979), 24 – 33.

<sup>40</sup> Wilkie, *CETHV*, 30.



TABLE 14: QNs GENERAL NURSE TRAINING - DISTRIBUTION OF HOSPITALS - SELECTED YEARS 1910 - 68

REGION:	South West/ Southern England	South East England/ Home Counties	London	East Anglia Suffolk	Middle England	North East England	North West England	Wales	Scotland	Eire	Northern Ireland	Overseas/HM Forces	NK	Total data set
YEAR of QNI Enrolment	%	%	%	%	%	%	%	%	%	%	%	%	%	N =
1910	5.8	3.2	29.2	0.0	8.3	5.1	19.2	0.0	16.3	4.8	6.1	1.9	0.0	312
1920	4.0	5.6	27.3	2.7	5.8	11.4	20.2	1.3	17.0	3.2	1.9	0.0	0.0	377
1930	4.8	3.4	18.5	1.4	10.9	17.3	19.1	2.3	17.3	2.1	1.8	1.1	0.0	439
1940	3.4	6.6	18.7	1.4	8.9	15.7	21.1	3.2	17.1	2.0	1.4	0.4	0.0	497
1950	6.6	11.2	15.3	2.2	11.0	12.4	15.8	2.0	18.5	1.2	2.0	1.5	0.2	589
1960	7.1	13.5	17.5	1.6	10.0	10.6	15.6	1.9	15.2	0.3	2.2	4.4	0.0	630
1968	5.5	11.1	20.5	3.2	9.1	10.1	12.2	2.3	19.8	0.4	2.0	3.0	0.7	711
TOTALS														3555

Source: see Appendix 1.

TABLE 15: QNs MIDWIFERY TRAINING - DISTRIBUTION OF CENTRES - SELECTED YEARS 1910 - 68

REGION:	South West/ Southern England	South East England/ Home Counties	London	East Anglia Suffolk	Middle England	North East England	North West England	Wales	Scotland	Eire	Northern Ireland	Overseas/HM Forces	NK	Total data set
YEAR of QNI enrolment	%	%	%	%	%	%	%	%	%	%	%	%	%	N =
1910	20.4	2.6	37.5	0.0	5.9	2.6	8.6	0.7	12.5	2.6	4.6	2.0	0.0	152
1920	23.2	3.2	17.7	0.5	9.1	6.4	10.5	0.5	19.1	4.5	0.5	0.0	5.0	220
1930	10.0	2.3	13.2	0.6	11.2	14.6	13.8	0.9	28.4	4.0	0.9	0.3	0.0	349
1940	5.5	3.8	16.8	1.0	13.3	10.5	16.3	2.0	26.3	2.5	1.3	0.3	0.5	399
1950	10.1	14.0	17.3	1.5	6.8	10.3	8.5	1.1	24.7	1.5	2.6	0.9	0.7	457
1960	5.2	14.6	20.3	0.9	7.5	7.1	10.7	0.0	26.0	0.7	2.1	1.8	0.2	439
1968	5.2	12.9	18.7	0.3	7.2	9.1	7.2	1.9	31.4	0.6	2.2	1.9	1.4	363
TOTALS														2379

Source: See Appendix 1.

well as of the politics of power and control. Three significant features can be identified: firstly the influence of the metropolis and the distinguished position of Scotland for midwifery training; secondly, the attractions of the southern environment; and thirdly, the continuing development of professional respectability and influence from the northern regions.

The final, and possibly most influential, pre-QN stage in the professional socialisation of a Queen’s Nurse was the wide variety of posts held and the range of responsibility experienced between qualifying as a SRN and undertaking the QN training (see Tables 16, 17 and 18). The QNI normally required a minimum of two years post-registration consolidation in general nursing for entry to QN training and, although between 1910 and 1930 this requirement was not always fulfilled (see Table 16), comparatively few nurses progressed immediately from general to QN training. Even in 1910 nearly two thirds of QN recruits had had some post-qualifying experience, and by 1968 less than 10% were without such experience; indeed, 18.5% had held 6 or more posts prior to QN training.

**TABLE 16: NUMBER OF NURSING POSTS PRIOR TO QN TRAINING - SELECTED YEARS 1910 – 68**

Year of QNI enrolment:	Posts held:						
	None %	1 < 3 %	3 < 6 %	6 < 9 %	> = 9%	NK %	TOTAL
1910	34.6	48.4	16.0	1.0	0.0	0.0	312
1920	24.1	59.2	14.9	1.9	0.0	0.0	377
1930	37.8	47.4	13.0	1.6	0.2	0.0	439
1940	14.1	50.1	31.9	3.0	0.6	0.2	496
1950	14.6	43.8	32.9	7.8	0.8	0.0	589
1960	5.9	39.7	0.4	12.1	3.0	0.0	630
1968	6.3	28.4	44.4	15.0	3.5	2.11	711

Source: See Appendix 1.

The diversity of skills and experience that the majority of nurses possessed on entry to QN training was remarkable (see Tables 17 and 18). Several features in particular stand out: the level and variety of posts held by nurses both at home and abroad; the contribution made by them within senior management; the high level of expertise required in clinical specialities; and the self-sufficiency shown in non-institutional settings.



TABLE 17: TYPE OF NURSING EXPERIENCE PRIOR TO QN TRAINING -  
SELECTED YEARS 1910 – 68

EXPERIENCE:	Staff nurse:	Ward sister	Matron:*	Specialist hospital – training/post:	Private	HMF:\$	Abroad:	Nursing home:	MW post/ training: ^	Other:	Sample
YEAR	%	%	%	%	%	%	%	%	%	%	N =
1910	5.4	2.9	1.6	29.2	1.3	1.0	2.6	9.3	26.9	0.0	312
1920	2.1	3.2	0.8	25.2	1.3	43.5	1.9	7.2	16.7	1.9	377
1930	5.0	3.2	0.7	25.1	16.2	0.7	1.4	12.1	41.2	0.0	439
1940	53.7	17.9	2.0	11.5	22.3	0.2	1.4	7.4	59.0	0.2	497
1950	51.6	22.9	2.4	10.2	7.5	6.5	2.9	4.6	95.1	0.0	589
1960	77.6	21.4	3.8	7.8	9.5	4.8	6.8	1.4	95.2	0.3	630
1968	73.8	25.3	4.1	6.2	12.2	2.1	6.9	1.4	42.5	1.5	711

Notes: \* Includes tutors and senior management posts  
\$ Does not include the service experience of military personnel as sick birth attendants, orderlies and other ancillary posts usually undertaken by servicemen of up to ten years plus.  
^ The Obstetrics Course was introduced in 1960 - 21.3% completed full MW training and 18.7% the Obstetric Course.  
Source: See Appendix 1.

Of special significance, however, were the number and type of community-based posts held prior to QN training, by far the highest percentage of which were in an untrained form of district nursing (see Table 18 column b). This growing trend after the Second World War only serves to underline the expedient nature of the response to the needs of the sick in the community, and the extent to which the district nursing role was misunderstood and undervalued. An increasing number of QNs had experience as HVs and in industrial settings; it is also clear that some nurses were beginning to show an interest in working in general practice (GP), thus becoming the fore-runners of practice nurses and anticipating the attachment of district nurses to GP practices.<sup>41</sup>

<sup>41</sup> Reedy, B, Metcalf, A, de Roumanie, M and Newell, D, ‘A comparison of the activities and opinions of attached and employed nurses in general practice’, *Journal of the Royal College of General Practitioners*, 30, 1998, 483 -89.



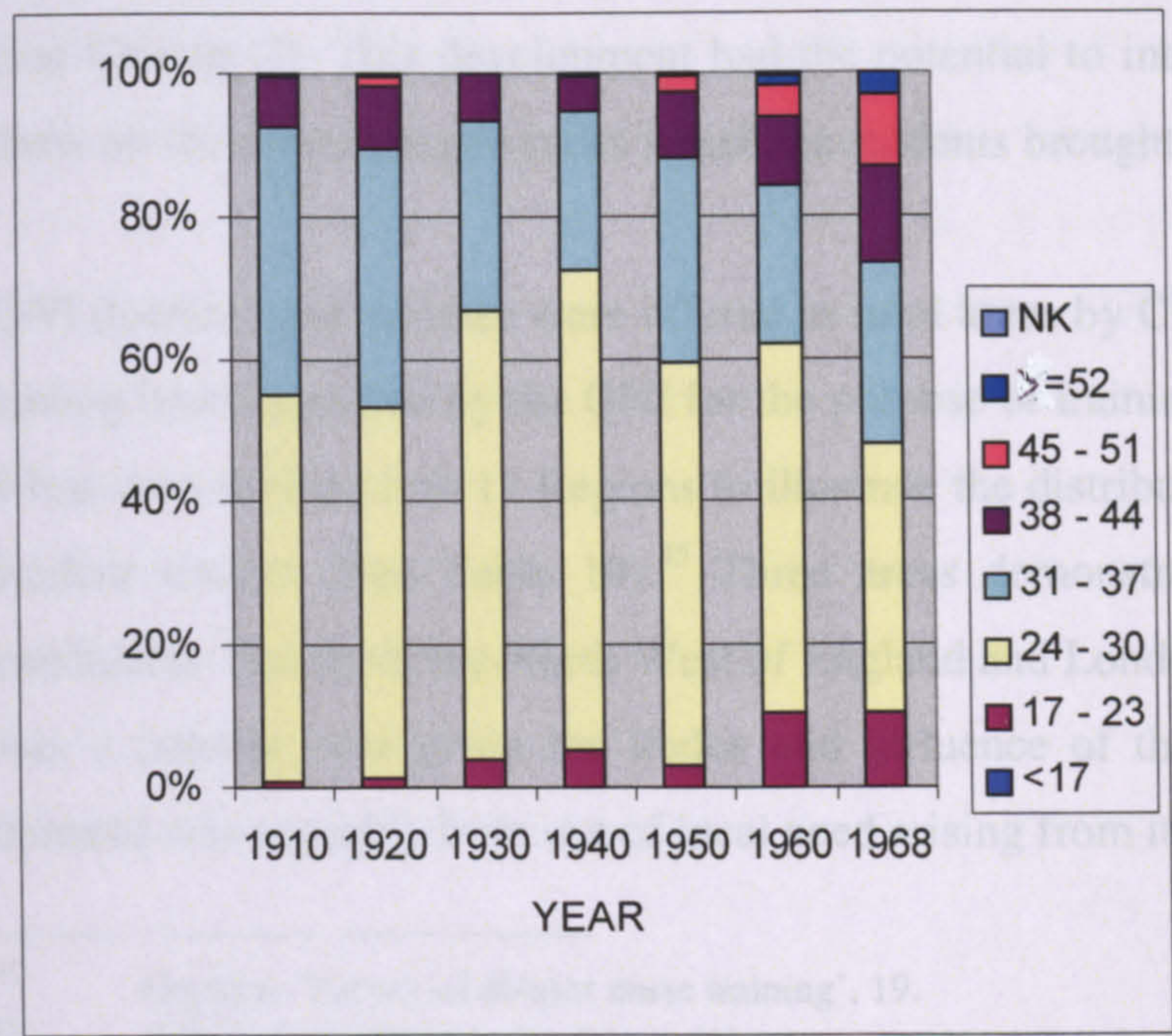
TABLE 18: RANGE OF COMMUNITY EXPERIENCE PRE-QN TRAINING

YEAR of QNI enrolment	a) HV post/ training:	b) District Nurse DN/MW VIN/MW:	c) Schools:	d) Clinic /surgery:	e) Industry:	f) Prison/ship:	g) Mental/ Geriatric Visitor:	% Tuberculosis/ Dispensary:	TOTALS:
	%	%	%	%	%	%	%	%	N =
1910	0.0	9.6	0.0	0.0	0.0	0.0	0.0	0.0	312
1920	0.3	8.2	0.3	0.0	0.0	0.3	0.5	0.5	377
1930	0.2	9.3	0.2	0.0	0.2	0.2	0.0	0.0	439
1940	0.2	10.9	0.2	0.2	0.2	0.2	0.0	0.0	497
1950	8.3	20.4	0.3	3.4	3.4	0.0	0.0	0.0	589
1960	14.1	30.3	0.5	0.2	3.7	0.0	0.0	0.0	630
1968	8.2	40.6	1.5	1.5	5.1	0.0	0.8	0.0	711

Source: See Appendix 1.

The most common age of entry to QN training was between 24 and 30 (see Figure3). From 1950, however, older recruits increased in numbers until in the 1960s they represented quite a

FIG. 3: AGE OF ENTRY TO QN TRAINING - SELECTED YEARS 1910 - 68



Source: see Appendix 1.



high proportion of the sub-set. This trend might have been due to the combined influence of the uncertainty surrounding the forthcoming withdrawal of the QNI from district nurse training, a desire to gain the prestigious QN status, and the pressure to qualify in anticipation of policy changes towards a mandatory qualification in district nursing (see Chapter 3). Hockey's 1962/3 survey also suggested that there were other factors: the reduction in the length of the course in the 1960s (see Chapters 3 and 7); the development of county schemes which allowed married nurses to train near to their home; and the secondment by many authorities to district nurse training on full salary.<sup>42</sup> Whatever the reason, this increase in older QNI candidates confirmed the number of district nurses who had been practising without training – an issue identified in the survey by Potter and Hockey from the comments made by nurses who wished they had received the benefit of the course much earlier in their careers.<sup>43</sup>

QN training, however, was not always viewed in a positive light. In the 1960s Hockey found that it was seen as 'too narrow' and 'divorced from the reality of the complexity of the work'.<sup>44</sup> District nurses who were qualified HV felt that the paucity of social science material disadvantaged candidates who possessed only the basic SRN qualification. The apparent limitations of the QNI syllabus were exacerbated by the short length of the course; and certainly by the QNI's concept of the course as an 'adaptation of hospital training', as opposed to preparation for a new sphere of practice. There was an increasing need for specially prepared teaching staff in the classroom and in the practice setting, and this evolved from the QNI's doctrine of supervision as the essence of standard setting and of safe practice (see Chapter 7). This development had the potential to integrate theory and practice, and to draw on the diverse experiences which the students brought to the course.

QNI district nurse courses were offered in rural areas by CNAs and in urban areas by DNAs, having been approved by the QNI for the purpose of training. The map included as Appendix 3 has been divided into 11 Regions to illustrate the distribution of QNI approved courses and student intakes (See Table 19).<sup>45</sup> Three areas demonstrate a consistently high intake of candidates: Scotland, the North West of England and London. It is not surprising that London was a popular area given the kudos and influence of the capital; in the North West, the demand was arguably born out of local need arising from its heavily populated conurbations,

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<sup>42</sup> Hockey, 'Survey of district nurse training', 19.

<sup>43</sup> Potter, D and Hockey, L, *District Nurses in England* (Edinburgh 1976).

<sup>44</sup> Hockey, *Feeling the Pulse*, 67 – 8.

<sup>45</sup> The map produced by the QNI also details to level of affiliation in 1949.



TABLE 19: QN STUDENTS INTAKE BY REGION – SELECTED YEARS 1910 - 68

YEARS:	INTAKE OF QN STUDENTS BY REGION:												TOTALS
	SouthWest / Southern England	South East England/ Home Counties	London	East Anglia/ Suffolk	East/West Midlands	North East England	North West England	Wales	Scotland	Eire - Dublin	Northern Ireland	Enrolled by special resolution	
	%	%	%	%	%	%	%	%	%	%	%	%	N =
1910	1.0	9.9	19.9	0.0	8.7	5.1	22.4	5.4	16.7	10.3	0.0	0.6	312
1920	2.7	10.1	15.4	0.5	8.0	9.8	17.8	3.7	24.7	5.6	0.0	1.9	377
1930	2.3	8.4	18.9	0.9	6.6	10.5	17.5	3.9	24.4	6.6	0.0	0.0	439
1940	2.2	12.7	16.9	0.2	9.3	13.7	16.7	4.4	19.1	3.2	1.6	0.0	497
1950	11.0	14.8	19.5	0.0	5.6	10.9	11.4	1.0	21.1	2.0	2.5	0.2	589
1960	7.0	17.1	22.4	0.0	8.6	10.2	12.9	1.0	14.4	1.6	1.9	0.0	630
1968	6.2	16.0	15.0	4.5	11.7	5.9	15.5	1.7	21.4	0.0	2.1	0.0	711

Reference: Mason, O, *The Gazetteer of England*, Vols. 1 and 2 (Newton Abbot 1972). Gelling, M, *Place-names in the Landscape* (London 1984), Introduction, Map of pre-1974 England, Wales and Southern Scotland.  
Merry and Irven, *District Nursing*, 19, Map of counties affiliated to the QNI pre-1974.

Source: See Appendix 1.

and reflected the north-south divide in which the ‘distribution of ill follows the contours of disadvantage’<sup>46</sup>; and in Scotland, intensive provision was made, with innovative practices based in Edinburgh and other major cities in response to the density of urban populations and the needs of scattered highland and island communities.<sup>47</sup>

The QNI regulated the location of courses and the number of places per district nurse training centre. The distribution of QN courses and the number of students in training is set out in Table 20 to compare the position in middle England; it would appear from the data that the same locations were popular for potential QNs undertaking both their general and their midwifery training (see Tables 14 and 15, p86). It can perhaps be deduced, therefore, that there is a link between the two. The varying picture of QNI influence in middle England was very interesting: Kettering, Nottingham and Coventry, being late investors in the QNI Affiliation scheme and training, clearly had no courses until the 1950s. Birmingham and Northampton initially had the largest share of the intake but Leicester and Worcester gradually made a more significant contribution. All courses were approved and regulated by the QNI for up to three intakes per annum . Leicester maintained an expanding training programme but, in the early days, as with several other centres, was approved to train only

<sup>46</sup> Graham, H, ed., *Understanding Health Inequalities* (Buckingham 2000), Introduction.  
<sup>47</sup> Gibb, P, ‘District nursing in the highlands and islands of Scotland: 1890 – 1940’, *History of Nursing Journal*, 4, 192/3, 319 –29.



TABLE 20: DISTRIBUTION OF QNI COURSES AND STUDENT ENROLMENT IN MIDDLE ENGLAND - SELECTED YEARS 1910 - 68

YEARS:	REGION							
	Birmingham	Coventry	Kettering	Leicester	Nottingham	Northampton	Worcester	TOTALS
	%	%	%	%	%	%	%	n = 302
1910	63.0	0.0	0.0	7.4	0.0	22.2	7.4	27
1920	76.7	0.0	0.0	3.3	0.0	6.7	13.3	30
1930	51.7	0.0	0.0	27.6	0.0	3.4	21.7	29
1940	52.2	0.0	0.0	23.9	0.0	2.0	21.7	46
1950	27.3	15.2	0.0	33.3	0.0	2.0	24.2	33
1960	42.6	11.1	0.0	22.2	16.7	0.0	7.4	54
1968	31.3	7.0	9.6	24.1	7.2	0.0	8.4	83

Source: See Appendix 1

two students per intake which raises questions about the cost and educational effectiveness of the QNI policy. Birmingham, with a higher intake, tended to decline not necessarily through a lack of commitment but as a consequence of the establishment of courses elsewhere and a reduction in Birmingham’s catchment area. Fluctuations in the economy, population structure, migratory processes and the way in which local authorities prioritised their resources also affected the rise and decline in admission rates.

Careers, commitments and conflicts

A number of factors seemed to influence a nurse’s choice of district nursing as a career: the holistic nature of the work involving the integration of basic and technical nursing; professional autonomy and clinical freedom in partnership with the domestic setting; family influences and friendships; and materialistic ambitions – a car, a house, a telephone and status within the community.<sup>48</sup> Perhaps the most telling comments about factors which

<sup>48</sup> McIntosh, J, B, *Work Study of District Nursing Staff* (Scottish Home and Health Department, Edinburgh 1976) Study 37; Bradshaw, *The Nurse Apprentice*, 117 – 22 examines the Royal College of Nursing’s misinterpretation of The Goddard Report (1953) as regrettable when in essence Goddard argued that basic and technical aspects of nursing were indivisible because the both evolved around the patient and preserved the ethos of nursing; Baly, M. E, *Nursing and Social Change* (Bath 1980), Appendix 1 examined the divided conclusions of the Wood Report (1947) when the Majority Report endorsed a



influenced student nurses towards the end of their general training were those reported by a hospital tutor: one student mentioned “the enormous opportunities of Queen’s”; another said, “In Queen’s there was more varied opportunity than any other profession of linking up human interest and service”; a third observed, “Health visiting was part of a machine, whereas in Queen’s you combined both district nursing and health visiting”.<sup>49</sup> The students’ views of the integration between health visiting and district nursing are endorsed by the work patterns of district nurses recorded by the QNI in 1910 (see Table 21).<sup>50</sup>

TABLE 21: QNI ANALYSIS OF DISTRICT NURSING WORK (1910)

REASON FOR VISIT:	% FREQUENCY: n = 312
Infant assessment	1.9
Infant welfare work	1.6
Mothers' clubs	2.2
Inspection of boarded out children (Child life protection)	1.6
School nursing inspections and follow-up	13.1
Tuberculosis and other notifiable diseases	14.1
Mental illness/Welfare visiting	1.9
Red Cross work/lecturing	7.1
Transfer of invalid soldiers from 'the front'	1.0
Talks on home nursing, hygiene, etc.	4.8

Source: see Appendix 1

Half a century later, Hockey’s study demonstrated the support given by a number of general practitioners (GPs) and district nurses for a combined district nurse/HV role – a position some district nurses would have accepted.<sup>51</sup>

By contrast, however, there were other problems affecting district nursing as an attractive career option. In 1919, the Federation of Metropolitan Nursing Associations expressed difficulty in attracting QNs who had recently returned from war service – the level of remuneration offered and competition from other areas of nursing were serious deterrents.<sup>52</sup> In 1920, the QNI Executive Committee heard that the unwillingness of QNs to practice midwifery was creating a serious shortage – 120 districts had vacancies with no immediate

division of labour in nursing by differentiating between technical and basic nursing – 30% of basic nursing was defined as ‘non-nursing’.

<sup>49</sup> WIHM, SA/QNI ‘Conference of Superintendents of Training Homes’, (1930), 8 – 10.

<sup>50</sup> Dingwall, Rafferty and Webster, *Social History of Nursing*, 198. The authors’ claim that denial of the overlap confused health visiting statistics because district nurses were doing HV work.

<sup>51</sup> Hockey, *Feeling the Pulse*, 130; Oral histories and personal testimonies of Leicester district nurses revealed contrasting views.



prospects of filling them.<sup>53</sup> The superintendents attending their annual conference in 1930 believed that rigid discipline, poor salaries, too little off-duty time and a dislike of possible confusion with 'county nurses' (VNMW) were factors that militated against a career in Queen's nursing.<sup>54</sup> By the 1960s, some district nurses and their superintendents were feeling undervalued and unable to fulfil the scope that their role offered, whilst others were enthusiastic about de-centralisation which gave greater autonomy to the QN and the closer working relationships with GPs.<sup>55</sup>

Friendship patterns which formed before or during nurse training can be traced throughout the data, as nurses moved together from general training and other hospital experiences to midwifery and eventually to district nursing, although the pattern was sometimes broken through marriage, illness, or home duties. For some nurses, the choice was like a 'blind date'. One nurse, for example, tells of her friend, a musician, for whom opportunities had arisen in Leicester: "I came with her knowing nothing about the place but saw district nursing as the answer because I would have a roof over my head, and so I stayed for over a quarter of a century".<sup>56</sup> Hockey's survey of candidates taking the 1962/3 district nursing course found that there were five significant factors which affected their choice of career: midwifery training (46%); general training (33%); the influence of a friend, relative, or district nurse acquaintance (6%); convenience (12%); predisposition – 'always had it in mind' (3%).<sup>57</sup>

From the perspective of women's history, however, district nursing gave single women the opportunity to experience life outside the confines of the parental home. They gained status through the possession of professional qualifications and developed as individuals in their own right, often to the highest level of the profession; they had the opportunity, unchaperoned, to travel extensively at home and abroad; they commanded prestige, were socially mobile and opened up a new marriage market – marriage partnerships between doctors and nurses combined professional and life skills, with a resulting benefit for the

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<sup>52</sup> WIHM, SA/QNI, Federation of Metropolitan Nursing Associations, General Committee Minutes 14 March 1919.

<sup>53</sup> WIHM, SA/QNI, QNI Executive Committee Minutes 19 May 1920. Miss Mearns, Leicester DNA spoke in support of improved remuneration; she also expressed doubts about the 'directed employment following training' which some QNs and the district found unsettling.

<sup>54</sup> WIHM, SA/QNI 'Conference of Superintendents of Training Homes', (1930), 8 – 10.

<sup>55</sup> Hockey, *Feeling the Pulse*, 66, 103, 111 – 2

<sup>56</sup> Pointon, G. Retired Leicester QN. Interview (1998)

<sup>57</sup> Hockey, 'Survey of district nurse training', 19 – 20.



practice population.<sup>58</sup> The perpetual shortage of district nurses and the availability of secure well-managed living accommodation and other amenities gave tremendous scope for freedom of movement and career development. In some cases changes in the location of QN posts seemed unrelated to promotion: for example, Mabel Andrews held 12 posts in 23 years within the SE and Midlands; Mary Thomas, 14 posts in 24 years - many in the northern region where she completed her general and QN training courses and in Leicester; Fiona Fraser, 12 posts throughout Scotland in 18 years; and Mary Tanks, 24 posts in 8 years. In others, however, there was clear progression: Frances Danvers followed a career in management from senior district nurse to assistant superintendent, and finally to superintendent; Dorothy James held four posts in 10 years beginning with a wide clinical experience, later becoming an HV and district nurse tutor, and finally a Department of Health and Social Security nursing officer with special responsibility for district nursing; Laura Singleton with 7 posts in 17 years, practised in London, Malta, Hampshire and the Midlands following a marked clinical career progression.

A systematic assessment of the number of years spent in district nursing after qualifying as a QN is shown at Table 22. The pattern shows varying degrees of commitment to the role of the QN and allegiance to the QNI and local associations. Prior to 1940, all newly trained QNs spent a period of consolidation in district nursing. A few were in post for less than one year, upon whom a penalty of a fine would have been imposed for breaking the QNI one year post-

**TABLE 22: LENGTH OF SERVICE IN QN AFTER QUALIFICATION - SELECTED YEARS 1910 - 68**

YEAR of QNI enrolment:	YEARS OF SERVICE:									TOTALS
	None*	< 1	1 < 2	2 < 5	5 < 8	8 < 12	12 < 25	>=25	nk	
	%	%	%	%	%	%	%	%	%	
1910	0.0	2.9	11.5	31.7	21.5	11.9	6.4	12.5	1.6	312
1920	0.0	4.0	14.6	31.8	16.2	10.6	18.3	2.1	2.4	377
1930	0.0	5.9	18.9	23.7	25.7	8.4	1.1	0.0	16.2	439
1940	0.4	3.0	23.7	22.7	14.9	8.7	11.5	10.7	4.4	497
1950	1.5	4.1	12.9	21.7	13.9	14.6	4.4	14.1	12.7	589
1960	0.0	8.6	19.8	11.6	0.2	0.0	0.0	7.5	52.4	630

Note: 1968 record format changed and this information is not available  
\* Includes nurses who did not enrol for various reasons or returned to their own country following Enrolment e.g. nurses from Greece whose training was supported under American/French War Relief.

Source: See Appendix 1

<sup>58</sup> Loudon, I. S. L, *Medical Care and the General Practitioner* (Oxford 1985).



qualifying training contract, but the majority of nurses demonstrated a commitment of between 2 and 7 years to district nursing. Thereafter the numbers continuing in district nursing gradually declined until the 25 year mark when the QNI Long Service Badge was awarded at an impressive ceremony held in one of the royal palaces – a practice that continued until candidates eligible from the last intake in 1968 had completed 25 years. Service was not always continuous, however, and a fuller assessment of the disruptions is presented as part of a later discussion.

The majority of QNs spent most of their district nursing career in clinical practice either in single roles or in posts combined with midwifery, health visiting, or school nursing, but some enjoyed a wide and varied career (see Table 23).

**TABLE 23: TYPE OF DISTRICT NURSING POSTS AFTER QUALIFYING AS QN – SELECTED YEARS 1910 - 1968**

Years:	None:\$	DN:	MW DN/MW:	HV/ Combined:	Emergency:	School/DN:	Ass Sup:	Superintendent*	Inspector:**			Special assignments: ***	NK	TOTAL:
									QNI:	MW:	Other:			
	%	%	%	%	%	%	%	%	%	%	%	%	%	N =
1910	1.0	96.8	4.5	3.8	0	8.3	7.4	7.4	0.3	1.9	0.0	1.0	0.3	312
1920	0.3	97.1	1.3	2.1	1.3	5.6	4.2	3.4	0.0	0.0	0.0	0.0	2.4	377
1930	0.0	84.3	0.9	0.5	1.8	1.6	2.7	1.1	0.0	0.0	0.0	0.0	15.5	439
1940	0.4	92.4	5.4	3.4	2.8	2.0	4.0	2.6	0.0	0.2	0.4	0.0	1.8	497
1950	1.5	89.5	15.3	11.7	1.0	1.5	4.9	2.2	0.0	0.0	0.5	0.7	5.6	589
1960	0.0	71.1	11.7	1.4	0.0	0.2	0.6	0.5	0.0	0.0	0.5	0.0	22.4	630

Notes: 1968 format of records changed and this information is unavailable  
\$ Includes nurses who did not enrol for various reasons or returned to their own country following Enrolment e.g. nurses from Greece whose training was supported under American/French War Relief.  
\* Includes tutors and senior management posts.  
\*\* Includes top management posts.  
\*\*\* Includes QNI special projects, secondments overseas and practical work teacher appointments.  
Source: See Appendix 1.

The pattern of career development, particularly since 1940, is illuminating and shows several features: slightly fewer QNs worked in single district nursing practices; more nurses engaged in combined duties and clinical specialities; less interest was shown in senior management and Senior District Nurse posts (S/DN); and teaching increasingly became an avenue for career development. The majority of QNs held additional professional qualifications and certificates of proficiency (see Table 24). It can be seen that from 1910 to 1950, between 70% and 90% of QNs held a midwifery qualification and during the same period about 3% held a



TABLE 24: QNs SPECIALIST PROFESSIONAL QUALIFICATIONS - SELECTED YEARS 1910 - 68

TYPE OF POST REGISTRATION QUALIFICATIONS:	YEAR:						
	1910	1920	1930	1940	1950	1960	1968
	n = 312	n = 377	n=439	n = 497	n = 589	n = 630	n = 711
	%	%	%	%	%	%	%
Massage, sunlight and electrical therapy	2.9	1.3	0.5	0.4	0.2	0.0	0.0
Dietetics and invalid cookery	2.2	0.3	0.5	0.2	0.2	0.0	0.1
Apothacaries	0.6	0.0	0.0	0.0	0.0	0.0	0.0
Medical Psychological Association (MPAC)* and RMN	0.6	0.0	0.2	0.6	1.5	1.0	3.0
Tropical diseases	0.0	0.0	0.0	0.2	1.2	0.3	0.1
Registered Fever Nurse (RFN)**	0.6	0.0	2.5	7.4	7.5	5.2	3.5
Tuberculosis, chest diseases and cardio-thoracic***	9.6	14.9	2.7	0.6	2.5	1.4	0.0
Registered Sick Children's Nurse (RSCN) and Nursery Nursing (NNEB)#	0.0	0.0	0.0	1.6	1.0	5.7	3.2
Mothercraft and premature baby care	0.0	0.0	0.0	0.0	0.2	1.7	1.1
Orthopeadic	0.0	0.0	0.0	0.0	1.2	0.6	0.8
Ophthalmic ##	0.0	0.0	0.0	0.0	0.2	1.0	2.7
Cancer nursing, renal nursing and counselling	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Family Planning ###	0.0	0.0	0.0	0.2	0.0	0.0	0.4
Gas and Air \$	0.0	0.0	0.0	4.4	9.5	0.0	0.1
State Enrolled Assistant Nurse (SEAN) \$\$	0.0	0.0	0.0	0.0	0.2	1.0	2.5
Housekeeping and Administration	0.0	0.0	0.0	1.0	1.9	0.3	0.3
Diploma in Nursing \$\$\$	0.0	0.3	0.0	0.0	0.5	0.5	0.0
Midwifery Teacher's Diploma (MTD), Health Visitor Tutor Cert (HVT).^	0.0	0.3	0.2	1.4	0.8	0.6	0.4
State Certified Midwife (SCM)	71.8	90.5	77.7	78.1	78.3	70.6	52.5
Health Visiting Certificate	3.2	2.7	3.6	14.5	24.1	8.9	1.4
Social studies, social work certificates ^^	0.0	0.0	0.0	0.0	0.2	0.2	0.3

- Notes:
- \* MPA founded 1841by mental hospital medical superintendents and the need for trained nurses
  - \*\* RFN awarded by GNC – prior to 1920 certificate of proficiency awarded by individual hospitals
  - \*\*\* Scope of medical sciences and practice broadened.
  - # RSCN awarded by GNC: NNEB - a non-nursing qualification issued by the Nursery Nursing Education Board – indicating an emphasis on the special needs of the sick and healthy child.
  - ## Special knowledge and skill in eye care was important in district nursing - QN without experience attended 8 sessions at Moorfields Eye Hospital, London.
  - ### Training and certification by Family Planning Association
  - \$ Administration of analgesia during childbirth - a qualification required by midwives.
  - \$\$ Awarded by the GNC following the opening a second level part of the Nurses Register in 1949. SEANs converted to SRN for entry to QN.
  - \$\$\$ Awarded by London University following a prescribed course of study and assessment - often a prerequisite to senior posts and higher qualifications.
  - ^ MTD Awarded by the Central Midwives Board in conjunction with London University: HVT awarded by the Royal College of Nursing in conjunction with Surrey University.
  - ^^ Courses leading to certification frequently offered by Universities, extra mural departments.

Source: Appendix 1.

HV qualification, rising to 24% in 1950. In addition, some expanded their knowledge and skills to meet changing social conditions, advances in technology, and medical and nursing practices. In the early years of the twentieth century, most of these gained accreditation in



physiotherapy-type treatments, dispensary work, dietetics and the specialist needs of those suffering from tuberculosis and contagious diseases. From the 1940s, however, the emphasis changed to include specialist nursing qualifications in mental illness, heart and chest conditions, the social and behavioural sciences, and, by the 1960s, cancer care and palliative nursing, both of which benefited from research and an increasing commitment to the prevention of suffering. In 1960 and 1968, over 70% and 50% respectively still held a midwifery qualification and nearly 9% and 2% respectively were qualified HVs, with around 5% holding more advanced qualifications in these specialities. A similar pattern was revealed by Hockey's survey of 685 candidates on district nursing courses in 1962/3 when 38% possessed only the SRN qualification, 52% were also State Certified Midwives (SCM), 3.5% were SRN/SCM and qualified HVs, and 6% held higher qualifications such as a Tutors' Certificate.<sup>59</sup> Interestingly she also found that candidates with SCM and HV qualifications achieved higher grades in the district nursing examinations. The decline in the percentage of QNs with midwifery and HV qualifications in the 1960s, although due to a number of factors, is particularly significant in that it coincided with the time when the district nurse course was shortened and the qualification failed to be awarded mandatory status; changes in the social characteristics of district nurses also occurred with the admission of men and married women.

In addition, although few in number, exceptional QNs exhibited unique qualities.<sup>60</sup> Some shared a commitment to scholarship with evidence of advanced teaching qualifications and interest in professional development through the Diploma in Nursing; others exhibited bravery combined with a sense of duty and strength of spirit in times of peace and war, and received due recognition. Meanwhile, the rank and file – the 'unsung heroes' – provided the ground force, often singled out for their civic and professional commitment (see Chapter 6).

The archival evidence refutes the perceived invisibility of district nursing in the war effort and by so doing should serve to change the official history of the country at war (see Table 25).<sup>61</sup> These QNs formed part of a corps of exceptional women as the distinguished service merit awards show. The same Table also reveals the QNI's commitment to staff welfare and career development in the form of hardship grants and scholarships. The Tate Fund was created from a legacy bequeathed by Sir Henry Tate, the golden syrup baron and long-term

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<sup>59</sup> Hockey, 'Survey of district nurse training' 20 – 1.

<sup>60</sup> Thompson, D, *Outsiders: Class, Gender and Nation* (London 1993), 77 – 90.

<sup>61</sup> Dingwall, Rafferty, and Webster, *Social History of Nursing*, 197 – 8 with reference to Ferguson, A and Fitzgerald, B 'Studies in Social Service', 1954.



TABLE 25: GRANTS, SCHOLARSHIPS AND MERIT AWARDS TO QNs -  
SELECTED YEARS 1910 - 68

AWARD:	YEAR:						
	1910	1920	1930	1940	1950	1960	1968
	N = 312	N = 377	N = 439	N = 497	N = 589	N = 630	N = 711
GRANTS AND SCHOLARSHIPS:	%	%	%	%	%	%	%
QNI Tate Fund Grant*	6.1	4.5	4.3	1.2	0.2	0.0	0.0
QNI 1930 Committee Grant*	1.6	0.3	0.2	0.0	0.0	0.0	0.0
QNI Scholarship	0.0	0.0	0.2	0.2	0.0	0.2	0.0
MERIT AWARDS:							
Coronation Medal	0.0	0.3	0.0	0.0	0.0	0.0	0.0
OBE/MBE	0.0	0.0	0.0	0.0	0.2	0.2	0.0
Medullae de la Francaise	0.3	0.0	0.0	0.0	0.0	0.0	0.0
Serbian Medal	0.3	0.0	0.0	0.0	0.0	0.0	0.0

\* Hardship funds. After 1911 QNs also benefited from the provisions of the National Insurance Act  
In 1930 QNs joined the federation Superannuation Scheme for Nurses.

Source: See Appendix 1.

benefactor of the QNI. Investment of this legacy in the stock market gave a long-term return from which QNs benefited on average through a single payment of £5, or several payments of £2, resulting in total payments of £531 in 1929 and £215 in 1940.<sup>62</sup>

Conditions of employment were often complicated by the fact that QNs were not a static community. An analysis of the interim reasons for QNs leaving district nursing, or receiving leave of absence from the QNI, is included as Table 26. There is little reason to doubt that the situation could be extended to district nursing generally - a view that will be substantiated in Chapter 6. The most frequent reason for a change in employment status was additional training, particularly in midwifery and health visiting which was usually funded by the QNI, because these qualifications were a prerequisite for promotion – a factor which put men at a disadvantage.<sup>63</sup> Personal reasons, however, accounted for the highest loss to the service, with sickness and home duties being the most common. By comparison with the interim causes of service disruptions, the reasons given for QNs finally leaving district nursing (see Table 27)

<sup>62</sup> WIHM, SA/QNI G1/6 Box 66. Tate Fund Cash Book.

<sup>63</sup> Anon.' Vital role played by men in nursing - but salary and prospects dim', Leicester Mercury 1954, - no scope for advancement to administrative posts in district nursing; WIHM SA/QNI H.28 Box 84 'Male Nurses' Collection of newspaper articles included Evening Standard 1949 'Men district nurses seek promotion and find there is a snag' – Society of Male Nurses reported to be requesting QNI to receive a deputation on the matter.



TABLE 26: QN INTERIM RESIGNATIONS AND LEAVE OF ABSENCE – REASONS – SELECTED YEARS 1910 - 60

REASONS	Training:			Hospital:	Private:	HV:	Abroad:	Comm'ty :	HMF:	Other:	Unaff'd District:	Personal:				NK	n =
	MW		HV	Other								Sickness and Fatigue	Home Duties	Marriage	Pregnancy	Religion	
YEAR of QNI enrolment	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
1910	8.0	0.0	0.0	0.3	1.9	0.6	1.9	0.0	19.9	4.2	0.3	7.4	7.7	1.6	0.0	0.6	0.3 312
1920	15.9	0.5	0.0	0.0	1.9	0.0	3.2	0.3	0.0	2.4	0.0	6.9	8.0	0.3	0.0	0.0	1.6 377
1930	9.1	2.7	0.5	0.5	1.8	0.2	0.5	0.2	0.2	0.9	1.4	5.7	3.4	0.9	0.0	0.0	0.5 439
1940	9.5	6.0	0.2	2.0	1.0	1.8	0.6	1.8	0.6	2.4	1.0	4.6	5.2	4.2	0.4	0.4	0.4 497
1950	2.5	13.9	0.2	1.2	0.0	0.2	1.7	2.0	0.0	2.4	0.5	1.5	4.1	3.9	0.8	0.2	0.5 589
1960	0.3	0.6	0.0	0.3	0.0	0.0	0.3	0.2	0.2	0.2	0.2	0.0	1.0	0.6	1.1	0.2	0.2 630

Note: 1968 format of record changed and this information if no longer available.

TABLE 27: QN FINAL RESIGNATIONS – REASONS – SELECTED YEARS 1910 - 60

REASONS:	Trainin g			Posis:								Personal:					Dismissed *	Left /Nk:	Total:
	MW		HV	Other	Hosp.	Private	Abroad	Comm'ny Incl. HV	HMF *	Other	Unaff'd district	Retired	Sickness And Fatigue	Home duties	Marriage	Pregnancy	Religion	Death	n =
YEAR of QNI Enrolment	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
1910	8.0	0.0	0.0	0.3	2.2	5.1	4.5	6.0	1.0	0.3	0.6	8.3	9.0	7.4	21.8	0.0	1.0	11.2	312
1920	1.1	0.0	0.3	0.3	2.7	5.3	6.9	2.9	0.5	14.9	0.3	1.3	4.8	4.8	17.5	0.0	1.1	24.7	377
1930	2.1	0.5	0.5	0.5	5.5	4.1	1.8	4.5	0.0	8.9	0.0	0.7	4.1	3.6	17.3	0.0	0.5	37.4	439
1940	2.0	2.8	0.0	0.0	5.0	1.6	2.0	7.4	1.8	10.3	1.2	3.2	6.0	9.5	19.9	0.0	0.8	18.9	497
1950	0.7	2.7	0.7	0.7	3.7	0.0	5.8	7.2	1.0	4.2	1.4	0.3	4.8	9.7	14.6	0.7	0.8	42.3	589
1960	1.3	3.0	0.5	0.5	3.8	0.0	4.1	1.6	0.2	0.0	0.0	0.0	2.2	8.7	6.2	2.4	1.0	34.1	630

Note: 1968 format of record changed and this information if no longer available.

- Includes removal from the Roll, exclusion from future employment as a QN.



were different: further training featured less strongly; personal reasons remained fairly constant, with marriage being the most significant until after 1950 when less discriminatory policies against the employment of married district nurses were introduced; while pregnancy subsequently became a factor that both interrupted and ended the QN career. The pattern of morbidity and mortality among QNs reflected that of the general population and the archival evidence shows that QNs were affected by contagious, systemic conditions such as nephritis and malignancy, mental illness with evidence of 'nervous breakdown' and 'suicide', violence such as being 'attacked by a maniac', accidents on bicycles, involving loss of limb, or at sea, resulting in drowning.

Although details about the 'country of origin/nationality' of QNs did not form part of the structured record before 1960 (see Table 9, p78), there is evidence of a small but continual influx of overseas people – mainly from Europe but also from America, Africa and Australia. In times of shortage, district nurses were actively recruited from the continent and further afield.<sup>64</sup> The links between this country and Australia are well documented in relation to the development of district nursing in South Australia.<sup>65</sup> Migratory processes resulted in an increasingly multicultural profession typified by the population of Leicester, particularly from the end of the Second World War.<sup>66</sup> For the professions, overseas-trained nurses presented issues of comparability and reciprocity of qualifications, and for society, cultural integration and health-care management had implications both for service providers and professional educationalists.

Gender, marital status and family commitments each affected the careers of district nurses. Before 1950, unmarried QNs practising in the urban areas were required to live in a Nurses Home under the supervision of a QN superintendent; in rural areas, they were provided with a house or rooms at the home of one of the nursing association's committee members.<sup>67</sup> These single women regularly experienced a conflict of loyalties between their family and their profession. The role of single daughters within the family was frequently regarded either as a substitute parent, particularly following the death of a mother, or as a

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<sup>64</sup> WIHM, SA/QNI Minutes of QNI Council and Nursing Sub Committee (1930).

<sup>65</sup> Lin, R. *Angels of Mercy: District Nursing in South Australia 1894 - 1991* (Norwood, South Australia 1993); Merry and Irvén, *District Nursing*, 11 –2; Stocks, *100 Years of District Nursing*, 128, 183 and 189.

<sup>66</sup> Baly, *Nursing and Social Change*, 236; Nash, D and Reeder, D, *Leicester in the Twentieth Century* (Leicester 1993), 4 – 6; Shkimba and Flynn, 'In England we did nursing' in Mortimer, and McGann, *New Directions in the History of Nursing*, 141 –49.

<sup>67</sup> Stocks, *100 Years of District Nursing*, 94.



practical resource for the family business.<sup>68</sup> As can be seen from the data, the burden of 'home duties' figures as one of the most frequent reasons for leaving or taking leave of absence (LOA) (see Tables 26 and 27, p100). Many women entered nursing to avoid this trap or to escape the lack of self-fulfilment and the subordinate position of women generally in society – such women, who defied the constraints and conventions of the society in which they lived, were indeed exceptional.<sup>69</sup>

District nursing was an exclusively female profession until the mid-1950s when a few men were appointed. The recruitment of men into nursing *per se* was influenced by two main factors: an involvement with a medical role in the forces during the Second World War and the employment opportunities available in civilian life. Many men were attracted by the advantageous conditions of service in district nursing, such as the provision of a house, a car and a telephone, and the flexible working hours that fitted in with family routines.

The admission of married nurses to the Roll in 1947 carried implications both for employment and the sustainability of family life, the welfare of children and the role model that the mother portrayed. In 1966, Hockey's study showed that, for a married nurse, the husband's place of employment determined the area in which she practised and was therefore a factor to be taken into account in terms of recruitment and retention of nursing staff.<sup>70</sup> Consequently, in areas with a thriving economy and a variety of employment opportunities, the district nursing service was likely to be up to establishment.

In the 1950s, the married status of QNs and the presence of children brought a new dimension to the integration between the private and professional life of district nurses. The vulnerability of a district nurse's marriage followed the trend of the general population, as family breakdown began to be a feature (see Figure 4).

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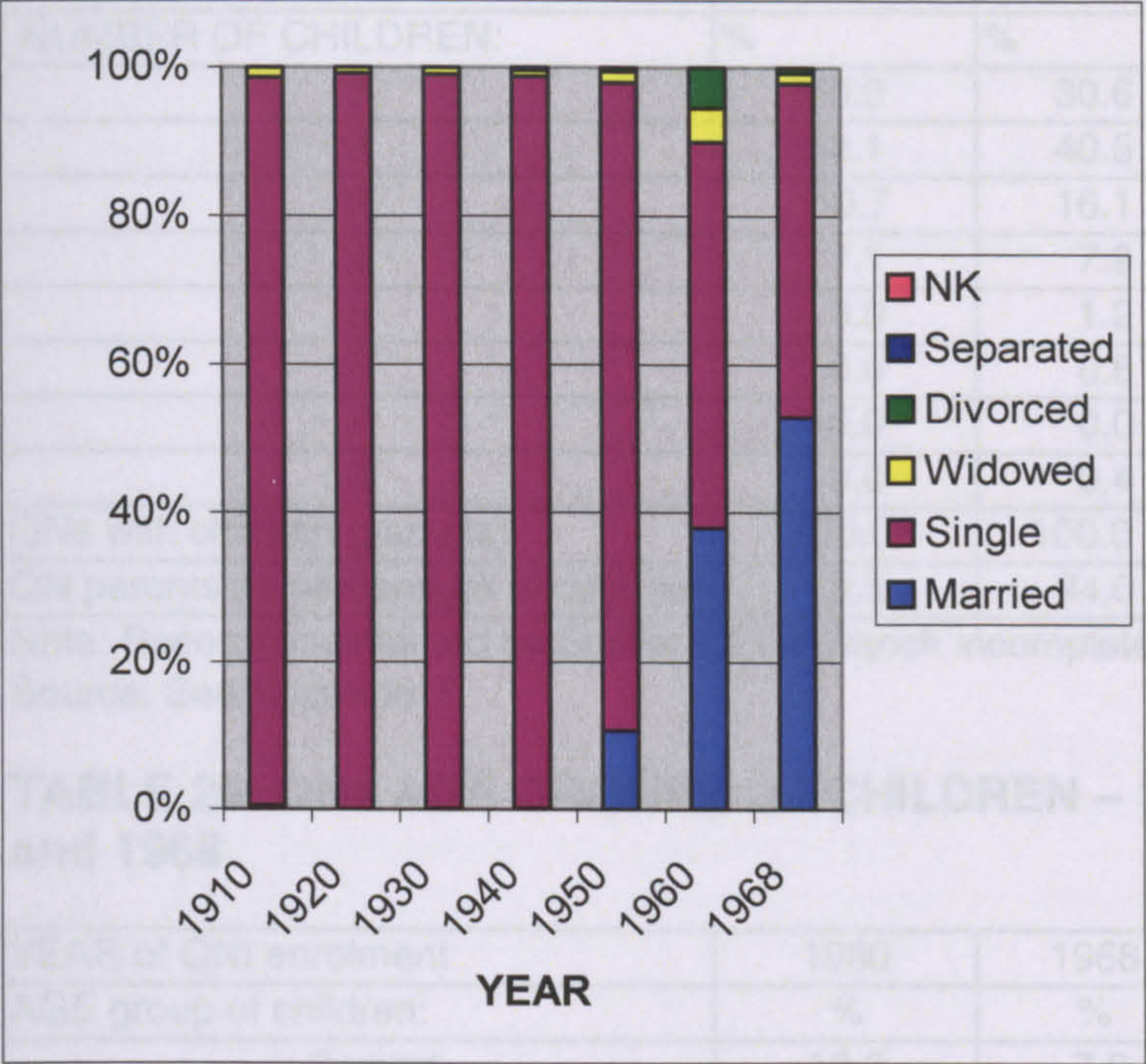
<sup>68</sup> Lewis, J, *Women in England 1870 – 1950* (Brighton 1984), 92.

<sup>69</sup> Masson, Pictorial History of Nursing, 23 – 4; Grundy, P, 'The businesswomen of Leicester', in Hinks, J, *Aspects of Leicester* (Barnsley 2000), 79 – 88; Smith, J, 'Public responsibilities: The entry of women into public life in Leicester 1870 – 1920', Leicester University MA thesis, 1995.

<sup>70</sup> Hockey, *Feeling the Pulse*, 31 and 37.



FIG 4: QNs MARITAL STATUS - SELECTED YEARS 1910 - 1968



Source: See Appendix 1.

The QNI took a pro-active role in looking at the personal circumstances of both men and women being appointed as QNs, arguably prompted by a belief in the importance of a continuous loving relationship in the lives of children and the identification of child-abuse and its clinical and social pathology.<sup>71</sup> The increased practice of foster or day-care arrangements for young children created particular concern. Government inquiries into the risks to which children were exposed, both at home and when cared for by others, gave rise to legislation that could not be ignored by employers and regulators of the profession.<sup>72</sup> From the 1960s, the QNI records included a new section on child-care arrangements (see Tables 28, 29 and 30). Whilst the number of QNs with children were in the minority, the evidence shows several interesting features of social change in relation to the overall structure of the QN’s family, the role of adults and women’s work: firstly, the number of QNs with children increased from 13% in 1960 to 34 % in 1968; secondly, the size of the family increased, with a reduction in the number of families with single children. Thirdly, there was a notable increase in the age of children, with the under-school age group decreasing to one quarter in 1968 compared with one third in 1960,

<sup>71</sup> Bawlby, J, *Child Care and the Growth of Love* (London 1960); Kempe, R. S and Kempe, C. H, *Child Abuse* (London 1978); Kempe,C. H, ‘Child Abuse’, *Journal of the American Medical Association*, 181, 1, 1962, 7 - 14

<sup>72</sup> McEwen, M, *Health Visiting* (London 1962), 68 –70 referencing the Curtis Report (1946) on the Care of Children and the Children Act (1948).



TABLE 28: QNs FAMILY SIZE - 1960 and 1968

YEAR of QNI enrolment:	1960	1968
NUMBER OF CHILDREN:	%	%
1	50.0	30.6
2	32.1	40.5
3	10.7	16.1
4	7.1	7.9
5	0.0	1.2
6	0.0	0.8
7	0.0	0.0
8	0.0	0.4
QNs with children (parents)	100.0	100.0
QN parents as percentage of data set	13.3	34.0

Note: Records maintained by Scotland QNI Branch incomplete.  
Source: See Appendix 1.

TABLE 29: QNs AGE GROUPS OF CHILDREN – 1960 and 1968

YEAR of QNI enrolment	1960	1968
AGE group of children:	%	%
< 2 years	13.3	7.0
2 - < 5	16.1	15.7
5 - < 8	16.1	22.1
8 - < 11	21.0	19.5
11 - <15	20.3	18.5
15 - <18	8.4	7.0
18 and over	3.5	9.8
NK	1.4	0.4
Total children (N =143/498)	100.0	100.0

Note: Records maintained by Scotland QNI Branch incomplete.  
Source: See Appendix 1.

TABLE 30: QNs CHILD CARE ARRANGEMENTS – 1960 and 1968

YEAR of QNI enrolment:	1960	1968
PROVISION:	%	%
Other parent*	1.4	8.8
Relative	2.1	28.9
Friend/neighbour	0.0	8.4
Nursery/day/school/residential	0.0	2.2
School/day or boarding	0.0	9.0
Paid help/au pair/ foster/nanny	0.0	6.2
Combination of above	0.0	3.4
Independent (18 and over)	7.0	12.2
Not given	89.5	16.1
Total number of children (N =143/498)	100.0	100.0

Note: Systematic child care records introduced in 1968  
: Records maintained by Scotland QNI Branch incomplete  
\* Includes children remaining overseas



while the over-school age 'independent' group showed a significant increase from nearly 4% in 1960 to 10% in 1968, thus reflecting the post-war trend for entry to QN when the children were older. Finally, QNs deployed a range of child-care resources but family members, usually grandparents, were the main providers of child-care – a reflection of accumulated obligation and reciprocity that had both utilitarian and economic by-products.

To illustrate the effect of personal, parental and professional conflict, evidence is presented from three different perspectives. The first perspective is one of professional misconduct that arose because of the conflict between parental obligation and a duty to care:

A District nurse on night duty in an inner city area left her 8 year old daughter in the care of an intoxicated and aggressive husband – she needed to work because of the financial burden of supporting the family.

On arrival at a patient's home she encountered two drunken and boisterous men in a dark passage through which she needed to pass. Having come from a similar scene at home, the nurse was too frightened and distressed to proceed. She returned to her car and made several other calls. An hour later she returned to the house to find the situation unchanged. She did not call her senior officer, mainly because the hospital was providing cover, but made a false entry in the records.

The district nurse was summoned to appear before the General Nursing Council for alleged professional misconduct.<sup>73</sup>

The second situation illustrates the team effort of the family upon whom a district nurse often relied:

A male QN had severely ill patients to attend on an evening round in dense fog. His wife secured their two children at home and accompanied her husband – alighting from the car from time to time to guide it where visibility was obscured by the fog. The wife commented – "He had to go; I wanted him home safely and the children were sensible".<sup>74</sup>

The third involved two situations illustrating the different effects on children of having a mother who was a district nurse:

Situation one presented a negative role model; the woman recalled "I dreaded the sound of the telephone and seeing my mother go to her cupboard to collect her black bag – I vowed my children would never have to go through that".<sup>75</sup>

Situation two by contrast involved a district nurse whose mother was a QN. She described the pride she always felt in her mother's work and her standing within the local community – "I never wanted to do anything else but be a district nurse when my turn came".<sup>76</sup>

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<sup>73</sup> Pyne, R. H, *Professional Discipline in Nursing. Theory and Practice* (London 1981), Appendix B Case A8.

<sup>74</sup> Cuthbert, B, Widow of a Leicester QN. Interview (1998).

<sup>75</sup> Heap, J, daughter of a Leicester district nurse– informal discussion.

<sup>76</sup> Anon – casual contact with daughter of a Leicester QN.



## QNI – altruism versus cost-effectiveness

In several historical accounts about the QNI and the development of nursing, the QNI's commitment to the welfare of QNs receives minimal recognition.<sup>77</sup> In the analysis undertaken throughout this chapter, it is clear that the QNI was a progressive and benevolent organisation in staff management, arguably to its disadvantage. It was involved in three different approaches to welfare provision: the QNI itself initiated such schemes as 'The QNs' Benevolent Fund', established in 1913; it also managed legacies such as 'The Tate Fund' and Bryn-y-Menia House, Bangor; lastly, it worked in partnership with local affiliated DNAs to provide support through schemes such as 'The Long Service Fund', established in 1925.<sup>78</sup>

The archives do not give sufficient evidence to apportion precisely the balance of power between the QNI and local DNAs, but three issues seemed to threaten the economic stability of district nursing in the face of unsustainable growth and an increasing demand for the service: seepage of resources; instability and change; altruism and a culture of investment in staff welfare. As can be seen in Table 26, p100, the QNI and local DNAs were very generous in awarding leave of absence to QNs in times of personal and family crisis and to enable them to pursue further training and professional development. In both instances, prior to and alongside National Insurance and other state benefits from 1909, and the Nurses Federated Superannuation Scheme from 1930, support was provided by the QNI through trust funds and scholarships (see Table 25, p99). Was QNI welfarism and staff benevolence a wise investment or a costly mistake? Certainly the QNI Council expressed considerable sympathy for the stresses under which the QNs worked and clearly accepted responsibility for the nurses' welfare by such comments as 'exhausted', 'in need of a rest', but the implications for staffing and finance were considerable.

Under conditions of the extreme shortage of nurses, the QNI appeared to work on the assumption that staff welfare and opportunities for further training and career advancement would aid the recruitment and retention of QNs. Such an assumption is questionable, however. There is little evidence of a systematic approach to manpower planning but rather a reaction to peaks and troughs in the availability of nurses and service demand, the latter often determined by local factors (see Chapter 5 and Chapter 6). A

<sup>77</sup> Baly, *QNI*; Baly, *Nursing and Social Change*; Stocks, *100 years of District Nursing*; Abel-Smith, *History of the Nursing Profession*; Dingwall, Rafferty and Webster, *Social History of Nursing*.

<sup>78</sup> Stocks, *100 Years of District Nursing*, 162.



pattern of unsustainable growth and increasing demands can be inferred from Table 2, p71, where the achievement of full cover by a professional QN service to the community seemed an unachievable goal; any apparent growth was arguably overshadowed by difficulties of replacement and a shortage of well-qualified nurses. Abel-Smith argued that there was just too much to do and too few to do it.<sup>79</sup>

Wastage was also a factor that came in many guises. The heavily subsidised midwifery and health visitor training for QNs, although justifiable for the future staffing of senior district nursing posts, arguably constituted a drain on staffing and financial resources that was questionable. This was particularly the case given that, prior to the introduction of the NHS in 1948, the majority of QNs worked in urban areas where the Ministry of Health prohibited combined district nurse/midwifery practices. The practice of short term/temporary contracts resulted in unstable staffing situations, and the exclusion of male and married female QNs for the first half of the twentieth century was arguably a misguided failure to use valuable resources and to exploit scarce skills, though consistent with social attitudes prevailing at the time.

The strength of the QNI lay in its willingness to embrace innovation and new ways of working both at home and abroad, and in its highly motivated staff.<sup>80</sup> At home, the integration between health visiting and district nursing was a goal towards which the QNI continually strived in the face of overwhelming competitive forces that were not unique to Britain.<sup>81</sup> The calibre of professionalism and range of skills embodied within a community of QNs was worthy of much wider recognition and application, since greater structural and professional integration between QNs, health visitors and midwives would have provided the much-needed flexibility and cost-effectiveness required in the service of diverse

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<sup>79</sup> Abel-Smith, *History of the Nursing Profession*, 125 - 7

<sup>80</sup> Oral histories and personal testimonies of Leicester district nurses revealed exceptional satisfaction and motivation – “The happiest days of my career”; Wilson, D, ‘Satisfaction – the reward of a district nurse’, *Leicester Mercury* (undated), a tribute to Dorothy Wilson, on the occasion of her retirement after 30 years as a QN in Leicester; Pointon, Gwen and Abner, ‘Nursing couple retire after 61 years service’, *Leicester Mercury* 1 June 1977 – *expressing the pride and privilege of being a QN*; Dunne, B. T, *Journey into the Unknown* (New York 1992), 21 – 3 “I was so happy doing the job I loved in the homes of people – it was like being in heaven.”

<sup>81</sup> Damant, M. ‘A case study of community nursing in America: Innovations in shared learning and team working in Wisconsin and South Carolina’, King’s Fund College Library, (Unpublished 1990); Burbach, A. A and Brown, B. E ‘Community Health and Home Health Nursing: Keeping the concepts clear’, *Nursing and Health Care*, 9, 2, 1988, 97 –100 – the authors’ claim that not to distinguish between the two will compromise the integrity of both.



communities. Abroad, the QNI sponsored initiatives in district nursing such as the exchange of students and high-ranking officers; this was part of a much bigger exchange of resources between Britain and the Commonwealth, which influenced custom and practice in both.

## CONCLUSIONS

This chapter has focused on the distinctive group of district nurses designated as QNs. Although comprising less than half of the total district nursing work-force, QNs led the way and made a very significant contribution to the professionalisation of district nursing as a whole. Other types of district nurses may well have demonstrated similar characteristics but we have little consistent or reliable information on which this can be assessed. Leicester is an exception; hence its centrality in this study.

From the detailed analysis of personal records and other archival sources presented here, it is clear that Stocks was right in her assumption that QNs were highly qualified, professional women who were intelligent and physically strong.<sup>82</sup> In addition, based on the personal records of over 3000 individuals the evidence presents a full picture of the diverse social backgrounds of nurses who earned the designation of QN, and sets out their achievements and career rhythms. QNs required the ability to think and take action outside the sphere of traditional nursing, and the QNI was committed to identifying the attributes which would enable QNs to meet this requirement.

The QNI promoted the position of women within a rapidly changing society and a developing scientific community in the face of increasing demands for health-care and welfare. QNs both confirmed the traditional stereotype of women's work and broke the mould; they were well-educated, both socially and geographically mobile, specifically qualified, and available for consultation as experts in their field. They pursued a career which overlapped the boundaries of the male dominated territories of medicine, professional administration and politics.

The next section of this thesis 'Leicester – the local context' presents a case study of the development of district nursing in an urban setting. Chapter 5, the first chapter in this section, starts from 1866, twenty-two years before the establishment of the QNI.

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<sup>82</sup> Stocks, *100 Years of District Nursing*, 89.



# APPENDICES

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## 1: DATA SOURCE

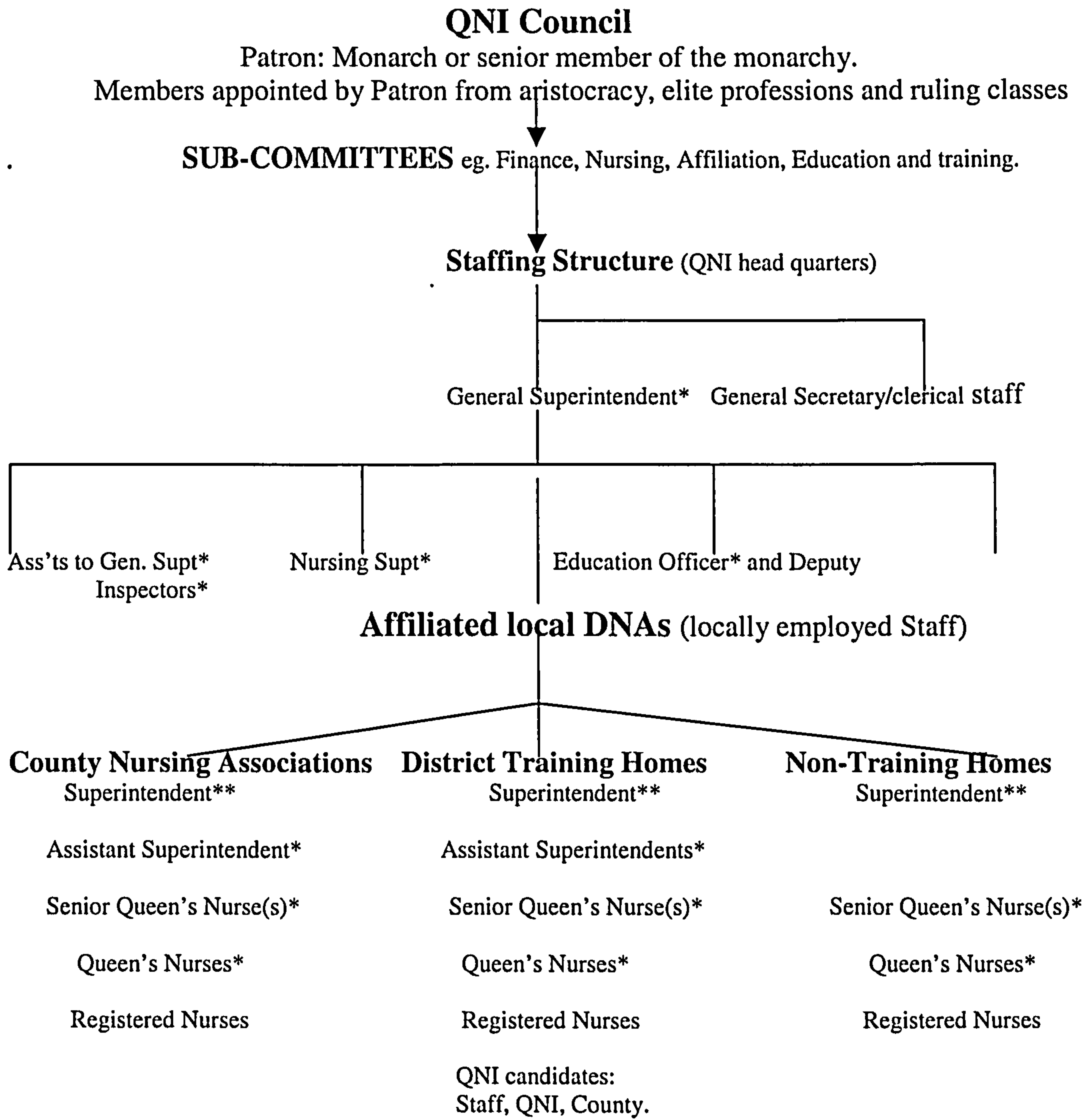
Wellcome Institute for the History Medicine (WIHM), Supplementary Archives (SA)/  
Queen's Nursing Institute (QNI) Roll of Queen's Nurses:

J. 3/16 July 1909 – April 1910  
J. 3/7 April 1910 – April 1911.  
J. 3/24 January 1918 – January 1920  
J. 3/25 1920  
J. 3/26 O/S 27 1920  
J. 3/39 O/S 40 1930  
J. 3/40 O/S 41 1930  
J. 3/41 O/S 42 1930  
J. 4/11 1940  
J. 4/12 1948 – 50  
J. 4/13 1950 – 51  
J. 4/20 1958 – 60  
J. 4/21 1960 – 61  
J. 6/11 Training of Student District Nurses 1968  
J. 6/12 Training of Student District Nurses 1968



APPENDIX

2: QNI STRUCTURE AND ORGANISATION



Key:    Queen's Nurse (QN)– a registered general nurse with an additional qualification in district nursing awarded by the QNI and whose name is currently recorded on the QNI Roll of Queen's Nurses

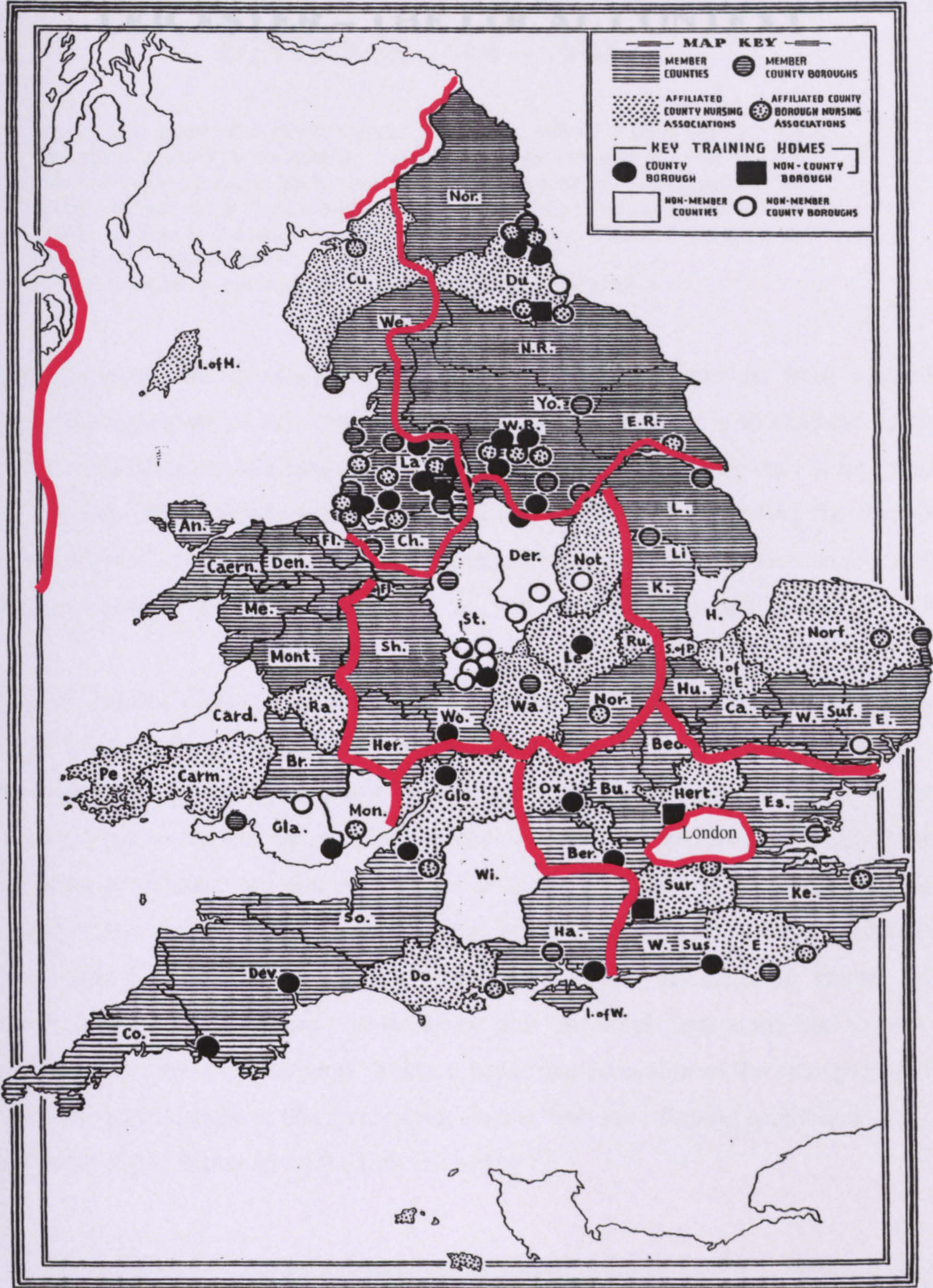
\* QNI Qualification (QN), \*\* QNI, Health Visitor (HV) and midwifery qualifications required

Source: Adapted from Merry, E. J and Irlen, I. D. *District Nursing* (London 1948), 16.



APPENDIX 2

3: MAP OF BRITAIN DIVIDED INTO 11 REGIONS



Source: QNI publicity material (1949) showing the level of affiliated urban (district) and county nursing associations. NB. The independence of Derby, Nottingham and Stafford in the Midlands



# SECTION 2

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## LEICESTER – THE LOCAL CONTEXT



## 5

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## LOCAL INITIATIVE AND THE RELIEF OF DISTRESS 1866 – 1908

During the intense heat of the summer (1852), the task of visiting the sick was physically repulsive in the extreme. I shall never forget one poor old widow ..... She was literally frying in her bed and reeking with perspiration.... principally caused by the ill construction of the dwelling .... slated roof close to the ceiling that was too low .... making it impossible to produce a fit temperature.... neither was there any back door or back windows.<sup>1</sup>

(Observation by Joseph Dare, Missioner, Leicester Domestic Mission.)

Having examined the development and practices of district nursing from a national perspective the purpose of this chapter and the remaining chapters is to examine the local scene by using Leicester as a case study. In this chapter, Leicester's response to the relief of human distress and suffering will be described and evaluated, highlighting the distinctive approach adopted in the formation and development of an organised district nursing service from 1866, when the service was established, to 1908, when it became affiliated to the QNI.

The above vignette illustrates an encounter with human need and suffering in the Victorian slums of Leicester fourteen years prior to the introduction of that service; the plight of this woman also presents a picture of the powerlessness of ordinary people caught up in the turmoil of urbanisation and the conflicting ideas of those with the power to effect change.<sup>2</sup> This picture of sickness and distress was one of many described by the Rev. Joseph Dare, appointed as Missioner to the Leicester Domestic Mission in Leicester in 1845. The Mission's interest focused on 'the neglected poor and despised, and the uncaring attitude of an increasingly materialistic society', in the belief that 'the local community had to bear the responsibility of caring for its poor'. It was a belief that encapsulated the emerging spirit of district nursing, an enterprise that Dare argued would 'help our suffering neighbours' and 'confer incalculable blessings on the sick and needy'.<sup>3</sup>

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<sup>1</sup> Records Office for Leicester, Leicestershire and Rutland (ROLLR) L288 SRI, Haynes, B, *Working Class Life in Victorian Leicester: The Joseph Dare Reports* (Leicester 1991), 43.

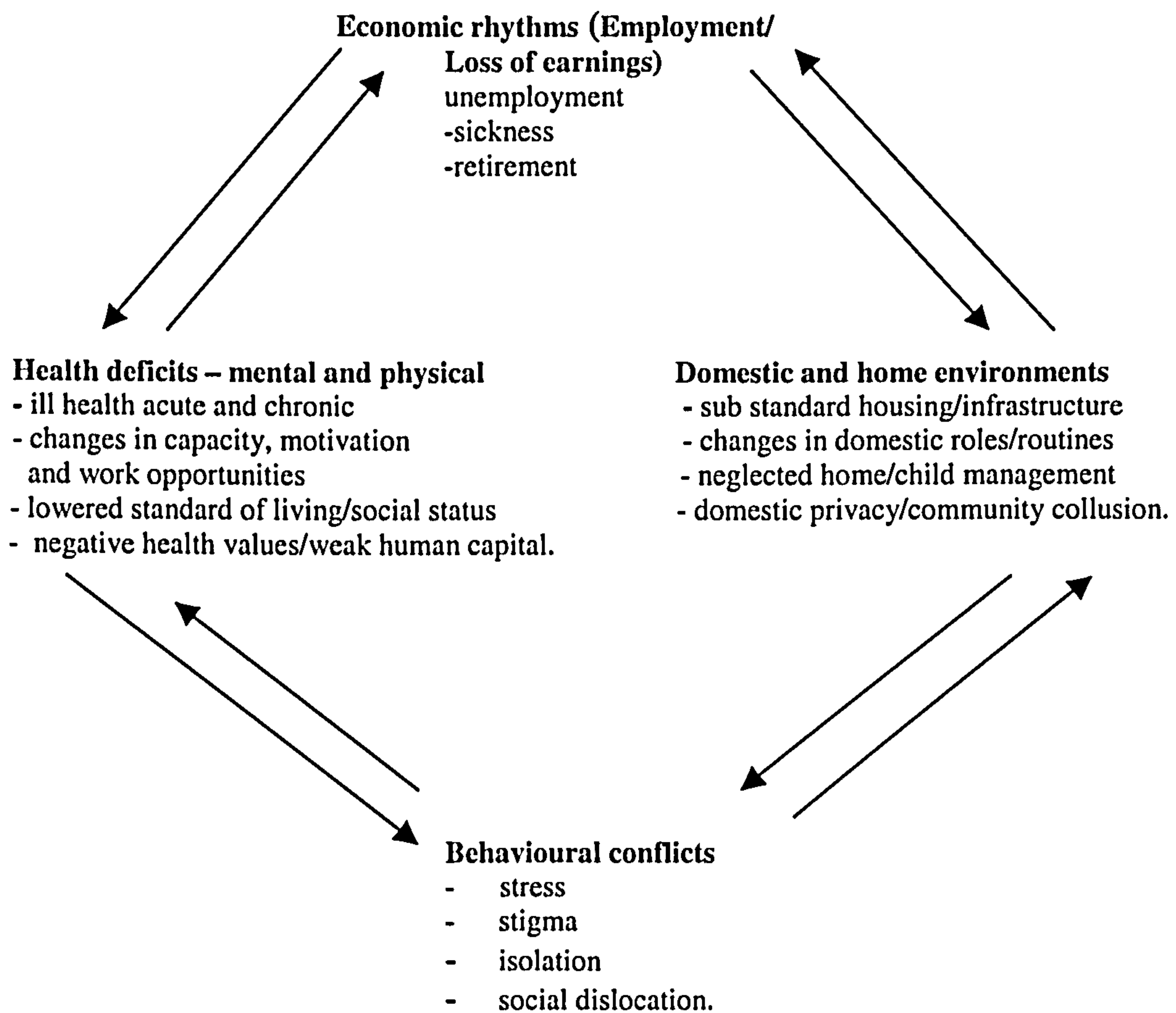
<sup>2</sup> Hennock, E. P, 'The Urban Sanitary Movement in England and Germany 1838 – 1919: a comparison', *Continuity and Change*, 15, 2000, 269-296 – a dispute between medical opinion and Chadwick's agenda on the cause of disease; Hardy, A. *The Epidemic Streets* (Oxford 1993), 269-270.

<sup>3</sup> Haynes, *Joseph Dare Reports*, 52.



It is the intention here to evaluate Dare's thesis as an integral part of the assessment of how and why district nursing emerged, and the ways in which it interacted with culturally determined processes within the context of industrial Leicester. A model of deprivation and social dysfunction has been conceptualised and presented in Figure 1 below.<sup>4</sup> It is a model that captures the substance of this study and illustrates the linkages between socio-economic factors, domestic and environmental stresses and health deficiencies, from which a role for district nursing between 1866 and 1908 can be drawn.

**FIG. 1. A CYCLE OF DEPRIVATION AND SOCIAL DYSFUNCTION:**



Source: Adapted from Fitzpatrick, R. M, 'Society and changing patterns of disease', in Scambler, G, ed., *Sociology as Applied to Medicine* (London 1991), 3 – 17; Bulmer, M, 'The underclass, empowerment and public policy', in Bulmer, M, Lewis, J and Piachaud, D, *The Goals of Social Policy* (London 1989), 245 – 57.

<sup>4</sup>

Hardy, *Epidemic Streets*, passim; Harris, J, *Private Lives, Public Spirit: Britain 1870-1914* (London 1993), Chapters 2, 3 and 4; Lewis, J, *Women in England 1870-1950* (Brighton 1984) passim; Morris, R. J, 'Urbanisation' in Morris, R. J and Rodger, R, eds., *The Victorian City. A Reader in British Urban History 1820-1914* (London 1993), 114 – 148; Rose, M. E, *The Relief of Poverty 1834-1914* (London 1972), passim; Thompson, F. M. L, *The Rise of Respectable Society: A Social History of Victorian Britain 1830-1900* (London 1988) passim; Briggs, A, *Victorian Cities* (London 1968).



Some examples are presented in Chapter 2 of the ways in which initiatives were taken throughout Britain and Europe by charities and voluntary agencies to meet the needs of the sick poor in their own homes in the last third of the nineteenth century. From that time, the district nurse worked increasingly as an autonomous practitioner in professional isolation from her colleagues, within situations where the patient might be less compliant than in a hospital setting, and where prioritisation and the constraints imposed by scarce resources were not always visible.<sup>5</sup> In this capacity the district nurse was involved in a wide range of activities and skills: providing trained nursing care to the sick, frail and dying in their own homes; promoting self-care and involuntary benevolence by example and precept; collaborating with other agencies to sustain an optimum environment for recovery, re-adjustment, or a peaceful death; advocating for the patient and empowering decision-making within the family, neighbourhood and wider social systems; and operating within an organisational framework, with close adherence to its standards and obligations of accountability.<sup>6</sup>

The early steps taken in Leicester to establish a district nursing service were stimulated by social reforming agencies such as the Domestic Mission, religious societies, medical and hospital institutions, the town's capitalists, and ordinary citizens.<sup>7</sup> A chronology of the developments, primarily associated with Leicester Infirmary (LI), leading to a formally constituted system of district nursing in the form of the Institution of Trained Nurses for the Town and County of Leicester (ITNL), is presented as Table 1. The impetus under-pinning the process outlined at Table 1 was grounded in three facets of urban life: firstly, the industrial setting of Leicester; secondly, its impact on the health of individuals and families; and thirdly, the patchwork of *ad hoc* health-care provision that evolved in the urban society of Leicester. It was within this context that a role for district nursing emerged and developed.

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<sup>5</sup> Loane, M, *The Queen's Poor. Life as they found it in Town and Country* (London, 1909), an autobiography of a district nurse – the 'they' therefore refers to district nurses.

<sup>6</sup> Wellcome Institute for the History of Medicine (WIHM), WY 100, 1889, C89g, Craven, D, *A Guide to District Nursing and Home Nursing* (London 1890; Stocks, M. *A Hundred Years of District Nursing* (London 1960), *passim*.



TABLE 1: CHRONOLOGY: DISTRICT NURSING IN LEICESTER (> 1860 – 1908)

DATE	EVENTS/PERSONALITIES	RELATED DEVELOPMENTS
Pre 1860	LI financial instability: staff shortages, low morale and standards, increase in long-stay patients, rise in population .	1849 - Fee paying medical pupils.
1861/2	Rathbone's lay agency in Liverpool provided nurses to work in the hospital, and the home.	Model adopted by Manchester & Salford (1864), Leicester (1866).
1862	LI applied to St Thomas' for nurses .	First 3 fully trained nurses at LI.
1866	ITNL inaugurated.	ITNL request to LI to train nurses rejected.
1868	Leicester (Voluntary) Ladies Committee. (Mrs Walker and Mrs Vaughan)	The Committee funded training in London for 4 district nurses. Leicester divided into 5 Districts - inability to recruit nurses resulted in only 4 Districts
1870	ITNL renewed request to LI to train nurses.	6 probationers admitted for I year training - fee 5/- per nurse. Probationers later admitted for 3 years training free of charge.
1874	Appointment of new Lady Superintendent (ITNL) & Matron (LI) – Miss Burt	ITNL undertook responsibility for nursing on two LI wards.
1875	Positive relationship between LR and ITNL	ITNL undertook responsibility for all nursing at the LI.
1879	Supt. Burt resigned – new appointment made.	Nursing standards fell.
1883	Newly appointed Superintendent resigned. Amidst considerable dissension between the Board of Governors and medical staff all links with ITNL were severed	LI Board resolved to appoint all future Matrons itself.
1883-1908	ITNL District Nursing Branch continued with a separate branch for Private Nursing	12 districts gradually formed and 12 district nurses appointed.
1909	ITNL commenced negotiations with the QNI for Affiliated status.	ITNL renamed The Leicester District Nursing Association

Source: Frizzelle, E and MartinJ. D, The Leicester Royal Infirmary 1771 – 1971 (Leicester 1971), 145 – 44; Ellis I. C, Nineteenth Century Leicester (Privately printed 1935), 6 and 81 – 90; The Leicester District Nursing association (LDNA), *A History of the LDNA 1867 – 1953* (Leicester, 1953), passim.

<sup>7</sup> Haynes, *Joseph Dare Reports*, 52; Frizelle, E, *The Life and Times of the Royal Infirmary at Leicester (LRI): The making of a Teaching Hospital 1766-1980* (Leicester 1988), Chapter 1; ROLLR L914.2 ELL. Ellis, I. C. *Nineteenth Century Leicester* (Private Publisher 1935), Chapter 11.



## Industrial setting of Leicester

It was both the social and the clinical pathology of Victorian Leicester that provoked the need for district nursing.<sup>8</sup> A range of perspectives on deprivation is presented here to highlight the needs of individuals within the context of the family, the cornerstone of Victorian society and the centre of activity for district nursing.<sup>9</sup> Personal and communal aspects of urban life are considered alongside relationships with the sanitary infrastructure and social institutions that function as part of the fabric of society. It is the context in which the life cycle events of individuals and powerful family dynamics were interwoven – the ‘off-stage army in the drama of medical advance’.<sup>10</sup> The nature of urban society and the economic rhythms of industrial communities are reflected in the physical dimension, demography, morphology, and the quality of life experienced by the people. For example, Nash and Reeder examined the way in which Leicester evolved from a market town through the eighteenth and nineteenth century to an industrial conurbation in the twentieth century.<sup>11</sup> Economic fluctuations were a feature of that growth and these affected all aspects of urban life in both the private and the public domains – the working classes were not the only victims of economic uncertainty.

During the nineteenth century, in addition to economic fluctuations three features can be identified that also had a bearing on district nursing. Firstly, in the political sphere, the emergence of modern municipal politics in Leicester was associated with increased local autonomy which created the potential to respond to local health needs.<sup>12</sup> Secondly, Leicester’s physical boundaries were extended to include the adjacent communities of Aylestone, Belgrave, Knighton and North Evington.<sup>13</sup> Thirdly, important changes in the social structure

<sup>8</sup> See for example ROLLR, L614, 84/64 Leicester Corporation Health Reports (LCHR); Nash, D. and Reeder, D, eds., *Leicester in the Twentieth Century* (Leicester 1993), Chapters 2-3; Elliott, M, *Victorian Leicester* (Surrey 1979); Brown, A. E, ed., *The Growth of Leicester* (Leicester 1972); Pritchard, R. M, *Housing and Spatial Structure of a City* (Cambridge 1976).

<sup>9</sup> Smith, F. B, *The People’s Health 1830-1910* (London 1979), 9-11, this work promoted a critical approach to medical history as one of social relationships with the patient as client, not always passive, and the doctor as only another of the forces shaping the well-being and ill-being of people; Donnison, D. *The Politics of Poverty* (Oxford 1982), 26; Chinn, C, *Poverty amidst Prosperity* (Manchester 1995), 44;. Rowntree, B. Seebohm, *Poverty: A Study of Town Life*. (London 1899), 117, 119-120; Luckin, B and Mooney, G, ‘Urban history and historical epidemiology: the case of London 1860 – 1920’ *Urban History*, 24, 2, 1997, 37-55.

<sup>10</sup> Smith, *The People’s Health*, 10.

<sup>11</sup> Nash and Reeder, *Leicester*, Chapters 2-3.

<sup>12</sup> Elliott, *Victorian Leicester*, 55, 77-78, 92-98 a selection of literature is cited by Elliott showing that the unsatisfactory nature of Leicester’s working conditions and sanitary infrastructure were legend, only to be aggravated by its antagonism towards compulsory smallpox vaccination in 1853 and the formation of the controversial Anti Vaccination League.

<sup>13</sup> Martin, J. D and Wilson, P, ‘Aylestone’ in McKinley, R. A. *The Victorian History of the Counties of England; A History of Leicestershire* (Oxford 1958), Vol. 4, 415-9; McKinley, R. A and Martin, J. D, ‘Belgrave’, in McKinley, *Victorian History*, 420-7; Martin, J. D and Pidgeon, B, ‘Evington’, in



and leadership roles took place as Leicester's economy produced a generation of upwardly mobile men and women, thus eroding the centuries-old order of the 'City Fathers' – the "dynasty builders" as Freer called them.<sup>14</sup>

As a consequence of population expansion and the need for a better standard of housing for the working class, the availability of land for housing development and mains services became an issue. For instance, towards the end of the nineteenth century, the majority of houses had yet to be supplied with piped water or connected to a safe sewage system even though the first water and sewage works began to operate in the 1850s.<sup>15</sup> It was another twenty years before anything like a satisfactory system was achieved. Meanwhile water supplies became infected by sewage and the low-lying terrain of the town aggravated the insanitary conditions.<sup>16</sup>

The incidence of disease and social distress was intensified by the environmental conditions in which the working classes of Leicester lived. Joseph Dare gave a picture of life in the back-to-back dwellings of the poor in Leicester: '...a building, no back opening, two small rooms (one up, one down); a father, a mother and six children (elder two grown up, youngest a babe in arms) plus a man lodger'.<sup>17</sup> Rodger also examined the terraced-building strategy designed to 'pack as many houses as possible on a limited site'.<sup>18</sup> The rows of terraced houses surrounded inner courts, closed at both ends either by houses or the communal court privy and water supply. The practice of sub-letting, particularly in dwellings such as those in the Belgrave Road and Wharf Street areas that included a cellar or attic, was no different in Leicester to the situation in other cities. In Leicester, the difference between such abject poverty and the grandeur of housing provision for upper class establishments, such as those in New Walk and the newer housing developments for the upper classes adjoining London Road, made a striking statement of social stratification in the 1860s.<sup>19</sup> Geographical

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McKinley, *Victorian History*, 434 – 8; Martin, J. D and Bird, R, 'Knighton', in McKinley, *Victorian History*, 443-6.

<sup>14</sup> Freer, D, 'The Dynasty-builders of Victorian Leicester', *Transactions of the Archaeological and History Society*, 53, 1977-78, 42 – 54 based on Freer, D, 'Business families in Victorian Leicester: A study in historical sociology', University of Leicester MPhil thesis (1975).

<sup>15</sup> Brown, *Leicester*, 72 -75.

<sup>16</sup> ROLLR L614 84/64, LCHR (1900), 1920 here the MOH reported pleasing progress on the installation of a mains water supply. But the 'red-pail' system, a receptacle for all typhoid discharges to be collected, replaced and the contents burned where a case of typhoid was nursed in the home (presumably by district nurses), was to be continued as a precaution; Hardy, *Epidemic Streets*, 161.

<sup>17</sup> Haynes, *Joseph Dare Reports*, 44.

<sup>18</sup> Rodger, R, *Housing in Urban Britain, 1780 – 1914* (Cambridge 1995), 32-33.

<sup>19</sup> Brown, *Leicester*, 66-70; Pritchard, *Spatial Structure*, 83, 84, 87.



segregation was symptomatic of social segregation and was driven by economic forces in which the culture of Victorian voluntarism flourished, providing the context in which the need for district nursing was identified and met.<sup>20</sup>

Housing is recognised as 'a fundamental factor in determining health'.<sup>21</sup> A theme that can be traced throughout Rodger's study of urban housing is the importance of the tripartite physical, social and emotional dimensions of housing, since a house provided much more than shelter from the elements and a collection of resources for group or solitary lifestyles.<sup>22</sup> The concept of the house as a home and domestic divisions of private space and organisation were important to district nursing, whose place in the patient's home at the heart of family life gave privileged access to secrets and a unique knowledge of a family's rituals and beliefs.<sup>23</sup> The role of district nursing as a form of empowerment arguably eased the situation, because 'the district nurse may be the forerunner in teaching the disorderly how to use imperfect dwellings, teaching without seeming to teach'.<sup>24</sup> However, Hardy was more critical of the position and questioned whether district nursing, for all it had to offer, was simply a 'placebo remedy' for a grave situation that was 'reducible only by the resolution of long-term poverty and other structural causes of ill health'.<sup>25</sup>

Housing development expanded in advance of adequate social and environmental services and sanitation, with the result that in the early days of the newly formed district nursing service, it was difficult to offer much more than palliative care, as the home environment severely restricted opportunities for health teaching by example or precept. The nurses not only spent more time creating a safe nursing environment from substandard resources, but also placed their own health at risk because of the heavy and unceasing workloads.<sup>26</sup> By the 1890s, however, the nature of Leicester's housing environment was very slowly beginning to change in several ways, both as a direct and as an indirect result of industrial and commercial

<sup>20</sup> Hardy, *Epidemic Streets*, 210 here philanthropy in the context of typhus and the 'burgeoning of middle class interest of the problems of the poor' in the late nineteenth century are examined.

<sup>21</sup> Conway, J, 'Housing as an instrument of health care', *Health and Social Care in the Community*, 3, 1995, 141-150.

<sup>22</sup> Rodger, *Housing*, passim.

<sup>23</sup> Bouquet, M, 'You cannot be a Brahmin in the English country-side', in Cohen, A. P, ed., *Symbolising Boundaries, Identity and Diversity in British Cultures* (Manchester 1986), 22 - 39; Wallum, A, 'The boundaries of household', in Cohen, *Symbolising Boundaries*, 50-70.

<sup>24</sup> Nightingale, F, 'Introduction to the history and progress of district nursing' cited in Baly, M. E. *A History of the Queen's Nursing Institute (QNI) 1887 - 1987* (London 1987), 8.

<sup>25</sup> Hardy, *Epidemic Streets*, 46.

<sup>26</sup> ROLLR L610.73 Institution for Trained Nurses for the Town and County of Leicester (ITNL) Annual Report (AR) (1898), Pamphlet Vol. 6, Districts 7 and 8; Hardy, *Epidemic Street*, 63.



enterprise. Industrial prosperity in the hosiery and footwear trades produced consistently high levels of employment for both men and women, and this in turn resulted in relatively stable levels of income. As a result, good quality, affordable housing was gradually becoming within the reach of the Leicester working class between 1880 and 1914.<sup>27</sup> At the same time the influence of Wakerley's initiatives between 1885 and 1914 produced village-like developments inter-laced with industrial units and public services in an urban environment to improve the experience of town life. Wakerley, together with visionaries elsewhere, developed the universal concept of the 'garden city'.<sup>28</sup> Although the changes presented yet another challenge to the district nurses, the improvements in the environment did ease their work little by little.

### Health perspectives and provision

Leicester was not a particularly healthy place to live in the second half of the nineteenth century. Leicester's annual mortality rate of 30 per thousand population was exceeded by only three other towns of similar size; the average expectation of life was twenty-five years, but only twenty years and six months for a working man.<sup>29</sup> By 1867, 14 years after the installation of the city's sewage disposal system, the situation had somewhat improved with a crude death rate of 24 per 1000 population.<sup>30</sup> It was, however, the high death rate among infants and young children that made a significant contribution to the overall high death rate;<sup>31</sup> the infant mortality rate at that time was 200 per thousand live births in Leicester as compared with an average of 150 per 1000 for England and Wales; in 1871 the figure rose even higher to 252.4 per 1000 live births, meaning that 1 in 4 children in Leicester died before they reached their first birthday.<sup>32</sup> Leicester's Medical Officer of Health (MOH) described the situation in his 1900 Annual Report as the annual 'slaughter of innocents'.<sup>33</sup> The regular outbreaks of summer diarrhoea were Leicester's chief problem; it represented one of the most consistently high causes of death included within the category of 'zymotic disease', a

<sup>27</sup> Rodger, *Housing*. Nash and Reeder, *Leicester*, Chapter 1.

<sup>28</sup> Rodger, *Housing*. Nash and Reeder, *Leicester*, Chapter 2; ROLLR L614, 84/64 LCHR (1907), 52-53 Purdom, C. B, *The Garden City* (London 1913); Miller, M, *Letchworth: The First Garden City* (Kent 1989) traced the origins of the Garden City development to the early nineteenth century including Port Sunlight, Birkenhead (1887) and Bournville, West Midlands (1889); Lewis, R, *Stafford Past. An Illustrated History* (Surrey, 1997), 10 refers to Sieman's development in Stafford which provided a suitable domestic, social and working community environment for workers transferred to the town when the firm relocated from Woolwich.

<sup>29</sup> Brown, *Leicester*, 72.

<sup>30</sup> Elliott, *Victorian Leicester*, 65 and 86 – 7.

<sup>31</sup> ROLLR L614. 84/64 LCHR, (1900), 16.

<sup>32</sup> Elliott, *Victorian Leicester*, 86.

<sup>33</sup> ROLLR L614.84/64, LCHR (1900), 9.



category heading the main eight causes of death at the turn of the century. The seven other main causes of death in order of frequency were categorised as 'respiratory', 'developmental' (including birth defects), 'nervous' (a wide category including mental illness and suicide), 'heart diseases', 'TB' (all forms), 'cancer' and 'violence'.<sup>34</sup>

It could be argued that, in Victorian England, all the benefits of urbanisation and wealth creation went to one sector of the community and the other sector paid the price. The town dwellers, particularly those whose homes formed an apron-like mantle around the air-polluting factories, suffered not only from the depressing psychological effect of a grey atmosphere but from the 'aggravating impurities' discharged from the industrial and manufacturing units that contributed to respiratory disease.<sup>35</sup> The internal environment of the factories also presented risks for the workers, such as the high incidence and morbidity of tuberculosis (TB), particularly in the footwear and hosiery industries. In 1861, Leicester experienced an incidence of TB of 64 per 1000 population, which raised the concern of the Privy Council, not only because the incidence was extremely high, but also because of the particular vulnerability of people working in 'the impure environments of Leicester's manufacturing industries'.<sup>36</sup> In Leicester, 'probably half the local manufacturing industry was carried out in the dwellings of the work people' and, although the Local Health Board was assigned the responsibility of taking action in private houses, it lacked sufficient authority for effective intervention. The 'home-based' industries that infiltrated family life had long been a particular concern as graphically portrayed by the following scenario:

'I found a female at work between 9 and 10pm, with her husband and 2 journeymen at work above her head up the stepladder over the kitchen she was occupying. Her age is 50 but she looked 70; she had been the mother of fifteen children, 10 of whom (male and female) she and her husband had bred to be stockings'.

Source: Extract from William Felkin, 1844.<sup>37</sup>

In the later half of the nineteenth century, Felkin estimated that some 150,000 people were working in Leicestershire's knitting industry, mainly women and children, of whom 50,000 were knitters and 100,000 menders, seamers, cutters and finishers, but out-workers were a

<sup>34</sup> ROLLR L614.84/64, LCHR (1900), 10.

<sup>35</sup> ROLLR 20D 72. LCHR (1907), 19.

<sup>36</sup> Elliott, *Victorian Leicester*, 78.

<sup>37</sup> Bowles, G. and Kirrairie, S, *Knitting Together: Memories of Leicestershire's Hosiery Industry* (Leicester 1990), No. 108, 3 with reference to Felkin's discoveries of home working conditions;



submerged work-force not listed as hosiery workers<sup>38</sup> - a situation, which clearly encroached on the needs of the sick and their care by district nurses.

The vulnerability of workers and their families to TB infection, which was a fluctuating problem throughout the period 1860 to 1914, had consequences for district nursing resources both in the care of the sick and for the personal health risk of the nurses. Between 1897 and 1900, phthisis remained constant as the sixth highest cause of death in the city.<sup>39</sup> To some extent TB can be used as a case study of infectious disease *per se*; TB was highly infectious with groups such as the very young, the debilitated, and those who lived and worked in overcrowded or vagrant conditions being the most vulnerable. Health policies in Leicester between 1831 and 1911 indicated several key developments: the growing importance of data collection; the systematic analysis of health problems; control through early diagnosis, notification, and the isolation and treatment of both the source and the host; structural changes within the environment and social policy decisions.<sup>40</sup> The imperfect state of medical skill and scientific knowledge was one factor that hampered this process; germ theory was in its infancy and, whilst the bacillus causing TB was discovered by Koch in 1882, the tests and preventive measures which evolved from this work were several decades away.<sup>41</sup> Problems of incorrect or dishonest diagnosis not only delayed appropriate treatment but also skewed statistics and reduced the potential effectiveness of surveillance and control. The state of the doctor's knowledge and expertise may also have resulted in TB not being recognised, described 'euphemistically' or labelled as a condition that carried less stigma such as bronchitis or pneumonia.<sup>42</sup>

In addition, ignorance, apathy, and the fear of stigma and loss of earnings through sickness impeded diagnosis, treatment and control. The reluctance of patients to 'admit they were ill'

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<sup>38</sup> Felkin, cited in Bowles and Kirraine, *Knitting Together*, 30.

<sup>39</sup> ROLLR L614.84/64, LCHR (1900), 10.

<sup>40</sup> Jordon, T. E, 'Historical perspectives on health: Assessment of national progress in public health in England, 1832 - 1911, *The Journal for The Royal Society for the Promotion of Health*, 119 (2), 1999, 121-129. Donaldson, R. J and Donaldson, L. J, *Community Medicine (Lancaster 1984)*, 117-118; Clinical Sciences Library E/C/20 Leicester City Council, *150 Years of Public Health in Leicester* (Leicester 1996); ROLLR L614, LCHR (1906), 63 recorded the beneficial effects of the voluntary notification of TB cases - 'medical-men' were paid 2/6d for each case notified.

<sup>41</sup> Dormandy, T, *The White Death: A History of Tuberculosis* (London 1999), 130.

<sup>42</sup> Bryden, L, 'Not always one and the same thing: The Registration of Tuberculosis deaths in Britain 1900-1950', *Social History of Medicine*, 9, 1996, 153-166; Philips, R, Sir. 'Present day outlook on Tuberculosis', Inaugural address to the Institute of the Chair of Tuberculosis in the University of Edinburgh, 1918, cited in Bryden, '*Tuberculosis Deaths in Britain*', 254; Niemi, M. 'Health, Experts and the Politics of Knowledge: Britain and Sweden 1900-1940' University of Leicester Ph.D. thesis, 1999, 9; McKeown, T, *The Role of Medicine: Dream, Mirage or Nemesis* (Oxford 1979), xii.



was certainly a factor in a sample of 50 patients admitted to hospital, where 15 (30%) had been ill between nine months and one year, 16 (32%) between six and nine months, and 19 (38%) between three and six months.<sup>43</sup> Not all patients were admitted to hospital but languished at home, categorised as 'chronic sick' or 'incurables' in the district nursing records. The Infectious Disease Notification Act (1889) was a positive step forward for prevention but the benefits were doubtful owing to problems of concealment, bad practice and the rejection of imposed controls. The true extent of the problem remained undetected because of imprecise diagnosis, and subjective notification and classification.<sup>44</sup> The introduction in 1902 of voluntary notification of TB by medical practitioners in Leicester was unproblematic, but the inmates of the Poor Law institutions were not covered by legislation until 1908. Thus the clinical and social dimensions of infectious disease in the nineteenth and early twentieth centuries impinged upon the district nursing service as both a hidden and observable risk. The role of statistics in identifying these problems and informing policy decisions was crucial for effective curative, preventive and rehabilitative health-care strategies.<sup>45</sup> Public health authorities, however, were 'not always willing or able' to use the information, often because it was incompatible with a different socio-economic and political agenda.<sup>46</sup>

'Domestic nursing', which by Hardy's definition included district nursing, was recognised as one of the 'essential' elements in response to infectious diseases within the 'standard of living' versus the 'structuralist' debate.<sup>47</sup> The debate provided the historical context for Hardy's study on the behaviour of infectious disease and the part played by preventive medicine in the nineteenth century. Hardy's study confirms the added dimensions to the role of district nursing as it re-emerged under the wider aegis of a developing scientific community. It also captures the essence and concerns expressed about the way in which

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<sup>43</sup> ROLLR L614, LCHR (1907) 32-34.

<sup>44</sup> Szreter, S, 'The GRO (General Register Office of England and Wales) and the public health movement in Britain 1837 -1914', *Society for the Social History of medicine*, 4, 3, 1991, 435 - 63. The GRO provided authoritative information on mortality rates - aware that 'categorisation' can be another name for 'generalisation', the identification of 'preventable diseases' was the consistent and central aim of the GRO; Szreter, S, 'The importance of social intervention in Britain's mortality decline 1850 - 1914: a re-interpretation of the role of public health', *The Society for the Social History of Medicine*, 1. 1. (1988) 1-37. a paper that compared McKeown's thesis that gradual improvements in standards of living made the major contribution to the decline in TB compared with traditional view of the lead role played by public health .

<sup>45</sup> Szreter, 'The GRO', 435 -63.

<sup>46</sup> Niemi, 'Health, Experts and Knowledge', 206 - 7, the situation was described as that of health authorities 'manufacturing ignorance to justify non-action'.



policy-making depended on what the “experts” expected or wanted to see.<sup>48</sup> Was the priority poor housing (structural), or poverty and its concomitants (standard of living)? District nursing was caught between the two. On the other hand, there was no argument about the significance of the role of mothers and the benefits of education for health, fresh air, and sunlight, which were at the heart of district nursing.<sup>49</sup>

The prevalence of TB and other infectious diseases was a major concern but, to put them into perspective, other health problems of the late nineteenth century such as malignancy and stress-related conditions were also beginning to take their toll.<sup>50</sup> An increase in ‘nervous’ disorders in particular indicated a new problem in the sphere of personal health as the MOH observed;

‘..they are more common than 20 years ago..... (probably) due to the quicker rate of living and doing .... thoroughly in one hour what used to take our ancestors two hours...hurrying.....cramming....curtailing of meals....leading to dyspepsia and over-indulgence in self-medication and a hypochondriacal attitude to life ....suicide is part of this unhinged nervous system.’<sup>51</sup>

Stress, particularly from loss of earnings through illness, from conflict, from the disruption of family routines in the presence of suffering and incapacity, and from neglect and social isolation, constructed a context within which district nursing often functioned. The fear of a general deterioration in the health of the population overshadowed the early Edwardian period; although unproven, it highlighted the plight of the unskilled and casual manual worker and caused central government to address the ‘social ills’ of the nation.<sup>52</sup> District nursing was seen as a means by which to prevent pauperism by functioning as ‘an agency of an order calculated to watch over potential chaos emanating from the poor; the district nurse would prevent disease and alleviate its effects at the very origin’.<sup>53</sup>

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<sup>47</sup> Hardy, *Epidemic Streets*, 1 – 4, 34, 214 and 267- 94 considers the nineteenth century ‘standard of living’ versus ‘structuralist’ debate between the McKeownists and the Szreterists; Niemi, ‘Health, Experts and Knowledge’, 27.

<sup>48</sup> Niemi, ‘Health, Experts and Knowledge’, Chapters 4 and 5.

<sup>49</sup> Lewis, *Women*, 32, 38, 82, 98 and 100.

<sup>50</sup> ROLLR L614. 84/64, LCHR (1908) reports on the ‘serious’ increase in deaths for cancer from 75 in 1888 –92 to 214 in 1908.

<sup>51</sup> ROLLR L614. 84/64, LCHR (1900), 11-12.

<sup>52</sup> Szreter, ‘The GRO’ with reference to the Interdepartmental Committee on Physical Deterioration (1904).

<sup>53</sup> Dean, M and Bolton, G, ‘The administration of poverty and the development of nursing practice in the nineteenth century’, in Davies, C, ed., *Rewriting Nursing History* (London 1980), 76-101.



Clearly, a healthy workforce was essential to the success of the local economy and was also the basis from which charities and voluntary agencies were resourced. As a consequence, the early detection of ill health, prompt remedial action, and a quick return to work were vital to both the employer and the employed.<sup>54</sup> But Leicester in the nineteenth century, as in other East Midland towns, with its light industrial and manufacturing craft developments, created a space for women in the workplace. Thus a vacuum existed in the form of care in the home and informal benevolence in the community in times of sickness, chronic illness and frailty in old age. District nursing attempted to fill this role by enabling a speedy return to work of the wage earner, although in many instances it was a revolving door, as fitness to work often became unsustainable (see Chapter 3 with reference to working environments in the late nineteenth and early twentieth centuries).

Firms elsewhere in the country sought to ease the tension between home and work during periods of sickness through the creation of health-care schemes that became increasingly associated with district nursing, with the result that by the 1870s joint appointments of district/industrial nurse were developing.<sup>55</sup> There is no evidence to suggest similar arrangements in nineteenth century Leicester, but clearly a role for an organised form of district nursing was beginning to emerge from within the different strands of health and social care.

In the second half of the nineteenth century there was a fairly wide range of health-care provision in place in Leicester to address the prevailing health and social problems of the community. The various strands of this provision were largely unco-ordinated, having sprung up piecemeal in an *ad hoc* response to need. A range of health-care provision in institutions, clinics and by peripatetic services was offered by the three main providers – charities and voluntary organisations, statutory services and private enterprise. The Leicester branch of the

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<sup>54</sup> The Webbs 'The Charity Organisation Society and the Ratan Tata Foundation', in Bulmer, Lewis and Piachaud, *Goals of Social Policy*, 27 - 63, Introduction, with reference to the publication by Bulmer, et al, the monetarist view is considered that 'mass unemployment is a necessary technique'.

<sup>55</sup> Charley, I. H, *The Birth of Industrial Nursing* (London 1978). A study of 'Industrial nursing' (later known as Occupational Health Nursing) including early beginnings in the sixteenth century and Cowley Iron Undertakings, Surrey to the factory welfare reforms of the mid-nineteenth century. Nurses were sponsored by individuals, charities and in conjunction with Insurance, or Workers Welfare Schemes or District Nursing Associations (Sister Dora was such a notable individual), the Belper Humane Society founded in 1824 also led the field in industrial health nursing schemes later associated with district nursing; Prochaska, F. K, 'Philanthropy', in Thompson, F. M. L. *The Cambridge Social History of Britain 1750-1950, Social Agencies and Institutions* (Cambridge 1990), Vol. 13, 357-393 records the contribution of Carrow's of Norwich – a firm which from 1856 hired nurses and established links with other welfare agencies; Damant, M, Martin, C and Openshaw, S, *Practice Nursing; stability and change* (London 1994), 117 gives a brief history of joint appointments in association with district nursing.



Charity Organisation Society (COS) was set up in 1876 in an attempt to eliminate overlap in charity-sponsored provision and there were individual efforts made to take a collaborative approach to various projects, but all organisations and institutions remained autonomous.<sup>56</sup>

In the nineteenth and early twentieth centuries, the majority of the large institutions had been set up by charities or other voluntary organisations and had been providing general medical care for hundreds of years; Trinity Hospital had been established in 1331, Wyggeston Hospital and almshouses in 1513, and the Leicester Royal Infirmary in 1771 – and all were still going strong.<sup>57</sup> Towards the end of the nineteenth century, Leicester Corporation began to take responsibility for meeting specific medical needs by establishing hospitals such as the Fever Hospital in 1875, and the Isolation Hospital and Smallpox Hospital in 1900.<sup>58</sup> These hospitals were, of course, set up as much for the protection of the rest of the community as to alleviate the suffering of the sick themselves.

The institutions in the voluntary sector normally catered for patients who had the wherewithal to make some contribution towards their care whether through their own resources or through insurance schemes. Free care was available but only to those who could get a recommendation from one of an institution's benefactors. The Leicester Provident Society, established in 1833, initially offered medical relief to the poor, but in 1862 it was reconstituted to provide medicine through its dispensary and the services of doctors to subscribers only.<sup>59</sup> In the early twentieth century, two hospitals were established by the Society: John Faire hospital in 1903, and the Leicester Maternity Hospital in 1905. On the same principle, the Saturday Hospital Fund was formed in 1903 to provide several convalescent homes for the people of Leicester. Additional private health-care was also available but the fees were prohibitive to all but the wealthy.

For the very poor, the disabled and the destitute there was very little help available apart from the statutory services provided under the Poor Law enacted in 1601 and reformed in 1834. Under this law, the poor could expect to receive the dubious attentions of the pauper nurses,

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<sup>56</sup> ROLLR 361.7, Martin, J. D, *The Leicester Charity Organisation 1876 – 1976: A Centenary Review* (Leicester 1976).

<sup>57</sup> Cocks, T. Y, 'The Hospital of Holy Trinity Leicester', in Hinks, J, ed., *Aspects of Leicester* (Barnsley 2000), 9 – 24; Fizzelle, LRI;

<sup>58</sup> Harrison, C, *In Sickness and in Health* (Leicester 1999), 37 – 60.

<sup>59</sup> Harrison, *In Sickness and Health*, 70; ROLLR, Pamphlet Vol. 521, 'Leicester Homeopathic Dispensary Rules 1887'. Haynes, *Joseph Dare Reports*, 24, Dare observed in 1866 that the Dispensary was regarded in the most 'affectionable and grateful manner' by the people.



who visited the sick in their own homes, or, *in extremis*, the even more dubious benefits of the Workhouse.<sup>60</sup> It was not until the very end of the nineteenth century and the beginning of the twentieth century that institutions were established under the Poor law to cater for the health and social needs of the very poor; the Countesthorpe Cottage Homes were founded in 1894 and the North Evington Poor Law Infirmary in 1905. There were, however, three voluntary organisations at work in the community which gave a ray of light to those in a desperate situation, and which offered supportive links to the district nursing service when it was established in 1866.

Firstly, the Domestic Mission was set up in 1845, with the Rev. Joseph Dare appointed as its first Missioner, as has been described at the beginning of this chapter. Motivated by his horror of working class poverty and the 'quackery' to which the poor resorted, Dare aimed to elevate the poor physically, intellectually and spiritually.<sup>61</sup> He believed passionately in the benefits of a fully trained district nursing service and supported the efforts of other philanthropic reformers to that end – a process that will be examined later in this chapter.

Secondly, blind and partially sighted people in Leicester benefited from a self-help type of initiative when, in 1859, Robert Mackley, who was himself blind, provided the early impetus for the establishment of the Leicestershire Association for Promoting the General Welfare of the Blind.<sup>62</sup> The Association, which provided residences, a comprehensive welfare scheme, and workshops where the blind could be taught a trade, was strongly supported by the Rev. David Vaughan, who was among those who spearheaded the cause for a district nursing service in Leicester. It was perhaps not surprising that such a link was established, given the multiplicity of health and social problems associated with blindness, which often passed unrecognised and untreated except by the type of palliative care provided by the district nursing service.

Thirdly, in another equally small beginning, a service was established in 1898 for the 'crippled class who had no Society to which they could look for relief and sympathy', the inspiration for which came from Sister Carroll Hogbin of the society of Deaconesses and

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<sup>60</sup> ROLLR I362.5/ SR1 Thompson, K. M, 'The Leicester Poor law Union 1836 – 1891 University of Leicester Ph.D. thesis 1988.

<sup>61</sup> Haynes, *Joseph Dare Reports*, 10, 43, 44, 52.

<sup>62</sup> Seaton, D, *Light Amid the Shadows: Royal Leicestershire, Rutland and Wycliffe Society for the Blind 1858 – 1993* (Leicester 1994), 3 – 4.



Arthur Holmes, a hosiery manufacturer.<sup>63</sup> The Leicester Guild of the Crippled provided social activities and welfare provision for people with various disabilities, who were erstwhile confined in their own homes. The district nursing service also provided a safety net in the homes of many invalids such as the people who attended the Guild.

The framework presented at Figure 2 below illustrates the various strands of health-care provision available in Leicester in the nineteenth and early twentieth centuries, and the disparate and unco-ordinated nature of that provision. As can be seen from the framework, Leicester Corporation gradually became a more significant provider of all types of medical care in the first half of the twentieth century, but in the nineteenth century voluntarism still held sway and successive medical officers for public health, the first of whom was appointed in 1846, had to work with all other providers to achieve the improvements which they were aiming for. The district nursing service was one such provider and the Leicester (Voluntary) Health Society, which initiated and funded the first HV appointment to work under the direction of the Medical Officer of Health (MOH) in 1895, was another.<sup>64</sup> Collaboration with the Health Society enabled the MOH to set up the School Medical Service in 1905, with HVs going into the schools to check on the children's health and give advice. A further collaboration, this time between the MOH and the Leicester branch of the COS, brought about the opening of a Milk Depot in 1906 for the supply of safe milk to vulnerable groups of infants and children in order to combat the so-called Leicester disease of 'summer-diarrhoea'.<sup>65</sup> The examples of health-care provision illustrated in Figure 5 reflect two prominent themes in this study: firstly, the centrality of the spirit of Victorian philanthropy and voluntarism expressed through charities and voluntary organisations; and secondly, the close involvement in the relief of distress by both the religious and secular sections of society in Leicester.

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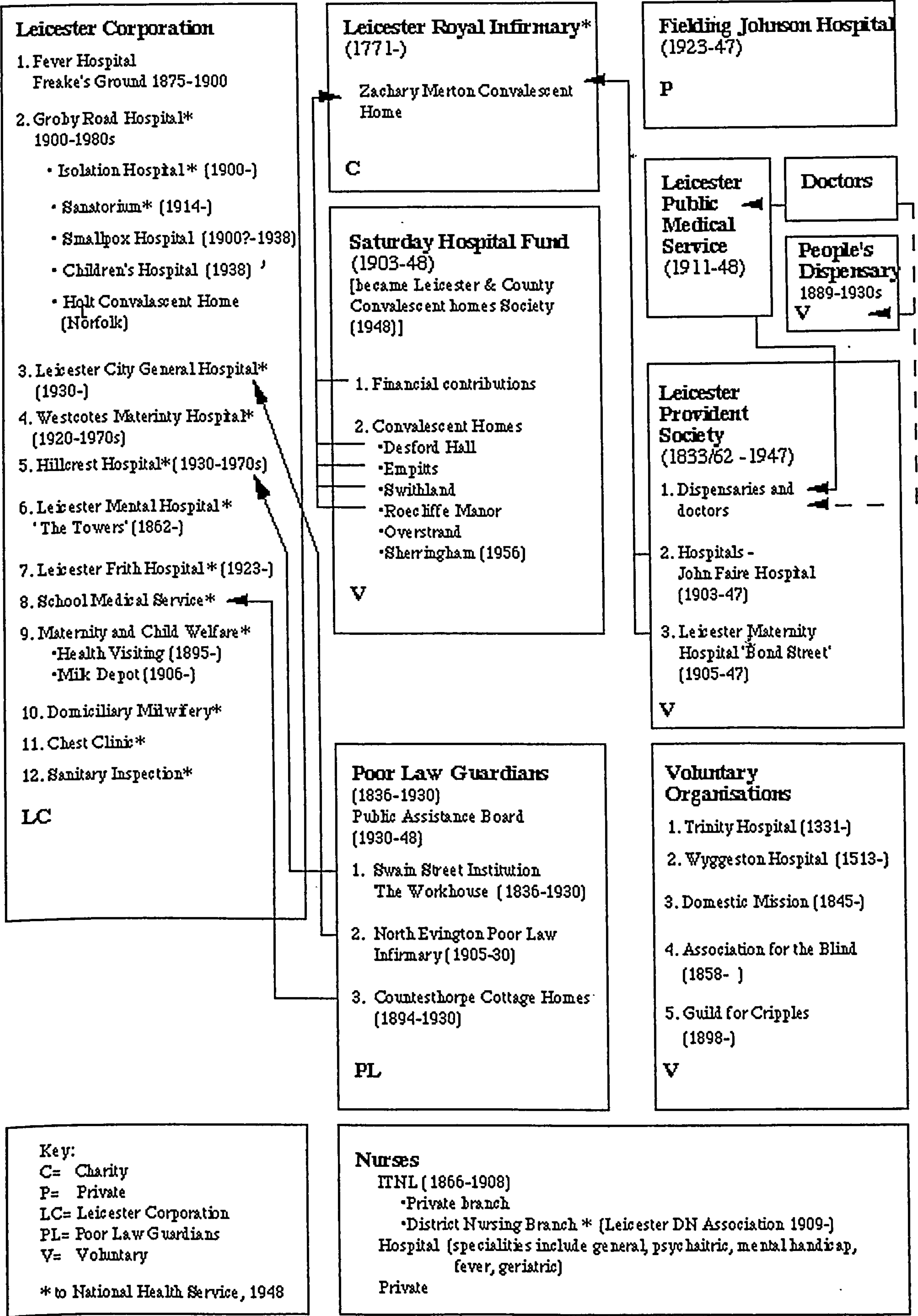
<sup>63</sup> Seaton, D, *From Strength to Strength: A History of the First 100 Years of the Leicester, Leicestershire and Rutland Guild of Disabled People 1890 – 1998* (Leicester 1998), 1 – 3, 5 – 6; Leicester Guild of the Crippled Annual Report: 'In memoriam of Sister Carroll 1902 – 1921', (1922); Leicester Guild of the Crippled Golden Jubilee Report 1898 – 1948 'The Story', NB. The Society of Deaconess to which Sister Carroll belonged was one of the main sources of home-care provision for the sick and dying prior to the foundation of the ITNL..

<sup>64</sup> LDNA, *A History*; Elliott, *Victorian Leicester* 97 – the first HV appointment in Leicester in 1896.

<sup>65</sup> Welshman, J, *Municipal Medicine in the Twentieth Century* (Oxford 2000), 120 – 1; ROLLR, L614 84/64 LCHR (1900), 17 – 8 and (1906) Appendix 1 Report of the Leicester Corporation Infants Milk Depot; Aucott, S. R, *Leicestershire Remembered: Mothercraft and Maternity* (Leicester 1997) and Aucott, S. R, 'The maternity and child welfare movement in Leicester' University of Leicester M.A thesis, 1993 offers a perspective of Leicester's response to the risk factors associated with maternal and child health and the laudable role of women's organisations.



FIG. 2: FRAMEWORK OF HEALTH-CARE IN LEICESTER (1866 – 1974)



Source. Adapted from Harrison, C. *In Sickness and in Health* (Leicester 1999), Appendix F, 131.



It is perhaps not surprising that the results of the 1850 multi-denominational Religious Census suggested that Leicester was 'remarkably devoted in its religious observance'. By contrast, Dyos perceived the multicultural dimensions in Leicester and its 'complete spectrum of religious sects without much feeling of piety' to be rather superficial. He also regarded the City as embodying 'the qualities of bourgeois success...A rather puffy pride without any real sense of community, a desire to lead without any real taste for adventure' – a position which on the other hand may have sharpened the need for an organised district nursing service and other voluntary activity in the absence of the informal benevolence of neighbourliness and community spirit. It is within such a climate that Leicester emerged as one of the early trailblazers for district nursing in the nineteenth century. How far district nursing sustained this position or displayed any 'real taste for adventure' is another of the principal themes of this thesis.

### **The emergence of a role for district nursing in Leicester**

In 1865, the gap in nursing provision for the relief of distress of the sick and dying in their own homes became a sharper focus of concern in Leicester. A group was formed to draw up proposals to plug the gap, and interest centred on the 'free nurses' working in London and Liverpool.<sup>66</sup> Having consulted widely, the group resolved at a meeting in May 1866, chaired by the Lord Bishop of the Diocese, to place a formal proposal before a public meeting the following month, in spite of the fact that a long-hoped-for response from the County had not been forthcoming. The proposal recommended the founding of an Institution of Trained Nurses for the Town and County of Leicester (ITNL) to organise and sustain a nursing service for the sick poor in their own homes.<sup>67</sup> The objects of the enterprise were to secure:

a central Home in Leicester as a permanent residence for the nurses employed among the poor, and an occasional residence for those employed in private families or county parishes, during intervals of employment;

the services of a qualified nurse as Lady Superintendent, Head of the Institution and answerable to the committee of management, to oversee the management of the Home, dispense comforts to the sick poor through the district nurses, and to recruit district nurses;

an appropriate number of properly trained district nurses for the poor in Leicester;

a given number of properly trained nurses to be hired out by families in the town or county on a fixed rate charge, or in the poor country parishes on negotiated terms.

It was reported in the local press that a proposal to establish the ITNL was placed before a public meeting in June 1866 and met with huge enthusiasm and support from those present – 'ordinary men and women'; notable members of the local gentry; the church and medical

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<sup>66</sup> Ellis *Nineteenth Century Leicester*, 81-90.



professions; and representatives from various levels of industry and commerce – the four cornerstones of voluntarism. The constitution gave the ITNL a high profile in the community, and protected the organisation from charges of corruption such as those levelled at the Poor Law, where there was evidence of maladministration together with unaudited and unchecked expenditure. The membership of the ITNL General Committee included ten persons from such groups as civic leaders, doctors, business people, the clergy, and/or the relatives of these people thus giving the ITNL credibility and links within the medical and economic communities of Leicester (see Appendix 1). Members of the aristocracy were also represented and the MOH in an ex-officio capacity provided the essential link with the public health services. It is significant that district nurses were directly represented on the Committee by the Chief Lady Superintendent and the Lady Superintendents of the Districts.

In Leicestershire, two decades after the establishment of the ITNL, microcosms of urbanisation demonstrated the same fourfold community involved in creating autonomous units that offered networks of expertise through the formation of voluntary district nursing associations (DNAs). For instance, Market Harborough Nursing Association, established in 1885, had strong links with ITNL through a joint committee member, Mrs Wartnaby, who ensured that when the nurses' health broke down 'Leicester nurses were resorted to as reliefs'.<sup>68</sup> The value of interconnected branches facilitated the sharing of expertise and resources for a common purpose. By contrast, Loughborough DNA, established in 1896, was affiliated to the Queen's Nursing Institute (QNI), the national body which had been established in 1887 for the co-ordination and control of standards in district nursing (see chapters 3 and 4). The QNI supplied a 'Queen's' trained district nurse (QN) for the Loughborough area.<sup>69</sup> Two years later, the mining areas of Hugglescote and Coalville established a QNI affiliated scheme,<sup>70</sup> but it was to be another six years before the neighbouring mining town of Ashby-de-la-Zouch was able to support a DNA<sup>71</sup>

Leicester, whilst considerably more advanced in the provision of a district nursing service than other Midland towns, was not alone in its concern for the sick poor in their own homes.

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<sup>67</sup> *Leicester Journal and Midlands County Advertiser*, 'Institution for Trained Nurses', July 1866, 3.

<sup>68</sup> The Harborough Museum, 76/1987/61. Anon, 'Notes for a short history of Market Harborough Cottage Hospital' (Unpublished manuscript 1971); Davies, J. C, and Brown, M. C, 'Yesterday's Town, Victorian Harborough' (Buckingham 1980), 76-77; McKinley, R. A. 'Market Harborough'. *The Victorian History of the Counties of Leicester: A History of Leicestershire* (London 1964), 133-153.

<sup>69</sup> National Archive (NA) 30/63/266 (1897). Loughborough District Nursing Association (DNA). QNI Inspector's Reports.

<sup>70</sup> NA 30/63/262 (1898) Hugglescote DNA. QNI Inspectors' Reports.



For example, an Institution of Trained Nurses in Northamptonshire was formed in 1877, an organisation with which members of the aristocracy, including the Spencer family, were involved, and the origins of which can be traced back to the Northamptonshire Invalid Loans Society some twelve years earlier.<sup>72</sup> Further north, the Royal Derby and Derbyshire Nursing Association was well established by 1896 and equally well supported by the four cornerstones of voluntarism, so that by 1901 the King had acceded to a request to grant his patronage to the Association.<sup>73</sup>

Three major challenges confronted the ITNL in 1866. The first of these was the universal challenge of recruiting sufficient trained nurses. The ITNL consulted widely and were committed to Rathbone's model, namely that district nurses should be women of good education, fully trained in hospital techniques, and employed by a responsible organisation.<sup>74</sup> This was a critical stage in the last half of the nineteenth century when nurse training was in its infancy and provided as a local arrangement. Whilst Derby secured a supply of trained nurses from the local hospital, early initiatives in Leicester were abortive, as previously shown in a Chronology of district nursing and related events at Table 1, p115,. Mrs Walker, a member of The Leicester Domestic Mission Committee, prepared an alternative scheme by which trained nurses could be obtained to work in Leicester as district nurses. Mrs Walker's scheme, with the support of Mrs Vaughan, a fellow member of the Leicester Ladies Committee, was accepted in 1866 and funds were raised by the Committee to train four nurses at hospitals in London the following year.<sup>75</sup>

The second major issue was that of funding. The single most important and expensive item was the district nurses' salaries. A financial estimate of £500 was quoted at the inaugural public meeting in June 1866 to start the ITNL, with an annual income thereafter of £500 to maintain the service in sufficient working order. The patronage of several 'noblemen and gentlemen', including His Grace the Duke of Rutland, the Lord Bishop of Leicester and C.W Packe MP, was attracted to secure the level of financial commitment needed. In addition, members of the Committee were drawn from equally illustrious ranks of society, such as Sir Arthur Hazlerigg,

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<sup>71</sup> NA 30/63/261 (1904) Ashby-de-la-Zouch DNA. QNI Inspectors' Reports.

<sup>72</sup> Northampton Records office (NRO)/ DMAP 45. The First Annual Report of the Northamptonshire Institution for Trained Nurses for the year ending 1<sup>st</sup> March 1878. NRO/ Queen's Institute of District Nursing. Canon Lewis, J. T. *Diamond Jubilee Report 19877 – 1937*.

<sup>73</sup> Derbyshire Records Office (DRO) D4566/1/1 Royal Derby and Derbyshire Nursing and Sanitary Association 1896-1914. Special Meeting of the Board of Management(1896) and Board of Management Meeting (1901).

<sup>74</sup> Merry, E. J and Irven, I. D, *District Nursing* (London 1948), 4-5.



Venerable Archdeacon Fearon, Major Frear and notable members of Leicester's business and manufacturing fraternity. The Committee invited the involvement of 'clergymen, ministers, medical men and other appropriate persons' willing to subscribe either £2.10p upward annually or single donations of £25.<sup>76</sup> In addition, the sick poor who were able to make a donation were encouraged to do so. Thus there was an opportunity for everyone, at every level, to become stake holders in the enterprise and the essential elements of a 'Trust' were established.<sup>77</sup>

The third factor was the promotion of positive working relationships. Clearly, the creation of inter-agency networks was critical to the success of the enterprise. For example, it was important to instil confidence in local benefactors for their financial support in a high-risk undertaking, and a professional relationship between district nursing and the medical profession that did not threaten or usurp the role of the doctor was essential for quality patient care. The sick poor sometimes needed encouragement to use the service, which they may have resented as an intrusion into their private lives and because it carried the stigma of charity. Leicester was among the first boroughs in Britain to establish a Trained Nurses Institution in 1866 and only the third locality in the country to adopt the Rathbone model of district nursing. To achieve these ends the ITNL formulated an inclusive and open Constitution through representative membership and a system of collective responsibility and public accountability (see Appendix 1). A General Committee held overall responsibility for strategic planning and financial control; patient care decisions, and executive and budgetary control were localised through District Committees. The Victorian 'District' Model (see Figure 3) was adopted by the ITNL to construct manageable areas of the town for the day-to-day working of district nurses'.<sup>78</sup> The districts were not entirely coterminous with local authority divisions but they were often closely associated with the parochial boundaries.

As mentioned previously, the chief Lady Superintendent was a member of the General Committee, where she represented professional district nursing issues and was also responsible for the executive control of the work carried out in the Districts. Each District was managed by a Lady Superintendent, a lay person - usually the wife or a relative of Leicester's elite, assisted by a Lady Visitor, who was of similar background.

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<sup>75</sup> Ellis, *Nineteenth Century Leicester*, 93; *Leicester Journal*, 'Institution for Trained Nurses', 6.

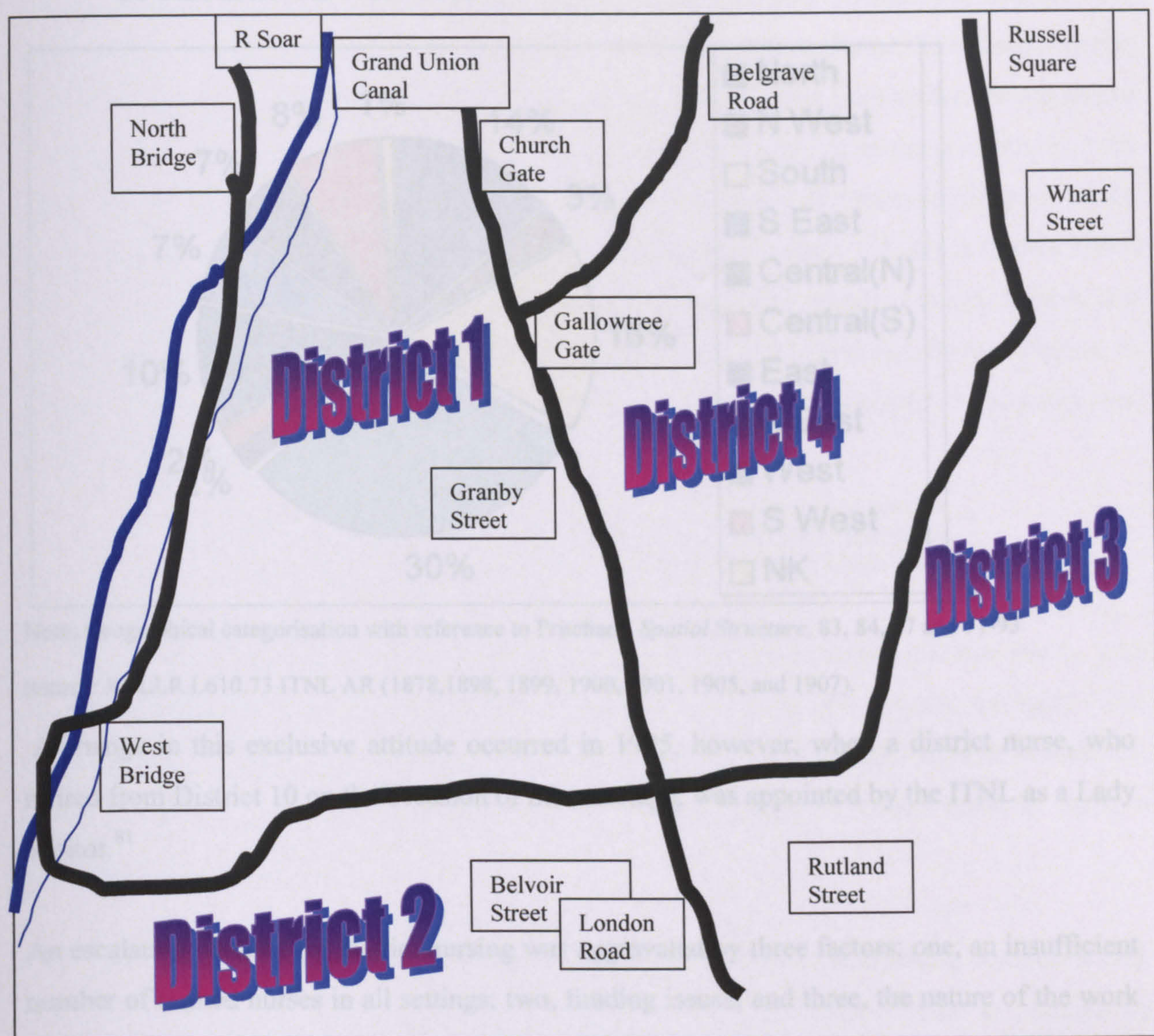
<sup>76</sup> Converted to decimal currency.

<sup>77</sup> Clift, B and Tomlinson, J, 'Tawney and the third way', *Journal of Political Ideologies*, 2002, 7, 3, 315–31, 'Third way' refers to an economic system derived from the communities of civil society, rather than an imposed capitalist economy, of government funding. See also Giddens, A, *The Third Way and its Critics* (Cambridge 2000), 62 – 65 on 'communitarianism'.

<sup>78</sup> District divisions of local administration also date back to Roman times – see Chapter 2



FIG. 3: ITNL FOUR DISTRICTS (1869)



Source: ROLLR L610.73 ITNL AR (1898)

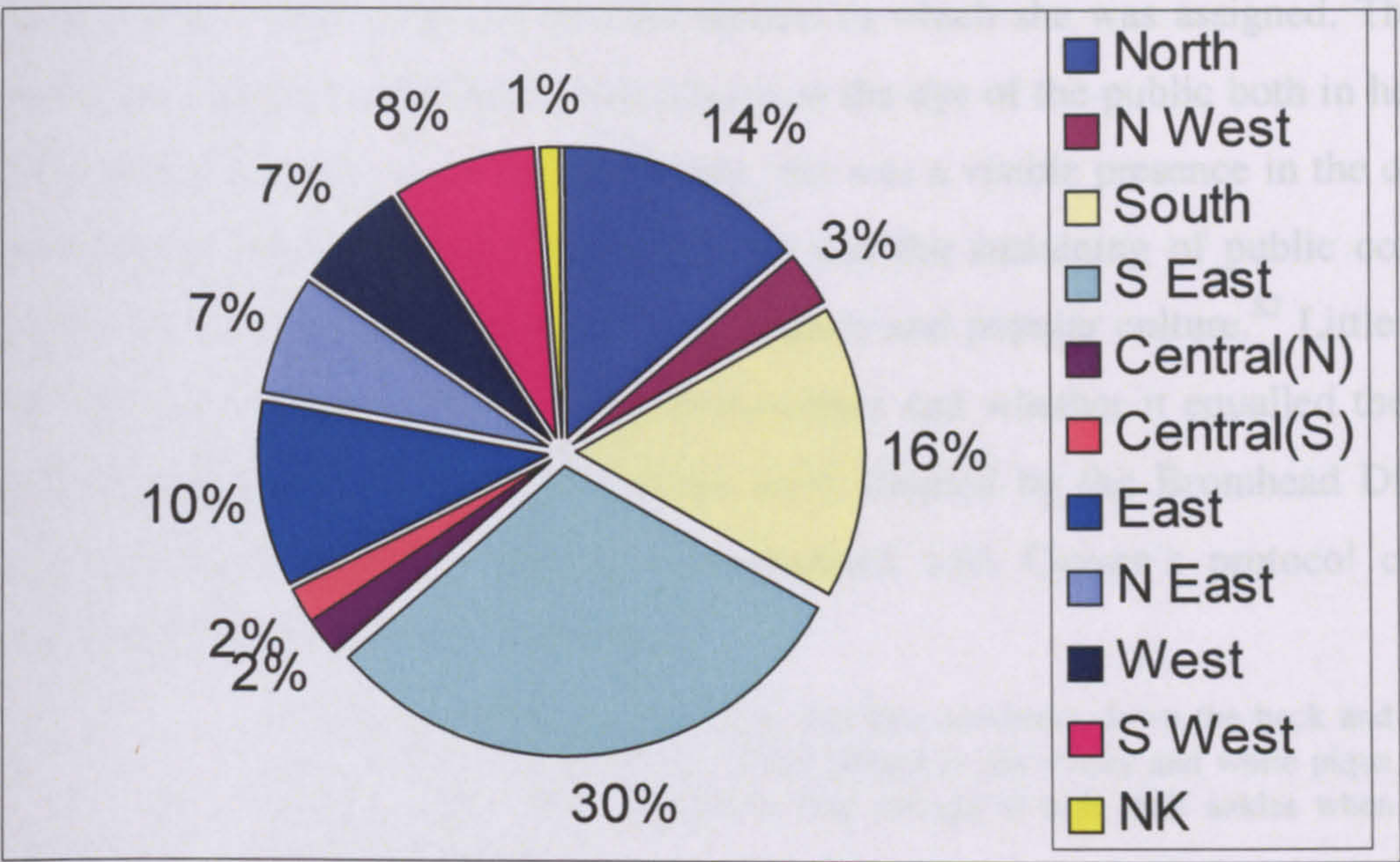
The position of the Lady Superintendents and Visitors brought added benefits to the ITNL through their wide socio-economic and public relations network. Evidence suggests, on the basis of their kinship network and place of residence, that both groups were drawn from the upper and middle classes.<sup>79</sup> The Ladies did not normally live in their Districts but tended to live either in the new fashionable or long-established upper class regions of the city away from the poorer central and north west areas (see Figure 4). The hierarchy of class within the ITNL seemed to reflect what was perhaps commonly considered to be the natural order of things; 'it would be in the highest degree unlikely for a resident in the poorer districts of the town to be a member of the benefactor group'.<sup>80</sup>

<sup>79</sup> Pritchard, *Spatial Structure*, 43-45. Assuming that abode can be used as an indicator of social class.

<sup>80</sup> Chambers R.C, 'A study of three voluntary organisations', in Glass D.V, ed., *Social Mobility in Britain* (London 1954 ), 383.



**FIG. 4: ITNL LADY SUPERINTENDENTS' AND LADY VISITORS' AREAS OF RESIDENCE 1866 - 1908**



Note: Geographical categorisation with reference to Pritchard, *Spatial Structure*, 83, 84, 87 and 91-93

Source: ROLLR L610.73 ITNL AR (1878,1898, 1899, 1900, 1901, 1905, and 1907).

A change in this exclusive attitude occurred in 1905, however, when a district nurse, who retired from District 10 on the occasion of her marriage, was appointed by the ITNL as a Lady Visitor.<sup>81</sup>

An escalating demand for district nursing was aggravated by three factors: one, an insufficient number of trained nurses in all settings; two, funding issues; and three, the nature of the work and conditions in which the nurses practised. Effective administration was a critical feature of the ITNL financial solvency. The District Lady Superintendent's management of budgets and accounting systems was just as important as the welfare and supervision of district nurses and their standards of practice. Assistance was provided by Lady Visitors, who shared responsibility for the patients in the district and the supervision and support of the district nurse. The role of the Lady Visitor seemed to involve the assessment of patients – firstly, to legitimise their need for the district nursing service, and secondly, to check their ability to pay or contribute to the nursing care. At this time, district nursing was free to the poor but those who could, even if poor, were encouraged to make a donation, however small. This approach reflected the ethos of Victorian charity and its abhorrence of dependency, the relinquishing of responsibility and the removal of the dignity of the individual.

<sup>81</sup> ROLLR L610.73 ITNL AR (1905) General Committee Report and District 10 Report.



The district nurses were hospital trained but rarely received any additional preparation for their specialised role and function in the homes of the sick poor. Unlike the Ladies, each district nurse lived within or near the district to which she was assigned. The district nurse, unlike her hospital counterpart, was always in the eye of the public both in her private and in her professional life. Like the policeman, she was a visible presence in the community, with far-reaching implications for accountability and the sustaining of public confidence, whilst sometimes running the gauntlet of local custom and popular culture.<sup>82</sup> Little is known about the uniform worn by district nurses in Leicester and whether it equalled the distinctive and symbolic apparel of the police, but the style adopted by the Bromhead District Nurses in Lincoln (see Chapter 2) seemed to correspond with Craven's protocol of propriety and practicality within the style of the era.<sup>83</sup>

‘pleated net ruches on their caps with two streamers down the back and waistcoats over their bodices of red flannel in the winter and white pique in the summer. Their skirts were long enough to hide their ankles when bending over beds.’<sup>84</sup>

As elsewhere, the most common form of transport for the Leicester district nurse, who travelled around her district in all weathers, was either on foot or by public transport – the donation of a bicycle was always reported enthusiastically.<sup>85</sup> In inclement weather conditions, a public-spirited individual or the emergency services might be called upon to assist a stranded nurse.<sup>86</sup>

The work of the district nurse was varied; patients suffered from debilitating conditions and, for many, the prognosis was poor. The patients' needs were multifarious, as claimed by

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<sup>82</sup> Storch, R. D. ‘The policeman as domestic missionary: Urban discipline and popular culture in Northern England 1850-80’, in Morris and Rodger, eds., *Victorian City*, 281 – 306; Swires, E, widow of a Leicester QN, (Interview 1999); Wells, M, retired Leicester district nurse, (Interview 1999); Pointon, G, retired Leicester QN, (Interview 1998).

<sup>83</sup> Craven, *Guide to District Nurses*, passim. Here the district nurse is directed to reform and recreate even in the homes of the poorest and most wretched. She must be the eyes and ears of the doctor whom she rarely sees, sometimes not at all. She must be unadorned by ‘fringes or frizettes’ and scrupulously clean, washing with hot water at night and a cold sponging each morning – under-linen changed twice weekly. Tact, skill, observation and sound knowledge is the essence of district nursing.

<sup>84</sup> Bray C, Grantham K and Wright A, *The Enemy in our Midst: The Story of Lincoln's Typhoid Epidemic 1905* (Lincoln 1987), p22

<sup>85</sup> ROLLR, L610.73 ITNL AR (1900) – Friends purchased a bicycle for the nurse to economise on time and strength; Anon, ‘Market Harborough Cottage Hospital’ the gift of a bicycle for the district nurse 1897 was also welcomed because ‘it greatly increased her sphere of usefulness’.

<sup>86</sup> Clarke, J, ‘Every picture tells a story’, *Daily Mail*, 2002, 76 – a district nurse's experience of being assisted by the public services in the inclement Lincolnshire weather, although outside the historical context of the chapter the experience is timeless as indicated by informal anecdotes from rural and urban nurses in Leicestershire; Gibb, P, ‘District nursing in the highlands and islands of Scotland: 1890 – 1940’, *History of Nursing Journal*, 4, 1992/3, 319 – 29; Anon, ‘Footsteps in the snow’, *Nursing*



Hardy, and every case represented not only one person in distress but a back-up army of relatives (sometimes children), friends and neighbours, who were equally demanding of the district nurse's teaching, counsel and support. The nub of the problem can be illustrated by the circumstances affecting District 3 (see Table 2), which covered one of the poor low-lying

**TABLE 2: ITNL DISTRICT 3 -TYPE OF CASES BY RESULTS (1878)**

TYPE OF CASE:	OUTCOME :							TOTAL CASES	
	Recovered	Relieved	Dead	Infirmity	Union	Unsuitable	Contin'd		
	%	%	%	%	%	%	%	N =.	%
Abcess	5.7	0.0	9.1	14.3	0.0	0.0	16.7	6	6.2
Accident	2.9	5.0	0.0	0.0	0.0	0.0	16.7	3	3.1
Bronchitis	14.3	15.0	13.6	0.0	20.0	0.0	0.0	12	12.4
Childbirth	20.0	5.0	0.0	0.0	0.0	0.0	0.0	8	8.2
Cancer	0.0	0.0	4.5	0.0	0.0	0.0	0.0	1	1.0
Consumption	0.0	15.0	22.7	0.0	0.0	0.0	0.0	8	8.3
Debility	22.9	10.0	9.1	14.3	0.0	0.0	0.0	13	13.4
Dropsy	0.0	0.0	4.6	14.3	0.0	0.0	0.0	2	2.1
Erysipelas	0.0	5.0	0.0	14.3	0.0	0.0	0.0	2	2.1
Fever	2.9	0.0	4.6	14.3	0.0	0.0	0.0	3	3.1
Heamorrhage	8.6	0.0	4.6	28.6	0.0	0.0	0.0	6	6.2
Heart disease	0.0	5.0	4.6	0.0	0.0	0.0	0.0	2	2.1
Paralysis	0.0	5.0	9.1	0.0	0.0	0.0	66.7	7	7.2
Rheumatism	5.7	20.0	0.0	0.0	0.0	0.0	0.0	6	6.2
Various	17.1	15.0	13.6	0.0	80.0	100.0	0.0	18	18.6
TOTALS: (n=) %	(35) 100	(20) 100	(22) 100	(7) 100	(5) 100	(2) 100	(6) 100	97	100

Source ROLLR Pamphlet Vol. 76 ITNL AR (1878) District 3.

areas to the east of the town where people lived in substandard housing in close proximity to the canal and surrounded by factories. Perhaps not surprisingly 'bronchitis' and 'debility' were the most frequent types of case, at 12.4% and 13.4% respectively.<sup>87</sup> The outcomes for patients under the care of the district nurse suggest that over one third (36%) of all cases 'recovered'; the most positive outcomes were in cases of 'childbirth', 'bronchitis' and 'debility', whilst 'accidents' and 'fever' had the lowest recovery-rate. Only about one fifth (21%) of all cases were 'relieved' from the effect of an immediate crisis. Nearly one quarter (23%) succumbed to their illness, with consumption (TB) being one of the highest causes of

*Times*, 89, 1993, 5; Morrissey, J. 'The Irish district nurse – 85 years ago', *Journal of Irish Nursing*, 1980, 21.

<sup>87</sup> 'Debility' see for example Hamlin, C., 'Public Health and Social Justice', cited in Hennock, *The Urban Sanitary Movement*, and the belief that 'inadequate income and harsh working conditions are causes of debility that could lead to sickness'.



death - a major health problem in Leicester.<sup>88</sup> The outcomes tabled as 'Infirmity' and 'Union' refer to the cases transferred to institutional care. It is worth noting that few patients (12%) were admitted to institutional care, and those that were tended to be emergency-type incidents such as 'haemorrhage' rather than the more chronic and longer term conditions of the slowly dying. This highlights the onerous and intense annual workload of district nurses, and the long-term requirements of two-thirds (66.7%) of all 'paralysis' cases and one-third (33.3%) of the acute cases which 'continued' through to the following year. It was a situation reinforced by the assessment made by District 4 that 'most of the cases are quite hopeless; many entirely unfit for the infirmity'.<sup>89</sup> 'Unsuitable' referred to patients whose needs were not appropriate to district nursing and probably included those requiring welfare relief only.

This evidence is the only surviving record in the ITNL collection to include a composite account of the type of conditions, the number and outcome of cases nursed in the districts.<sup>90</sup> Nevertheless, the record confirms a general impression of district nursing as responding to major health issues such as contagious diseases and related serious medical conditions from which over half of the patients recovered or were relieved during a specific crisis.<sup>91</sup> District nurses clearly held a wide remit, including an involvement with 'childbirth' before the establishment of legislative controls by The Midwives Act in 1902 that protected the title 'midwife' against the non-certified woman or care given by district nurses in situations that might have endangered the midwives' practice.<sup>92</sup>

In 1878, District 3, whilst acknowledging the 'great amount of unrecorded occasional help given', reflected that 'it is impossible to give the proper amount of time and care to cases lying so far apart ... the need for a fifth District is urged'.<sup>93</sup> Although by 1894, some sixteen years later, there had been a remarkable increase in the number of district nurses from four to eleven (see Figure 5), the adverse ratio of nurses to requirements was a continual constraint.<sup>94</sup> The 'rapid growth in the town's population' combined with an ever-expanding demand for

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<sup>88</sup> ROLLR L614 84/64, LCHR (1900), 10.

<sup>89</sup> ROLLR Pamphlet Vol.76. ITNL AR (1878), District 4.

<sup>90</sup> ROLLR Pamphlet Vol. 6. ITNL AR (1898).

<sup>91</sup> Hardy, *Epidemic Streets*, passim.

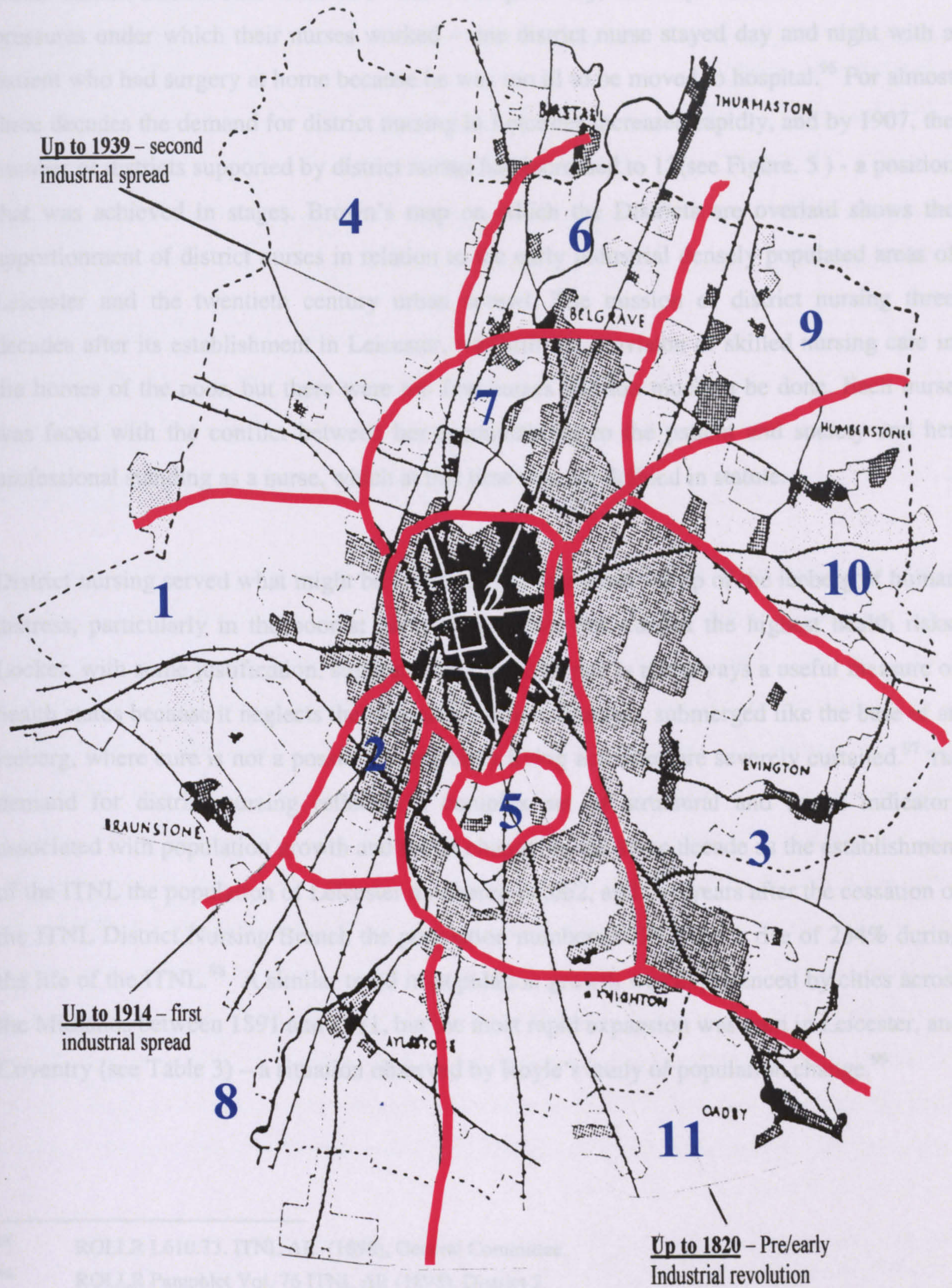
<sup>92</sup> Miles, M. *Textbook for Midwives* (Edinburgh 1958), 625.

<sup>93</sup> ROLLR Pamphlet Vol. 76 ITNL AR (1878), District 3.

<sup>94</sup> LDNA, *A History*, 4.



FIG. 5: ITNL ELEVEN DISTRICT (1894) TWELVE DISTRICTS (1907)



Sources: Brown, A. E. ed., The Growth of Leicester (Leicester 1972), 7.  
ROLLR L610.73 ITNL AR (1907) District boundaries.



district nursing in 1898 made the work 'too heavy for the eleven nurses'.<sup>95</sup> Districts 2 and 4, which carried smaller case loads of 54 and 74 respectively, also expressed concern about the pressures under which their nurses worked – one district nurse stayed day and night with a patient who had surgery at home because he was too ill to be moved to hospital.<sup>96</sup> For almost three decades the demand for district nursing in Leicester increased rapidly, and by 1907, the number of districts supported by district nurses had increased to 12 (see Figure. 5) – a position that was achieved in stages. Brown's map on which the Districts are overlaid shows the apportionment of district nurses in relation to the early industrial densely populated areas of Leicester and the twentieth century urban sprawl. The mission of district nursing three decades after its establishment in Leicester, was still the provision of skilled nursing care in the homes of the poor, but there were too few nurses and too much to be done. Each nurse was faced with the conflict between her accountability to the patient and society and her professional standing as a nurse, which at this time was not defined in statute.

District nursing served what might be legitimately considered the tip of the iceberg of human distress, particularly in the poorest parts of the town that carried the highest health risks. Locker, with some justification, suggests that the death rate is not always a useful measure of health status because it neglects the long-term chronic diseases, submerged like the base of an iceberg, where cure is not a possibility and daily living activities are severely curtailed.<sup>97</sup> The demand for district nursing reflected a complex set of structural and social indicators associated with population growth and social change. In the same decade as the establishment of the ITNL the population of Leicester numbered 68,062, and two years after the cessation of the ITNL District Nursing Branch the population numbered 227,222 – a rise of 234% during the life of the ITNL.<sup>98</sup> A similar trend in population growth was experienced by cities across the Midlands between 1891 and 1911, but the most rapid expansion was seen in Leicester, and Coventry (see Table 3) – a situation observed by Royle's study of population change.<sup>99</sup>

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<sup>95</sup> ROLLR L610.73. ITNL AR (1898), General Committee.

<sup>96</sup> ROLLR Pamphlet Vol. 76 ITNL AR (1898), District 2.

<sup>97</sup> Locker, D, 'Living with chronic illness', in Scambler, *Sociology*, 81 – 92.

<sup>98</sup> Fizzelle, *LRI*, Appendix 1.

<sup>99</sup> Royle, E, *Modern Britain. A Social History 1750 – 1985* (London 1988), 60 here it is recorded that of the cities which grew the fastest between 1871 – 1911 four were in the Midlands, namely Coventry, Derby, Leicester and Nottingham.



During this period, whilst population changes attributable to migratory processes and boundary changes in part accounted for the demand for district nursing, other factors also had

TABLE 3: POPULATION TRENDS IN THE MIDLANDS (1891, 1901 AND 1911)

Admin Counties/CB/UDC/ Municipal Boroughs	Census Year	Census Year	Census Year	Population Increase %	Population Increase %
	1891	1901	1911	1891-1901	1901 – 1911
COVENTRY CB		69978	106349		52.0
DERBY CB	98620	114848	123410	16.5	7.5
LEICESTER CB	174624	211579	227222	21.2	7.4
NORTHAMPTON CB	75075	87021	90064	16.0	3.5
NOTTINGHAM CB	213877	239743	259904	12.1	8.4
STAFFORD MB		3887	4578		12.0

Source: *Census of England and Wales 1911*. Summary Tables for Midland Cities and Towns.

an impact. For instance, there was a changing social and clinical pathology associated with an increase in chronic illness and longevity, together with a perceptible change in the policy of selection of patients for admission to hospital based on human rather than on clinical interest.<sup>100</sup> A wider emphasis on health teaching created a need for district nursing at an earlier stage in the patient’s illness and gave greater emphasis to a holistic approach, particularly the way in which an individual’s life was ‘shaped by diet and personal hygiene’.<sup>101</sup> Statutory financial support contributed to the prevention of pauperism and, as a consequence, the sick poor received care in their own homes from the district nurse rather than the Poor Law institutions.<sup>102</sup> Fox also observes that people began to move away from folklore towards such services as district nursing. Undoubtedly, improvement in educational provision and more systematic intervention by central and local government into the lives of people in the nineteenth century created greater awareness, with a potential for the broadening of knowledge and receptiveness across the social classes. ITNL records show that the needy became more accepting of district nursing; in fact expectations began to rise, and the district

<sup>100</sup> Waddington, I, ‘General Practitioners and Consultants’ in early England. The sociology of intra-professional conflict’ in Woodward, J and Richardson, D, eds., *Health Care and Popular Medicine in Nineteenth Century England* (London 1977), 164 – 195; Fielding, J. ‘Public health in the twentieth century: Advances and challenges’, *Annual Review of Public Health*, 20, 1999, 13 – 30.

<sup>101</sup> Donaldson, L. J, ‘125 years of public health in the UK’, *The Journal of the Royal Society for the Promotion of Health*, 121 (3), 2001, 146 – 51.

<sup>102</sup> Fox, E. N, ‘District nursing and the work of district nursing associations (DNAs) in England and Wales, 1900 – 48’, University of London Ph. D. thesis, 1993, 80 – 1.



nurse was often cast in the role of mediator between the rich and the poor.<sup>103</sup> It could also be argued that district nursing benefited from the 'cultural status of science' and the prestige and authority it lent to medicine.<sup>104</sup>

Patterns of continuity and change in the work of the Leicester district nurses are identified by outcomes drawn from the 'Epitome of cases' set out in the ITNL's Reports for the years 1898, 1900, 1901, 1905 and 1907 (see Appendix 2). Based on the statistics and observations recorded in these ITNL Annual Reports, three main trends can be identified which had particular implications for the recruitment and retention of district nurses. Firstly, less than half of the patients recovered, with fewer patients in the poorer inner city areas recovering compared with those living further afield. Secondly, a similar pattern can be observed in relation to the number of deaths, with about one tenth of all patients dying. Thirdly, there was little mobility in the case-load, with only a small number transferring to the hospital or the country – additional help in the home by way of 'relief' being more frequently provided. Taking account of a sample of the type of cases and their outcome in 1878 (see Table 2), the epitome of cases over a longer time scale, and the comments included in the ITNL Annual Reports, two threads are discernible: the physical and emotional demands of the work; and the shortage of district nurses.

It has been seen that in 1898 the annual income could not support a long-hoped-for twelfth district to cope with the 'growth of the town's population' and the heavy demands on the existing 11 nurses - a situation that stretched nursing resources and, over time, had an adverse effect on the nurses' health and the retention of staff.<sup>105</sup> For the first time in over three decades of the ITNL's existence, its General Committee in 1898 sought alternative ways of augmenting the under-establishment and covering for the frequent absences of district nurses due to ill health by recruiting voluntary assistants who had taken a course of instruction in St John Ambulance classes. The resolution drew attention to the danger of four major cracks in the system: firstly, difficulties in recruitment (and retention) of district nurses; secondly, the absence of financial resources to fund more district nurses; thirdly, the need to improve working conditions and address the health risks (mental and physical) encountered by district nurses; fourthly, the seemingly expedient rather than planned introduction of a new division of labour.

<sup>103</sup> Rafferty, A. M, *The Politics of Nursing Knowledge* (London 1996), 4.

<sup>104</sup> Jordan, 'Historical perspectives on health', 121 – 9; Waddington, I. *The Medical Profession in the Industrial Revolution* (Dublin 1984), 198.



This increasing demand for district nursing and the challenges of recruitment continued throughout most of the lifetime of the ITNL. In 1898, Districts 2 and 4 stated, 'The case-load was larger than in any other year,' and, 'Many cases have been severe and long, including nine typhoid cases.'<sup>106</sup> District 5 also commented on the heavy and distressing nature of the cases, compounded by the long and tiring distances the nurse covered 'on foot'.<sup>107</sup> Similar pressures could be identified in other districts that were claimed to have contributed to the breakdown of the nurse's health.<sup>108</sup> The case-loads in 1898, which ranged from 106 in District 1 to 209 in Districts 4 and 5, represented a sharp contrast to the situation twenty years earlier when the case-loads of the then four districts varied from 54 – 97. The number of visits undertaken by the nurses gave a further indication of the intensity of the work and the discrepancy in workloads. For instance, District 5, in the heart of the town's poorest population, reported that during twenty three weeks of the year the nurse made 100-129 visits per week; assuming care was provided seven days per week, that is an average of 14 – 17 visits per day 'on foot'. On the other hand, the records for District 9 in the north east of the town, where 3,644 visits were paid to 141 cases in 1898, suggest an average number of 10 visits per day, based on the same assumptions of seven-day coverage per week and self-propelled transport.

At the turn of the century, several trends can be identified from the ITNL records that explain the increased demand for district nursing in Leicester, and reflect the national picture of structural and social change discussed above. Firstly, an increase in the population and spatial boundaries of the town had a serious effect; District 1 (West Leicester), in particular, felt the impact of new housing developments, long travelling distances and 'more patients than the nurse can deal with as thoroughly as she would wish'. Secondly, the town's doctors were asking for more help, particularly in short-term cases. Thirdly, a division of labour was created by the involvement of St John Ambulance assistants to combat the shortage of nurses, particularly in times of staff absences and seasonal fluctuations in workload, and this arrangement carried both potential risks for the patient and increased accountability for the trained nurse.<sup>109</sup> Fourthly, there was an increase in operations performed and nursed at home,

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<sup>105</sup> ROLLR 610.73. ITNL AR (1898), (1900), General Committee.

<sup>106</sup> ROLLR L610.73 ITNL AR (1896), Districts 2 and 4.

<sup>107</sup> ROLLR L610.73 ITNL AR (1896), District 5.

<sup>108</sup> ROLLR L610.73 ITNL AR (1896), Districts 5, 6, 7.

<sup>109</sup> Gibb, 'District nursing in Scotland, 319 – 29 here it is claimed that a lack of trained nurses had implications for the community in several respects: the inability to recognise and deal with the significance of the circumstance they encountered; errors in the carrying out of instructions and follow-up; and failing to grasping opportunities for health teaching.



'thus relieving the Infirmary and gratifying the wishes of patients'.<sup>110</sup> Fifthly, the fact that 'twice as many women were nursed as men ...children formed about one sixth of the case-load', emphasised the woman's role as carer and the position of women when they were ill.<sup>111</sup> Sixthly, there was a higher death rate among the cases nursed, arguably due to delayed referral - 'the nurse being called in only after the cases became hopeless'.<sup>112</sup> Alongside the physical demands of terminal illness, emotional factors were also present with the higher number of deaths in some districts. For instance, in District 2 the deaths in 15% of all cases nursed equalled the recovery rate, and in District 5 the deaths in 26% of all cases nursed exceeded the recovery rate of 22% - in sharp contrast to District 11, where the number of deaths represented 5% of all cases nursed compared with a recovery rate of 58%. Seventhly, in 1900 there was an increase in the number of infectious diseases nursed, particularly consumption (TB), with additional health risks for district nurses; gastric disorders and cancer were also more prevalent which increased the workload for district nurses.

This pattern and its resulting pressures continued in 1901 and 1905; a scarlet fever epidemic in the summer of 1901, together with typhoid and an increase in the number of chronically ill patients 'requiring great tact and patience', made for 'unusually unhealthy times' - some cases requiring two to three visits per day.<sup>113</sup> The number of surgical operations performed in the home increased in 1905; it was also a year in which 'a large number of cases required skilled dressings'. Such developments were a significant problem for district nurses whose hospital training did not cover the management of surgical wounds, which at that time were the province of the 'surgical dresser'.<sup>114</sup>

Several significant developments occurred in 1907. Firstly, the long awaited twelfth District came into being (see Figure 5).<sup>115</sup> The expansion was funded by a legacy bequeathed under the terms of the late Mrs M A Irvin's will to benefit the poor of Leicester;<sup>116</sup> the executor decreed that 'a Jubilee Nurse' (QN) to be known as the 'Irvin Nurse' should be maintained in

<sup>110</sup> ROLLR L614.73 ITNL AR (1900), General Committee.

<sup>111</sup> ROLLR L610.73 ITNL AR (1900), District 7.

<sup>112</sup> ROLLR L610.73 ITNL AR (1899), Districts 1, 2, 3, 4, 6.

<sup>113</sup> ROLLR L610.73 ITNL AR (1900), District 9, 11.

<sup>114</sup> ROLLR L610.73 ITNL AR (1905), Districts 2, 3 and 11; Youngson, A. J, *Medicine and Surgery in Early Victorian Britain* (London 1979), 25 - 33. The 'dresser' was usually a trainee doctor.

<sup>115</sup> ROLLR L610.73 ITNL AR (1905) and (1907).

<sup>116</sup> WIHM SA/QNI/92/11. Mrs M A Irvin's Will 1904 - 1905



with the result that inroads were continually made into 'Relief Funds' to ensure financial survival.<sup>124</sup> In 1894, the annual cost of providing a trained district nurse for each of the eleven districts at an annual salary of £62 was calculated to be not less than £700; the total contributions from all sources in 1893 was £568.<sup>125</sup> On the credit side, subscriptions, donations and bequests from a variety of sources are detailed, and on the debit side, the outgoing expenditure on nursing care is shown, plus a contribution of about £20.00 to the Institute's General Committee Fund.<sup>126</sup> What is evident from the annual reports is an in-built and very real concern regarding the funding of the district nursing service – an acknowledged Achilles' heel for any voluntary movement. For example, the ITNL Annual Report for 1878 recorded the following report from District 1:

'Owing to the depression of trade and consequent poverty, the year 1878 has been the most expensive one we have had in District 1. There has not been more illness ..... but patients have needed more help from the funds of the District in order to get the support necessary for recovery. .... where nursing has ceased, this help has continued at the discretion of the Lady Visitor in charge of the case. Thanks to the COS for their linen.'

The balance remaining in the District's account at the end of the year was 30p compared with the previous year when the balance in hand was £2. Like other districts, District 1 comprised a fairly autonomous unit in terms of its fund-raising responsibilities and budgetary control, but individually each district presents a unique set of social and environmental characteristics in terms of available and willing benefactors and degree of need. For instance, comparing the situation in two of the 'inner city' areas, namely District 1 and District 4 as recorded in the Annual Report for the same year, the similarities and differences are easily recognisable. District 4 (see Fig.3), can be observed to serve the Belgrave Gate, Frog Island and Blackbird Lane area, where most of the cases were reported as 'quite hopeless, many entirely unfit for the Infirmary', thereby accounting for 20 more nursing visits than in District 1. However, whilst the income of District 4 at £45 was lower than that of District 1, the balance sheet appeared to be somewhat healthier with a balance in hand of £5. This might suggest more efficient management with a more stringent budgetary control, or a less benevolent community with less spent on amenities for the patients such as nutrition and other 'comforts'.

Two decades later the financial position of all districts seemed to be somewhat more sustainable. Several districts in their Annual Reports in 1899 referred either to the benefits of

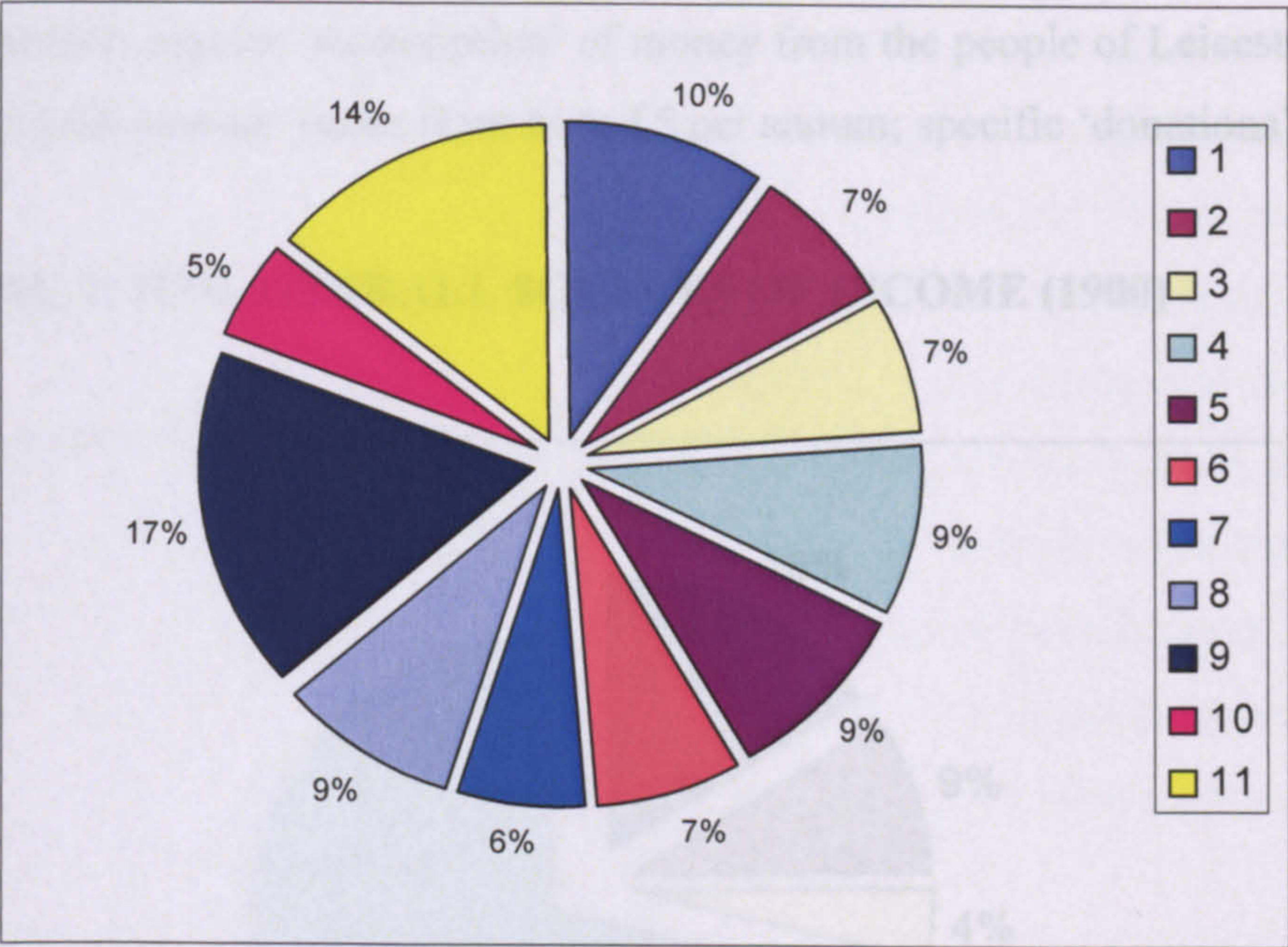
<sup>124</sup> ROLLR L610.73 ITNL AR (1878 – 1907).

<sup>125</sup> Leicester District Nursing Association (LDNA). *History of the LDNA 1867-1953* (Leicester 1953), 4.



an up-turn in the economy and fine weather, which enabled patients to be more self-supporting, or to local authority boundary extensions and general goodwill as a possible boost to the level of income through subscriptions. Nevertheless the impact of unique clinical, social and economic forces within each of the districts can be seen to account for some differences in income, expenditure and balance in hand, with the ‘new’ districts in the affluent suburbs in a financially healthier position (see Figure 5). To summarise the position at the start of the new century and to illustrate the finer points of budgetary control, a comparative analysis of expenditure and income for each District in 1900 is presented in Appendices 3 and 4 respectively. Although the largest single item of expenditure for each district was the donation to the ‘General Fund’, expenditure on food and pharmaceuticals collectively accounted for the largest proportion of the budget as detailed in Appendix 3. The overall difference in expenditure on these items between the districts is shown at Figure 6, where it can be seen

**FIG. 6 ITNL EXPENDITURE BY DISTRICTS NUMBERED 1 - 11 (1900)**



Source: ROLLR ITNL AR (1900)  
NB. For full details of the eleven Districts see Figure 5 above.

that Districts 1, 9 and 11, which served the more affluent areas of the town (see Fig. 5, p ), were the highest spending, and districts 2, 3, 5, 7 and 10, the less prosperous parts of the town, were the lowest spending and the least able to attract income. The situation illustrates the socio-economic variations, constraints and advantages within which the districts operated,

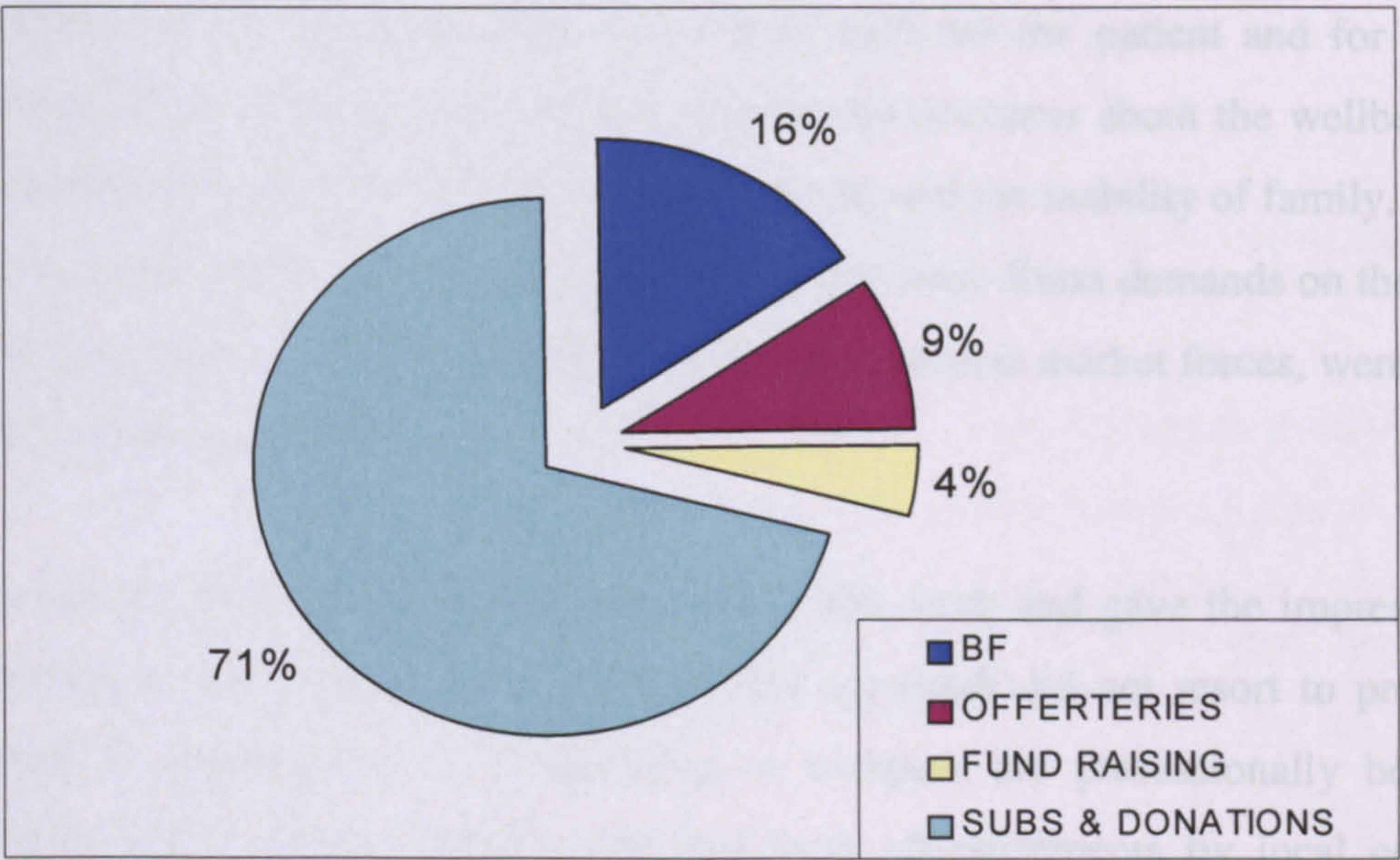
<sup>126</sup> ROLLR L610.73 ITNL AR (1900), Balance Sheet, the £20.00 contribution does not appear on all balance sheets, particularly in the early years.



but arguably of greater importance is the apparent inverse relationship between income and need. The poorest districts had the poorest resources.

Effective administration was a critical feature of the ITNL financial solvency. Lady Visitors, along with ‘officials’ of the General Committee, shared a responsibility for fundraising with various organisations; links with local businesses, working men’s clubs and the churches promoted practical, social and spiritual support (see Appendix 4); the COS was among the many other organisations and charities that gave financial contributions and support in kind to individual cases; the Kyrle Society provided comforts such as ‘drives for convalescent patients’; the Needlework Guild and Blanket Committee made ‘useful gifts’, such as clothing and bedding; on numerous occasions donations were made to the District by the churches from the proceeds of jumble sales, offertories and special events. For district nursing, the obligation expressed between individuals and between formal and informal networks was an important foundation for its very existence.<sup>127</sup> A comparative analysis of the main sources of ITNL income in Figure 7 shows the extent to which the ITNL relied on four main sources of income: regular ‘subscription’ of money from the people of Leicester – Annual Reports show that the amount varies from 5s to £5 per annum; specific ‘donations’ from the poor, who felt

**FIG 7: ITNL OVERALL SOURCES OF INCOME (1900)**



Source: ROLLR L610.73 ITNL AR (1900).

<sup>127</sup> Uphoff, N, ‘Understanding social capital: learning from the analysis and experience of participation’ in Dasgupta, P and Serageldin, I. eds., *Social Capital. A Multifaceted Perspective* (Washington, DC 2000), 215 – 52.



they should pay something, and from more wealthy benefactors, including generous legacies; fundraising activities such as garden parties, jumble sales and concerts arranged by organisations or individual members of the public; and church offertories. Subscriptions and donations comprised the largest source of income with a relatively smaller contribution from other sources.

The accounts serve to illustrate the fine margins within which the Institution operated. The contribution to the 'General Fund' was the largest single cost to be met by the Districts, and accounts of the General Committee show that the wages of the district nurses constituted the largest item of expenditure with additional demands in times of special needs such as the diphtheria outbreak in 1899.<sup>128</sup> In accordance with Trust principles, any excess of income over expenditure was reinvested with the ITNL for the common good and not paid out to subscribers as dividends.

In 1901, the ITNL estimated that an additional £100 per annum would be required to respond to the 'ever growing wants of the town'. District nurses' salaries were also increased by about 10% for what the General Committee described as 'weighty reasons', from £64 to £70 per annum (including uniform).<sup>129</sup> Information detailing the financial circumstances of the ITNL income and expenditure has been extracted from the balance sheets submitted by the districts to the Annual Meeting for the year 1900. The significance of the relationship between the ITNL and the local economy was critical both for the patient and for the viability of the organisation. Annual reports frequently carried concerns about the wellbeing of patients, the expeditious return of the breadwinner to work, and the inability of family, relatives, or friends to provide for the sick person when times were hard. Extra demands on the ITNL, particularly during periods of interrupted employment and adverse market forces, were serious matters for the organisation.<sup>130</sup>

In current parlance, marketing strategies were weak and gave the impression of an army of unsung heroes whose self-effacing *modus operandi* did not resort to promotional activities such as advertising; it is interesting to compare the professionally bound copies of the Northampton DNA records, interlaced with advertisements by local companies, with the

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<sup>128</sup> ROLLR L610.73 ITNL AR (1900) General Committee.

<sup>129</sup> ROLLR L610.73 ITNL AR (1901) General Committee.

<sup>130</sup> ROLLR L610.73 ITNL AR (1878 – 1907).



pamphlet-type ITNL records.<sup>131</sup> It might also appear that other agencies such as the voluntary infirmary in Leicester and its sub-units did not provide the support anticipated by the founders of the ITNL. The need for long-term objectives and fundraising had been overlooked by the ITNL, or overshadowed by the immediacy of the need to fill the gap for a nursing service for the sick and distressed in their own homes. Indeed, a traditional view of the role of a voluntary agency has been described as that of targeting a specific area of need by identifying the problem, pioneering a response and withdrawing for government to take over.<sup>132</sup> The transition of the ITNL seemed to suggest otherwise. After more than forty years, the work of the ITNL, by then a declining organisation, was handed over in 1909 to a differently constituted voluntary organisation (see Chapter 6).<sup>133</sup> The experience of the ITNL seems to have been one where optimism and disillusion went hand in hand – a caricature of emergence, growth and decline/survival.

On the one hand, the strengths and resources upon which the ITNL were able to depend, were infinite as is normally found in an organisation which enshrines the concept of a 'Trust'; firstly, the goodwill of religious and professional society, and the business and civic community of Leicester; secondly, the sustained support of a social/institutional network of individuals and collectives; and thirdly, the domestic/social management skills of the Lady Superintendents who were mostly drawn from the 'ruling' classes. On the other hand, problems with a mismatch between staffing levels and the need for district nursing were confronted by the ITNL at all stages of its operations. In 1898, the tension between supply and demand was expressed in emotional terms;

'There can be no doubt of its (district nursing) usefulness both directly in the relief of the sick poor and indirectly by the encouragement of a kindly feeling between rich and poor, between class and class. It (district nursing) must never be allowed to fail for lack of pecuniary support'<sup>134</sup>

The perennial problem of securing sufficient financial resources to sustain and develop the district nursing service was more clearly spelled out the following year as,

'finances remain in their usual unsatisfactory condition'....deficit of last year met out of reserve funds ...£100 annual income is needed to be on a sound financial

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<sup>131</sup> Howes, *Leicester Civic, Industrial and Social Life*, 270; Haynes, *Joseph Dare Reports*, 52. Political and Economic Planning (PEP), *Report on the British Health Services* (London 1937), 174 – 80.

<sup>132</sup> Sherrington, C. A, 'The National Society for the Prevention of Cruelty to Children (NSPCC) in transition 1884 – 1984: A Study of Organisational Survival', London School of Economics Ph.D. thesis, 1984), 11, 17 a study conducted to contribute to the 'seriously under researched voluntary sector' by using the NSPCC as a case study.

<sup>133</sup> LDNA, *LDNA*, 4.

<sup>134</sup> ROLLR L610.73 ITNL AR General Committee Report (1898)



footing ....plus another £100 to meet the ever-increasing scale of work in response to the growing wants of the town.<sup>135</sup>

A fundamental weakness in the system was the lack of systematic assessment of the district nursing needs rather than the ‘wants’ of the local community. Assessment, using such indicators as population size, structure and mobility, prevailing social and environmental factors, and changes in clinical practice, was over half a century away. At this stage the assessment of staffing levels was almost a knee-jerk reaction to the ever-expanding pockets of distress and human misery. Nevertheless it has been possible to extrapolate from documentation of the period the ratios that applied between 1871 and 1907 (see Table 4).

Assessing the position of Leicestershire, it would appear that Leicester and the much smaller urban conurbation of Loughborough, had a lower district nurse to population ratio with the hard times in Leicester appearing during the lifetime of the ITNL. It would be of value to assess the position of the sole practitioner in the rural areas, her relationship with other agencies – particularly the GPs and DNA Committee and its members - and the implication for her social and professional isolation compared with the relative collegiality of the urban district nurse. To date little work has been undertaken in this area.

**TABLE 4: DISTRICT NURSE POPULATION RATIOS (1871 – 1907)**

PLACE:	YEAR:	POPULATION:	DNs in post	DN: POPULATION
Leicester	1866	85,000	4	1:21,250
	1878	121,473	4	1:30,368
	1881	123,120	4	1:30,780
	1898	208,662	10	1:20,866
	1901	212,498	10	1:21,250
	1907	204,172	12	1:17,014
Market Harborough	1871	2,481*	1	1: 2,481
Ashby-de-la-Zouch	1894	5,000*	1	1: 5,000
Loughborough	1897	10,000*	1	1:10,000
Hugglescote and Coalville	1898	5,000*	1	1: 5,000

Sources: ROLLR L614 Annual Health Reports – Registrar General population estimates from which MOH assessed needs and set targets.  
NA 30/63/266/299/261/262 QNI Inspector's Reports.  
ROLLR 610.73 ITNL AR.

<sup>135</sup> ROLLR L610.73 ITNL AR of General Committee (1899)



## Public relations – the acceptance of district nursing

At the turn of the century, an earnest appeal for pecuniary support was again put to ‘our townspeople’. The Victorian era of voluntarism was a highly competitive time, and concerns regarding financial survival were considerable. Issues of rivalry were frequently reflected in competition for fundraising, recruitment of staff and often in the duplication of services. It might seem that the higher the status of the organisation/movement the more it attracted the patronage and benevolence of the wealthy and status-seeking middle classes. Indeed Gorsky suggested that committee work within the voluntary sector was often a fulfilling occupation that tended to delay ‘appropriation and change’. During this stage of emergence, the ITNL was growth-orientated, although its financial situation was finely balanced. It seems therefore almost paradoxical that, whilst the district nursing service received acclaim from many sources, its lack of self-promotion has frequently been a source of criticism. For example;

‘An invaluable but little advertised service to the community ..... without which much of the work of the general practitioner, particularly in the rural areas, would be impossible or extremely difficult’.<sup>136</sup>

Locally, the district nursing service was always regarded in a similar light;

‘It works quietly; it is free from advertisement; in fact, it is often chided by those most familiar with its noble record of unselfish and highly efficient service, that it is far too quiet and free from advertisement’.<sup>137</sup>

Several factors can be used to assess the esteem in which district nursing was held. Firstly, the contribution made by district nursing to the local community in the relief of suffering and to the economy by helping to sustain a healthy workforce was widely recognised. Secondly, the confidence with which doctors, other professionals and the public used the service was of critical importance.<sup>138</sup> Thirdly, the patronage of the aristocracy, the support of the business community, and the contributions made by the working classes indicated wide-ranging endorsement from all sections of the community.

Of course, Leicester was not unique in its deployment of district nurses. Direct comparison with other Midland towns is impeded by the nature of archival resources. However, samples of available data allow some analysis. Derby, with a population of about half the size of Leicester (see Table 3), employed fifteen nurses and one superintendent in 1903, and a total of 37229 visits were made, half to medical cases and, of the remainder, one third each to

<sup>136</sup> PEP. ‘*British Health Services*’, 174.

<sup>137</sup> Howes, *Civic, Industrial and Social Life*, 270.

<sup>138</sup> ROLLR L610.73 ITNL AR (1900), General Committee Report.



surgical, maternity and infectious disease cases.<sup>139</sup> Coventry Nursing Institution, founded in 1883 for a population which was approximately one third the size of Leicester, employed six 'specially trained' nurses and one superintendent in 1907 to care for the sick poor in their own homes; 722 new applications were received during the year but there is little more information.<sup>140</sup> Available data for Northampton in 1899 suggests a similar type of demand and resource network.<sup>141</sup> The situation in the midlands demonstrated several nationally shared features of district nursing: the spread of knowledge, skills and the level of competence required to embrace the clinical, social and psychological challenges presented by the management of medical, surgical, gynaecological and obstetric nursing in the home; the predominance of medical cases, which undoubtedly included the long-term illnesses associated with the slowly dying, infectious diseases and the attendant complications;<sup>142</sup> seasonal peaks in the winter and autumn, particularly for medical cases; the prominent position of doctors as referral agencies, with friends and the clergy also initiating district nursing intervention.

Nevertheless, in some areas mixed messages were received. For instance, when the new QNI scheme was established in the Leicestershire mining communities of Hugglescote and Coalville in 1898, the three doctors were reported to endorse the scheme and 'the 'pitmen' were very supportive and keen'.<sup>143</sup> The QNI Inspector's visit with the nurse, however, caused concern about the 'hopelessness of the cases' and the fact that, though doctors had not referred any cases to the nurse, she reported that 'they were very friendly'. The issue of delayed referral may not necessarily reflect medical negligence but rather the influence of consumer awareness, or possibly an expression of domestic privacy and community collusion. Society's response to district nurses as individuals, as well as the service, also seemed to be an important indicator of satisfaction and sustained public confidence in their role. For instance, some Leicester districts interpreted an increase in the subscriptions and donations given to the nurse as 'a gratifying testimony to the appreciation of her work by her

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<sup>139</sup> DRO, D4566, Societies and Voluntary Bodies – Medical, 'Royal Derby and Derbyshire Nursing and Sanitary Association Minutes of Annual Meeting' (1903) and Local press report.

<sup>140</sup> Lane, J, *The Making of the English Patient. A Guide to Sources for the Social History of Medicine* (Stroud 2000), 150.

<sup>141</sup> See for example previously quoted material from ROLLR L610.73 ITNL AR; Haynes, *The Joseph Dare Reports*; NRO/DMAP Northampton Town and County Nursing Institution District Nursing Fund (1900).

<sup>142</sup> Moore, W. E, *The Professions: Roles and Rules* (New York 1970), 5. Here it is argued that in the use of exceptional knowledge and skill the professional proceeds by his own judgement and authority – autonomy restrained by responsibility.

<sup>143</sup> NA 30/63/262, Hugglescote DNA. QNI Inspectors' Reports (1898)



patients'.<sup>144</sup> And where attitudes were previously negative, changes had occurred by 1899 so that, 'patients who were unfavourable to the nursing scheme are now making a real contribution'.<sup>145</sup>

## CONCLUSION

This analysis of the contribution made by the ITNL to Leicester between 1866 and 1908 supports Dare's belief in the value of district nursing and in the benefits it brought to individuals and their families as well as to the local economy and the community. The empirical evidence thus refutes the claim that the contribution of district nursing was a 'placebo'.<sup>146</sup> District nurses were unlikely to have a direct effect on defective housing, low wages and poor working conditions, but its skilled intervention ameliorated the impact of such environments for the sick, the dying and those who struggled with the burden of long-term chronic illness. In addition the evidence presented by the district nurses to patrons and committee members of the ITNL arguably influenced the perception and understanding of the town's leading citizens and prompted them to take action which might improve the conditions.

As has been seen in this chapter, the 'Trust' status of the ITNL with its stakeholder methods of funding, helped to erode barriers both between the classes and between the, deserving and undeserving poor (see also Chapter 8). The financial viability of the ITNL was dependent on the stability of the local economy, the goodwill of the townspeople and a supportive network. The evidence suggests that a weakness in any constituent part threatened the potential of the ITNL and its contribution to health-care and welfare.

During the period between 1866 and 1908 the principle of structured health-care and welfare was in its infancy. Organisations, like the ITNL, were set up on an ad hoc piecemeal basis and held together by sometimes rather tenuous threads of inter agency networks to improve the life chances of the poor and to contain feelings of injustice. Leicester was a trailblazer of developments in district nursing in this period, inspired by its nonconformist and utilitarian values, its radical traditions and the prospects of the local economy. In this context the evidence challenges Dyos's belief that Leicester was 'without any taste for adventure'.<sup>147</sup>

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<sup>144</sup> ROLLR L610.73 ITNL AR (1907), District 7; ROLLR L610.73 ITNL AR (1907), District 10.

<sup>145</sup> ROLLR L610.73 ITNL AP (1899), District 8.

<sup>146</sup> Hardy, *Epidemic Streets*, 46.

<sup>147</sup> Dyos, 'Essays in urban history', 9 - 59



Chapter 6 assesses the way in which Leicester continued in this vein but as part of a wider community of district nursing.



# APPENDICES

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## 1: ITNL CONSTITUTION AND ORGANISATIONAL STRUCTURE.

### COMMITTEE OF MANAGEMENT (Patrons – the ‘nobility’)

#### GENERAL COMMITTEE.

- OBJECT to:** Provide efficient trained nurses for the better nursing of the sick poor
- MEMBERS:** Governors for Life and Governors.  
10 persons elected by Governors and co-options e.g., doctors  
business people, the clergy and/or their relatives.  
Chief Lady Superintendent.  
Lady Superintendents of Districts.  
Lord Mayor of Leicester.  
Treasurer.  
Honorary Medical Officer (ex-officio).
- CHIEF OFFICER:** Lady Superintendent (qualified nurse)
- REMIT to:** Publicise/hold an Annual Meeting with provision to call special meetings.  
Produce a Report and Accounts to be read at the Annual Meeting.  
Ensure financial stability and promote fund raising.  
Organise the town into operation units called Districts.  
Manage district nursing.  
Appoint Lady Superintendents for the District.  
Approve Lady Visitors appointed by the Lady Superintendent.  
Appointment or withdrawal of Nurses.

#### DISTRICTS

- CHIEF OFFICER:** Lady Superintendent.
- REMIT to:** Carry out the Objects of the Committee.  
Manage a budget and promote fund raising.  
Appoint Lady Visitors and monitor their performance.  
Supervise the conduct and efficiency of nurses assigned to the District.  
Manage the supply of medical appliances and other comforts for the sick.

Source. ROLLR L610.73 ITNL (1878) Constitution



APPENDIX

2: EPITOME OF CASES 1898, 1900, 1901, 1905 and 1907.

RESULT	YEAR	Dist: 1	2	3	4	5	6	7	8	9	10	11	12	TOTAL:
RECOVERED	1898	11.2	11.4	7.6	11.7	8.7	6.0	10.1	7.9	10.3	7.6	7.5	0.0	100
	1900	11.2	7.6	9.9	9.3	4.4	7.6	10.3	8.0	11.3	6.4	14.0	0.0	100
	1901	8.5	10.2	8.8	10.0	7.9	4.9	7.3	12.9	9.5	6.0	14.1	0.0	100
	1905	4.1	10.3	9.8	8.4	5.3	11.3	7.8	8.8	12.9	6.7	14.7	0.0	100
	1907	6.2	7.7	10.3	9.5	4.7	8.9	8.6	13.1	9.8	7.3	10.2	3.7	100
RELIEVED	1898	9.9	12.9	0.0	4.3	28.0	18.5	7.3	0.0	0.0	10.3	8.6	0.0	100
	1900	13.1	18.0	0.0	5.9	20.8	17.0	6.9	4.8	0.0	6.2	7.3	0.0	100
	1901	15.8	15.8	2.4	5.5	13.4	18.2	9.1	5.1	0.0	4.0	10.7	0.0	100
	1905	8.7	7.0	4.4	5.7	7.7	12.1	5.7	4.0	20.8	9.7	14.1	0.0	100
	1907	8.0	5.2	6.8	3.1	9.6	16.7	8.0	7.7	19.1	7.1	5.6	3.1	100
DEAD	1898	9.5	12.4	6.4	12.9	10.6	8.5	9.8	7.0	9.3	8.5	5.2	0.0	100
	1900	12.5	15.3	7.9	11.8	10.8	7.2	7.7	5.3	12.0	7.2	2.4	0.0	100
	1901	10.5	11.8	8.8	13.7	7.8	9.3	6.6	5.9	12.7	6.9	5.9	0.0	100
	1905	10.7	13.8	8.2	9.2	8.4	8.7	5.6	9.2	8.2	11.2	6.9	0.0	100
	1907	12.7	8.8	7.3	9.9	6.2	13.0	11.7	4.7	8.6	6.8	4.2	6.2	100
TO INF/UNION	1898	11.3	12.0	5.3	9.0	11.3	14.3	12.0	6.0	5.3	11.3	2.3	0.0	100
	1900	13.8	7.7	10.0	6.9	7.7	8.5	10.0	6.9	3.1	16.2	9.2	0.0	100
	1901	8.0	11.6	9.4	8.0	9.4	10.1	4.3	5.1	7.2	13.0	13.8	0.0	100
	1905	6.9	5.1	6.3	10.9	12.6	14.3	2.9	8.0	7.4	12.0	13.7	0.0	100
	1907	3.0	5.9	8.9	17.8	8.9	8.1	5.2	8.1	11.1	14.1	5.9	3.0	100
TO COUNTRY	1898	37.5	6.3	3.1	21.9	9.4	0.0	9.4	3.1	0.0	0.0	9.4	0.0	100
	1900	28.6	14.3	17.9	0.0	3.6	0.0	0.0	0.0	0.0	0.0	35.7	0.0	100
	1901	32.1	0.0	7.1	7.1	14.3	7.1	0.0	0.0	0.0	21.4	10.7	0.0	100
	1905	20.0	12.5	0.0	10.0	12.5	0.0	2.5	0.0	2.5	7.5	32.5	0.0	100
	1907	55.0	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0	10.0	100
LEFT DISTR'T	1898	12.5	0.0	6.3	6.3	25.0	0.0	25.0	18.8	0.0	6.3	0.0	0.0	100
	1900	3.3	3.3	6.7	13.3	6.7	0.0	3.3	16.7	0.0	33.3	13.3	0.0	100
	1901	10.3	10.3	10.3	12.8	10.3	0.0	20.5	7.7	0.0	10.3	7.7	0.0	100
	1905	8.0	16.0	16.0	4.0	0.0	8.0	4.0	4.0	4.0	8.0	28.0	0.0	100
	1907	4.7	4.7	7.0	4.7	4.7	7.0	9.3	18.6	2.3	23.3	9.3	4.7	100
ON BOOKS	1898	9.5	7.9	5.3	10.0	5.3	6.8	7.9	22.6	7.4	5.8	11.6	0.0	100
	1900	14.8	5.7	9.1	9.1	9.1	4.5	9.7	7.4	9.1	5.7	15.9	0.0	100
	1901	13.8	6.3	6.9	6.9	9.4	8.8	8.8	6.9	11.3	9.4	11.9	0.0	100
	1905	10.7	4.8	5.4	8.9	8.3	11.3	10.7	7.7	11.9	8.3	11.9	0.0	100
	1907	13.2	9.2	5.2	7.5	8.6	11.5	8.6	6.3	9.2	5.2	10.9	4.6	100
TOTALS	1898	11.0	11.3	5.9	10.7	11.6	8.7	9.7	8.1	7.8	8.1	7.1	0.0	100
	1900	12.4	10.7	8.0	9.1	8.9	8.5	8.9	6.8	8.7	7.5	10.6	0.0	100
	1901	10.7	10.9	7.8	9.8	9.0	8.2	7.5	9.0	8.6	7.0	11.5	0.0	100
	1905	7.2	9.7	7.9	8.4	7.2	10.9	6.7	7.8	12.3	8.7	13.3	0.0	100
	1907	8.7	7.7	8.4	8.7	6.4	11.0	8.8	9.6	10.9	7.8	7.9	4.2	100

Source: ROLLR. L610.73 ITNL Annual Report's for the years 1898, 1900, 1901, 1905 and 1907.  
(NB. District 12 was a new District and in operation for only part of 1907)



APPENDIX 3: ITNL ANNUAL BALANCE SHEET – EXPENDITURE (1900)

DISTRICT:	ITEMS OF EXPENDITURE:				W/BED	UNIFORM	TEMP NURSE	GEN. FUND	EXTRAS	CONV.	OTHER	TRANSP.	C/F	TOTAL
	DAIRY	MEAT	PHARM.											
	£. p.	£. p.	£. p.	£ .p.	£. p.	£. p.	£. p.	£. p.	£. p.	£. p.	£. p.	£. p.	£. p.	£. p.
1	10.83	12.91	2.19	0.53	2.00			20.00	1.32				7.43	57.20
2			3.63	0.50	2.00			30.00	0.78				7.15	44.06
3		4.84	0.6	0.50	2.00			20.00		1.92			7.55	41.07
4	3.76	0.55	0.56	0.50	2.00			26.00	0.16				7.70	51.24
5	5.61	0.36	2.31	0.50	2.00	3.15		25.00	0.46		2.95		12.41	54.75
6	5.78	3.17	1.23	0.50	3.00			20.00	0.75	1.10		.	5.48	41.01
7	3.73	1.51	0.26	0.50	2.00			20.00	1.26	1.50	0.43	0.15	4.66	35.85
8				0.50	2.00			48.85						51.35
9	12.67	6.62	2.00	0.50	3.09			60.00	3.34	1.10		~	15.80	104.61
10			2.23	0.50	2.00			20.00		3.47			1.56	29.76
11	3.27	3.11	1.92	0.50	2.00			62.00	0.47	0.81	2.29		8.15	84.53
<b><u>TOTAL</u></b>	<b>45.65</b>	<b>33.07</b>	<b>16.93</b>	<b>5.53</b>	<b>24.09</b>	<b>3.15</b>		<b>351.85</b>	<b>8.54</b>	<b>9.9</b>	<b>5.67</b>	<b>0.15</b>	<b>77.89</b>	<b>595.43</b>

Source: ROLLR L610.73 ITNL AR (1900)



APPENDIX 4: ITNL ANNUAL BALANCE SHEET – INCOME (1900)

SOURCES OF INCOME:	DISTRICTS:		3	4	5	6	7	8	9	10	11	GRAND
	1	2										
	£. p	£. p	£. p	£. p	£. p	£. p	£. p	£. p	£. p	£. p	£. p	TOTAL
B/F from 1899	5.96	7.01	9.93	11.57	12.10	4.18	5.32		14.44	3.23	15.50	89.24
CHURCH OFFERTORIES												
St. Augustines	1.84											
St. Pauls	2.05											
Wyggeston Hosp.	2.70											
St. Martins		5.38										
St. Marys		3.25										
HolyTrinity		3.15										
The Martyrs		1.05										
St. Peters									2.50			
St. Michaels									1.50			
Nonconformist									1.25			
St. Saviours										13.66		
The Priory										1.00		
St. Stephens										6.00		
St. Bamabas										6.00		
TOTAL OFFERTORIES	6.59	12.83							5.25	26.66		51.33
FUND RAISING												
St. Matthews Rummage							5.60					
Charity Organs Soc.							0.75					
Rev. Brown							0.63					
Concert proceeds									16.33			
Mrs Yoxon										0.38		
TOTAL FUND RAISING							6.98		16.33	0.38		23.69
SUBS & DONATIONS	44.65	24.22	31.14	39.68	42.65	36.83	23.55	51.35	58.75		69.03	421.85
TOTAL INCOME	57.20	44.06	41.07	51.25	54.75	41.01	35.85	51.35	94.77	30.27	84.53	586.11

Source: ROLLR L610./73 ITNL AR (1900)



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## CENTRALISED CONTROL: DECENTRALISED AUTONOMY AND INDIVIDUAL ACCOUNTABILITY 1909 - 1947

‘The work of 12 district nurses in Leicester was observed in detail, their homes or lodgings visited, their books, bags and district appliances seen. The nurses are, without exception, kindly women, anxious to do their best for their patients. It is hoped that the Committee may see their way to re-organise such excellent work, so that it may increase still more in usefulness in the future’.

Queen Victoria Jubilee Institute for Nurses (QNI) Inspector’s Report on Leicester District Nursing Association’s (LDNA) Application for Affiliation 1909.<sup>1</sup>

The rigour of the QNI in assessing a local association’s application for affiliation is reflected in the Inspector’s Report set out above. After 33 years of providing a district nursing service in Leicester, the potential benefits of membership of a wider network of expertise were being contemplated for the first time.

The previous chapter demonstrated the spirited response of the ruling classes and social reformers in Leicester to the needs of the sick poor in their own homes, and the way in which a district nursing service was established and developed. The main purpose of this chapter is twofold: to show how Leicester fitted into the national picture; and to evaluate the next stage in the development of district nursing in Leicester from 1909, when it first became affiliated to the QNI, until 1948, when the NHS came into operation. The chapter begins, however, with a brief exploration of the situation for women generally in the first half of the nineteenth century.

### **Women’s work and its hidden factors:**

Williams argued that culturally nurses could only do what was expected of women as carers within the private domain of the home, whilst men’s space as earners was in the public sphere

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<sup>1</sup> National Archive (NA) 30/63/264, QNI Inspector’s Report on the result of a visit to LDNA following application for affiliation, 19 – 13 January 1909.



of work.<sup>2</sup> She also examined the nature of two distinct relationships within the world of nursing: firstly, the traditional division of labour in which doctors were assigned the monopoly of knowledge relating to disease and nurses worked in service to that knowledge; secondly, the relationship between the nurse and the patient, which had to be re-evaluated in situations where so many taboos were liable to be broken. Here, the culturally and socially defined discipline of district nursing will be examined with reference to women's history<sup>3</sup> and expanded beyond 'a case study in voluntarism',<sup>4</sup> or the 'language of conscience built on the doctrine of equal souls', (see Chapters 1 and 2).<sup>5</sup> Whilst many scholars expressed insights and developed theories about women's suffrage and the emancipation of women in various settings, nursing in general, in contrast to teaching, is rarely included as a distinct entity. Implicit within a surprisingly large proportion of nursing history and scholarly observations is a general acceptance of the *status quo* of nursing as women's work, and the exclusion of men from professional nursing in the late nineteenth and early twentieth centuries is rarely challenged.<sup>6</sup>

The marginalisation of nursing from women's history is complex, but three factors have been influential: firstly, nursing was overshadowed by a 'domestic ideology' and associated with the servant class from the mid-nineteenth century;<sup>7</sup> secondly, the emancipation of a discrete body of women, within or associated with nursing, passed almost unnoticed by historians because nurses were submerged within an ambiguous system of categorisation,<sup>8</sup> and were generally less organised and rarely posed a threat to a sphere of practice traditionally occupied

<sup>2</sup> Williams, K, 'Ideologies of nursing: their meanings and implications', in Dingwall, R and McIntosh, J. eds., *Readings in the Sociology of Nursing* (London ), 36 –46.

<sup>3</sup> Purvis, J, ed., *Women's History: Britain, 1850 – 1945*, (London 1995), preface; Purvis, 'From "women worthies" to post structuralism?' highlighting some controversies in women's history in Britain', in Purvis, *Women's History*, 1 – 22; John, A. V, 'The privilege of power: suffrage, women and the issue of men's support', in Vickery, A, ed., *Women, Privilege and Power: British Politics 1750 to the Present* (California 2001), 227 – 52; Vickery, *Women, Privilege and Power*, 1 – 22; Randall, J, 'John Stuart Mill, liberal politics, and movements for women's suffrage', in Vickery, *Women, Privilege and Power*, 168 – 200.

<sup>4</sup> Fox, E. N, 'District nursing and the work of district nursing associations (DNAs) in England and Wales, 1900 – 1948', University of London Ph.D. thesis, 1993, 14.

<sup>5</sup> Vickery, *Women, Privilege and Power*, Introduction, 1 – 55.

<sup>6</sup> Bendall, E.R.D and Raybould, E, *History of the General Nursing Council (GNC) for England and Wales 1919 – 1969* (London 1969); Stocks, M, *A Hundred Years of District Nursing* (London 1960); Abel-Smith, B, *A History of the Nursing Profession* (London 1977); Baly, M. E, *Nursing and Social Change* (Bath 1980); Dingwall, R, Rafferty, A. M and Webster, C. *An Introduction to the Social History of Nursing* (London 1988); Dingwall, R and McIntosh, J, eds., *Readings in the Sociology of Nursing* (London 1978); Fox, 'DNAs'.

<sup>7</sup> Roberts, E, *Women's Work 1840 - 1940* (Basingstoke 1988), 14 – 15; Lewis, J, *Women in England 1870 – 1950* (Brighton, 1984); Vickery, *Women, Privilege and Power*, Purvis, *Women's History*.

<sup>8</sup> Davies, C, 'Making sense of the Census in Britain and the USA. The changing occupational classification and position of nurses', *The Sociological Review*, 8, 1980, 581 – 609.



by men;<sup>9</sup> thirdly, interest in women's history, certainly in the late nineteenth and early twentieth centuries, focused on the status of married women, single women in domestic service, and the textile industries, whilst trained nurses at this time were usually recruited from the ranks of single women from the upper classes. At the other end of the spectrum, notable women, such as Florence Nightingale, provided a predominant focus but the 'higher qualities of womanhood' they represented tended to overshadow wider women's issues and distort the core values of egalitarianism.<sup>10</sup> Consequently, the 'varied lives and employment structures' of single women were largely hidden from history, whilst in reality many were employed outside the home and some pursued active careers.<sup>11</sup> Nevertheless, as 'warrior maids' throughout this period, reforming spinsters made a fundamental contribution to the emancipation of women from the 'dire conditions in which women did the work of marriage'.<sup>12</sup> Politically and socially motivated women gave inspiration to the endeavours of women in local communities.<sup>13</sup> Florence Lees was a district nurse who commanded great respect across gender boundaries. Even after her marriage to the Reverend Dacre Craven she continued to advance the professional domain of district nursing. Her upper class married status, and later motherhood, did not deflect her from her mission but produced a rare combination of privilege, social and intellectual freedom, and service to others that gave her the opportunity rarely enjoyed by women to study and gain experience overseas (see Chapter 2).<sup>14</sup> Locally, Gertrude Rogers, Matron at the Leicester Infirmary, played an active role in the development of nursing as a profession both in Leicester and further afield.<sup>15</sup> She established the Leicester Infirmary Nurses' League in 1903 to promote unity and professionalism, and introduced the League's annual journal.<sup>16</sup> The Leicester League together with St Bartholomew's Nurses' League and the Matrons' Council founded the National Council of Nurses of the United Kingdom in 1904. It was a move that gave all strands of nursing an

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<sup>9</sup> John, 'The privilege of power', in Vickery, *Women. Privilege and Power*, 227 – 52.

<sup>10</sup> Purvis, 'women worthies', 1 – 22.

<sup>11</sup> Hudson, P, 'Women and industrialisation', in Purvis, *Women's History*, 23 –49; Smith, J, 'Public responsibilities: The entry of women into public life in Leicester 1870 – 1920' Leicester University MA thesis, 1995.

<sup>12</sup> Jeffreys, S, 'Women and sexuality', in Purvis, *Women's History*, 193 -216.

<sup>13</sup> Lewis, *Women in England*, passim; Purvis, *Women's History*, passim. Such women included. Eleanor Rathbone, daughter of William Rathbone the 'father' of district nursing, Marie Stopes birth control campaigner and the Pankhurst suffragettes who disclosed and empowered the social, economic and political position of a sub-culture of oppressed men, women and children.

<sup>14</sup> Stocks, *100 Years of District Nursing*, 40 – 2; Anon, 'Profiles of pioneers: Lees, Florence Sarah (Mrs Dacre Craven) 1840 – 1922', *History of Nursing Journal*, 3, 1, 1979.

<sup>15</sup> Frizelle, E. R and Martin, J. D, *The Leicester Royal Infirmary (LRI) 1771 – 1971* (Leicester 1971), 144 – 59.

<sup>16</sup> Frizelle and Martin, *LRI*, 159 and 180.



international platform.<sup>17</sup> Gertrude Rogers earned the following accolade, which could equally be attributed to Florence Dacre Craven (née Lees);

‘a first generation of professional trained nurses: gentle born women of vigorous even remorseless energy enabled by the religious convictions and social conscience to break down the cramping restriction of their sex and class.’<sup>18</sup>

Nursing, of all health professions, was estimated to be the ‘closest to people and to the largest numbers of people’.<sup>19</sup> It has been shown in previous chapters how the new generations began to re-shape district nursing within the context of welfarism.<sup>20</sup> Nursing, as is shown here, was an important part of women’s history and, by analysing the ways in which district nurses took command of women’s work in the care of the sick in the homes of the poor, their contribution can be better understood. The research also investigates both the public and private spheres in which women ‘occupied a place at the cross roads of several inter-locking identities’, and the interests and loyalties women shared.<sup>21</sup> Of particular importance to the role of the district nurse was the obligation of all married women to manage their households and the duties that varied according to class and income.<sup>22</sup> Single women either shared this obligation, or acted as ‘kin-keepers’ within the extended multigenerational family network, often in addition to their work outside the home.<sup>23</sup>

The early twentieth century dawned with the establishment of a system of collective welfarism, directed by the state and developed against a background of political, economic and social turmoil. The campaign for women’s suffrage was at its height after a long period when the welfare issues of the mid-nineteenth century, rather than enfranchisement, were the

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<sup>17</sup> Bendall and Raybould, *GNC*, 6. The Council was pledged to support state registration and to represent the nurses of Great Britain at the International Council of Nurses, until its amalgamation with the Royal College of Nursing in 1963.

<sup>18</sup> Frizelle and Martin, *LRI*, 180.

<sup>19</sup> Skeet, M, *Notes on Nursing* (London 1998), 9; Mortimer, B and McGann, S ed., *New Directions in the History of Nursing. International Perspectives* (London 2005), 1, with the assertion that ‘nurses touched the lives of most people’.

<sup>20</sup> Macintosh, J. M, *Topics in Public Health* (London 1965), 1; Oswald, N. T. A, ‘A Social Health Service without Social Doctors’, *Social History of Medicine*, 4. 2. 1991, 295 – 315; Milio, N, ‘Nursing within the ecology of public policy: a case in point’, in White, R, ed., *Political Issues in Nursing – Past, Present and Future* (Chichester 1985), Vol. 1, 87 – 104.

<sup>21</sup> Hannam, J, ‘Women and politics’, in Purvis, *Women’s History*, 217 – 30.

<sup>22</sup> D’Cruze, S, ‘Women and the family’, in Purvis, *Women’s History*, 51 – 83. Household management included domestic work, family economy and child care – childbirth was a hazardous experience and women’s health was a central goal of emancipation but broad currents of change occurred throughout the twentieth century.

<sup>23</sup> Hareven, T. K, *Family Time and Industrial Time* (Cambridge 1982), 85 – 106. ‘Kin-keepers’, often the eldest daughter, whose centrality as helpers, arbitrators and pacifiers became more pivotal with age.



primary concerns. Even in the twentieth century, achieving the vote for women was not seen as an end but as a means.<sup>24</sup> By 1904, the fitness level of young people raised concern for the economy and the defence of the nation, as well as for each individual's personal fulfilment and contribution to the quality of life for others.<sup>25</sup> It was the beginning of a concern that became a central issue for social policy throughout the century, and district nursing formed part of the response.

Increasing health consciousness gave women, as household managers, a higher profile and a role that assumed new dimensions at the confluence of social change within the health and welfare dynamics of the nation and local community. Progressive legislation in the opening decades of the twentieth century raised the dignity of motherhood, and improvements in women's health were linked to their emancipation.<sup>26</sup> But in the process, working class women were often exposed to the rigours and demeaning experience of surveillance and instruction by health and welfare workers who invaded the privacy of the home and usurped their status within the family.<sup>27</sup> By contrast, the developing role and expectations of women, both in the home as wife and mother and outside the home as activists and career women, lay at the heart of district nursing.<sup>28</sup>

### **Changes in district nursing; Affiliation and the wider debate:**

The Queen's Nursing Institute (QNI), founded in 1887, was in the vanguard of developments in district nursing and the only collective voice for district nurses until the late 1950s.<sup>29</sup> It

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<sup>24</sup> Lawrence, J, 'Contesting the male polity: The suffragettes and the politics of disruption in Edwardian Britain', in Vickery, *Women, Privilege and Power*, 201 - 26.

<sup>25</sup> Kuh, K and Smith, G. D, 'When is mortality risk determined? *Social History of Medicine*, 16, 1 1993, 101 - 23 - a review of the Interdepartmental Committee of Physical Deterioration (1903) Cmnd. 2175, Vol. XXX11, Appendix , Committee Report; Greenwood, M, 'A Valedictory Address' *Journal of the Royal Statistical Society*, 99, 1936, 674 - 713, cited in Kuh and Smith, 'Mortality risk' endorsed the importance of childhood years on adult health risk and mortality and the forces that are primarily 'determined by the *stamina vitae* woven into childhood; Mackintosh, *Public Health*, 8-32 evaluated the findings of the Committee, its recommendations and policy outcomes; Rose, M. E, *The English Poor Law 1780 - 1930* (Newton Abbot 1971), 222 -320; Dwork, D, *War is Good for Babies and Other Young Children* (London 1987), passim.

<sup>26</sup> Lewis, *Women in England*, 23 - 25; Dwork, *War is Good for Babies*, passim with reference to legislation controlling midwifery practice to broader based Maternity and Child Welfare.

<sup>27</sup> Chinn, C, *They Worked all their Lives; Women of the Urban Poor in England 1880 - 1939* (Manchester 1988); Lewis, *Women in England*, 39, it is claimed that women had a dread of 'being superseded and dethroned' and was suspicious of anything that undermined her feeling of being the 'indispensable centre of her small world'.

<sup>28</sup> Roberts, *Women's Work*, 13 - 7; Lewis, J, ed., *Labour and Love: Women's Experience of Home and Family 1850 - 1940* (London 1986). Introduction and 4.

<sup>29</sup> Fox, 'DNA', 51 asserts that the QNI can be accepted as the authentic voice of district nursing because statistics and information emanating from it are reliable starting points for generalisation and that the QNI's work gave consistency before the NHS.



established standards and regulated the education, practice and conduct of district nursing under the professional surveillance of specifically qualified district nurses through schemes of affiliation (see Chapter 4). By the first decade of the twentieth century, however, district nursing comprised a much wider community than the QNI; a multiplicity of non-affiliated organisations operated beyond the control but not necessarily the influence of QNI practices (see Chapter 4). Furthermore, Congress revealed that district nursing was not exclusive to Britain, although standards and initiatives throughout the commonwealth and beyond had been inspired from Britain, leading to international affiliation. Membership of this world-wide community created further opportunities for reciprocity, international development and political activity.<sup>30</sup>

By the early decades of the twentieth century, the QNI had created a new body of power for women. Indeed, Fox perceived the QNI to be 'the centre of the world of women', offering professional autonomy and a career structure, but it was a time beset with internal and external conflict as well as opportunities.<sup>31</sup> Tension between district nursing and the medical profession heightened in 1910, as the developing expertise and expanding role of district nursing was perceived to be 'depriving doctors of their work'.<sup>32</sup> The situation was eased by an agreement that the district nurse would observe the clinical authority of the doctor and seek his direction on all medical matters. The root of the conflict was arguably one of self-interest provoked by the poverty associated with general practice rather than the inability of doctors to relinquish control.<sup>33</sup> Power struggles also existed in the relationship between government and the voluntary sector; as the state played an increasingly active role in the welfare of its citizens, the bourgeois image of the QNI became irksome. The QNI was paradoxically a victim of both its own success and its ineptitude (see Chapter 3).<sup>34</sup> On the one hand, the state resisted increased demands on hard pressed exchequer funds for a service currently supported

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<sup>30</sup> Stocks, *100 Years of District Nursing*, 132 – 44 and 183 – 191. with reference to a Congress of District Nursing held in Liverpool in 1909 which revealed the complexity of district nursing at home and abroad. Merry, E. J and Irven I. D, *District Nursing* (London 1948), 11- 2.

<sup>31</sup> Fox, 'DNAs', 146 – 7.

<sup>32</sup> Wellcome Institute for the History of Medicine (WIHM), Contemporary Medical Archives (CMA), (Queen's Nursing Institute (QNI) Nursing Committee, Special Meeting with the BMA (1910) to resolve the difficulties with the DNAs over the alleged usurping of the GPs role; Stocks, *100 of District Nursing*, 119.

<sup>33</sup> Waddington, I, 'General practitioners and consultants in early England. The sociology of intra-professional conflict', in Woodward, J and Richards, D. eds., *Health Care and Popular Medicine in the Nineteenth Century* (London 1977), 164 – 195.

<sup>34</sup> Fox, E. N. 'Falling at the last fence: District nursing's mismanagement of inclusion in the National Health Service', Cinderella Services Conference Paper (London 1999); Fox, 'DNAs', the situation to political ineptitude and naivety on the one hand, whilst having made an extraordinary contribution to society without the force of legislation on the other.



by voluntary effort.<sup>35</sup> On the other hand, however, an element of self-satisfaction and complacency reigned within the QNI, together with suspicion of state involvement and the infiltration of excessive control. Consequently, the ability of the QNI to influence social policy was weakened and its position became unstable due to lack of research and development (see Chapter 3), with adverse consequences for affiliates.<sup>36</sup>

The Leicester District Nursing Association (LDNA) made application to the QNI for affiliation in 1909, two years after the appointment of the 'Jubilee Nurse' – a Queen's Nurse (QN) designated 'The Irvin Nurse' (see Chapter 5). Leicester, having been one of the country's early pioneers in the establishment of a trained district nursing service, was disinclined to relinquish its independent status for nearly a quarter of a century after the establishment of the QNI. The stance adopted by Leicester with regard to district nursing arguably reflected the doubts which it had in submitting to the control of the QNI and its pride in the autonomy for which it was renowned.<sup>37</sup> On the other hand, personal investment made by the ruling classes and the sense of fulfilment it provided for their wives and daughters may have contributed to this apparent reluctance to change, as Gorsky found in his study of voluntary hospitals.<sup>38</sup>

The LDNA replaced the Institution of Trained Nurses for the Town and County of Leicester (ITNL) in 1908. The ITNL left a valuable legacy in the form of goodwill, trustworthiness, and a sense of obligation and reciprocity that bridged social class and institutional divides (see Chapter 4).<sup>39</sup> The LDNA was founded on the same principles as a 'Trust' to ensure public

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<sup>35</sup> The provision of a district nursing services was excluded from the 1911 National Insurance Act which gave free medical care to the insured; opportunities created by the 1929 Local Government Act and 1936 Public Health Act were left to the discretion of local government; the 1936 private members bill to bring district nursing under the auspices of local authorities failed whilst the Midwives Act in the same year made it compulsory for local authorities to employ sufficient midwives to meet the needs of their area; QNI Council Minutes (WIHM SA/QNI H13/7/2) record the refusal by government to give district nursing parity with general practitioners who received a fee for each civilian air-raid casualty referred by the hospital for domiciliary treatment.

<sup>36</sup> WIHM, CMA/QNI, Box 3. QNI Minutes of Council (1910), at this time 49 associations were affiliated to the QNI, an increase of 12 from the previous year.

<sup>37</sup> Records Office for Leicester, Leicestershire and Rutland (ROLLR), *Leicester Journal*, 'District Nursing Association Annual Meeting, March 1909; Dyos, H. J., 'Essays in urban history' in Cannadine, D and Reeder, D, *Exploring the Urban Past* (Cambridge, 1982) 9–58.

<sup>38</sup> Gorsky, M., 'Voluntary and municipal hospitals: a 'joined-up' approach to British health care before the NHS', University of Leicester Centre for Urban History Seminar paper, 2000; Gorsky, M and Mohan, J., 'London's voluntary hospitals in the inter-war period: growth, transformation, or crisis?', *Nonprofit and Voluntary Sector Quarterly*, June, 2001, 30, 2, 247–75.

<sup>39</sup> Merry and Irven, *District Nursing*, 5; ROLLR, L914.2 ELL Ellis, I. C, *Nineteenth Century Leicester* (Leicester 1935), 93; ROLLR 288 SR 1, Haynes, B., *Working Class Life in Victorian Leicester – The Joseph Dare Reports* (Leicester 1991), 51-2; Organisation for Economic Co-operation and Development (OECD), *The Well-being of Nations. The Role of Human and Social Capital* (Paris 2001),



probity, stability, and strategic continuity in the enterprise.<sup>40</sup> The need for change in 1908 was prompted by the accumulated pressures of economic fluctuations, a reconceptualisation of the causes of poverty, an emerging professionalisation, and changing scientific orthodoxies which shaped decisions in non-market institutions.<sup>41</sup> It was, therefore, more than the name of the ITNL that changed in anticipation of a new role and status as an affiliate to the QNI.<sup>42</sup> The affiliation debate began a process of transition that had implications for the locus of control, professional accountability and the stability of the service.<sup>43</sup> A preliminary visit by the QNI Inspector in January 1909 found that, 'without exception', the twelve nurses she met were 'kindly women, anxious to do their best for their patients', but standards of nursing care, supervision and administration were unacceptable.<sup>44</sup> For instance, the most elementary principles of nursing even by early twentieth century standards were infringed.<sup>45</sup> Few nurses washed their hands before or after attending a case, thermometers were rarely disinfected, surgical cleanliness was not always practised where required, patients were over-exposed during bathing and dressing, and lotions were not safely stored on completion of the visit. These poor standards were attributed to a lack of supervision. District nursing, 'hidden' within the homes of the sick, gave considerable autonomy and freedom to the practitioner, a situation which caused concern particularly in the first quarter of the century when standards of general training were extremely variable and subsequently considered incompatible with the requirements established by the General Nursing Council (GNC).<sup>46</sup> Supervision was central to the QNI doctrine, and this in many ways raised the prestige and standard of practice of district nurses, and contributed to their professional development. On the other hand, however, others

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41-41 here social capital is defined as 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups'.

<sup>40</sup> Rodger, R, 'Put your Trust in the City', Inaugural Lecture as Professor of Urban History, Leicester University 8 February 2000; Clift, B and Tomlinson, J, 'Tawney and the third way', *Journal of Political Ideologies*, 2002, 7, 3, 315 – 31.

<sup>41</sup> Leicester District Nursing Association (LDNA), *A History of the LDNA 1867 – 1953* (Leicester 1953). 3 –4; *Leicester Journal*, 'District Nursing Association Annual Meeting' March 1909; Witz, A, *Professions and Patriarchy* (London 1992), 128-159; Rose, *The English Poor Law*, 241 –7.

<sup>42</sup> LDNA, *A History*, 4.

<sup>43</sup> LDNA, *A History*; *Leicester Journal* 'LDNA Annual Meeting' (1909).

<sup>44</sup> NA, 30/63/264 QNI Inspector's Report on preliminary affiliation visit to Leicester 19 – 23 January 1909 with Affiliation Committee's response.

<sup>45</sup> WIHM, WY100 1889 C89g, Craven, D, *A Guide to District Nurses and Home Nursing* (London 1890) 9 – 67 and 71 –7; QNI, *Outline of District Nursing Techniques* (London, not dated but pre 1954), *passim*.

<sup>46</sup> McIntosh, J. B, *Work-Study of District Nursing Staff*. (Scottish Health Service Studies No. 37 Edinburgh 1976), *passim*; Kratz, C. R, *Care of the Long-term Sick in the Community* (London 1978), 92 – 3; Abel-Smith, *The Nursing Profession*, 125-6; Bendall and Raybould, GNC, 107 – 8 The Nurses Registration Act (1919) required the establishment of the nursing register. The register was initially constructed through a process of selective assimilation of nurses with hospital training of an acceptable standard.



in the medical professions, including HV, argued that this lack of autonomy diminished the status of district nurses as compared with themselves.<sup>47</sup>

The LDNA expressed concern about the substantial financial and recruitment implications of appointing a Superintendent and employing QNs as district nurses.<sup>48</sup> The QNI reaffirmed that all nurses employed as district nurses would need to possess the QN qualification and that suitable QNs would be encouraged to apply for posts in Leicester. Meanwhile, nurses currently in post would be considered for QNI training but those found to be unsuitable could only continue in employment on the understanding that, when the nurse(s) resigned, QNs, or nurses suitable to train as QNs, would replace them. Next, the appointment of a superintendent was expedited by the QNI, together with introductory visits to well-established Nurses' Homes that were similar in capacity to the requirement of the LDNA. Until the Home was established, the QNI recommended that new nurses should be installed in the same lodging as the Superintendent; those unable to comply should be allowed to resign. The QNI's perceived attempt to control the private and professional life of the district nurse by such means became a major source of discontent.

A proposal to apply for affiliation to the QNI was finally put at the annual meeting of the LDNA in March 1909.<sup>49</sup> It was accompanied with a reminder that the new order meant changes and new obligations at a time when the present expenses exceeded income by more than £200 – the issue of solvency was high on the agenda. Under the proposed scheme, an additional £100 per annum was required to cover the training and remuneration costs of employing QNs as district nurses. In addition, a special sum of £500 was required to establish a Nurses' Home. A "Superintendent" would take full charge of the nurses, thus relieving the Lady Superintendents and Visitors for other work. Many continued to work in a voluntary capacity as committee members and/or as Lady Collectors/Supervising Representatives of voluntary subscriptions and donations to the LDNA.<sup>50</sup> The Chairman countered objections and gained support with a reaffirmation of Leicester's need to advance along with the

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<sup>47</sup> Royal College of Nursing (RCN) Edinburgh Archives, RCN6/1/2, Meetings of the Public Health Section (1929), 63 (5d), health visitor membership negative attitude towards district nurses and rejection of the claim for equality. Note, at the inaugural meeting of the Public Health section in 1923 the General Secretary of the QNI was co-opted onto the Executive Committee.

<sup>48</sup> NA, 30/63/264 QNI, LDNA Affiliation Correspondence, (February 1909) between QNI Council and LDNA trustees, T. B Ellis, Company Director, G. C Turner, Boot and Shoe Manufacturer, J. W Barker, House Decorator and J. S. Sloane, Surgeon; ROLLR, DE 665/40 QNI *District Nursing Survey* (1934), 6 the cost of a QN, apart from her training was £231 per annum - £207 when working under a Superintendent with a larger staff – compared with a non-QN at £184. 10s.

<sup>49</sup> LDNA, *A History*, 5; *Leicester Journal* 'LDNA Annual Meeting' (1909).



‘majority of other large towns’ and to install a ‘proper system of inspection of the nurses’.<sup>51</sup> Mr Bond, a surgeon, supported the scheme and pledged £100 towards the venture. The motion was adopted and a public meeting followed. Miss Amy Hughes, QNI General Superintendent, addressed the meeting and gave full support to the proposed scheme, reiterating the conditions and benefits of affiliation. Members of the public were unanimous in their support of a resolution ‘to give full approval to the proposed scheme and to co-operate with the Committee in carrying it through’.

An ‘Agreement of Affiliation’ was issued on 11 June 1909. Thus the LDNA became part of a network for professional conference and discourse, a ‘coherent entity or social movement’ that was actually wider than the formally constructed system of affiliation, as QNI encouraged collaborative relationships with non-affiliated DNAs in the interests of raising standards of practice throughout district nursing.<sup>52</sup> The QNI acted with a fervour which was probably absorbed from the reforming zeal of individual liberal-thinking women of the mid-late nineteenth century.<sup>53</sup> The QNI was dedicated to safeguarding the vulnerable sick in their own homes through the provision of a specially qualified nursing service, thereby becoming a force for the empowerment of women both in the home and in the world of work. As part of this process, the QNI attempted to develop the nurse’s position from one of subordination to medicine into one of an interactive partnership.<sup>54</sup>

The organisation and administrative structure of the LDNA followed a fairly standard protocol (Appendix 1).<sup>55</sup> The Central Nurses’ Home was the first to be established in Leicester at 96 New Walk in 1909. The property was taken on lease for the first five years, and then was purchased in 1914 for £2300. With the aid of a grant from the King Edward VII Memorial Fund, a new wing was added in 1920. A House Committee, comprised of ‘prominent ladies who lived in the district in which the Home was situated’, administered the Home. Various functions were delegated to the Committee by Council, including the supervision of accounts, matters referred by the Superintendent and the appointment of

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<sup>50</sup> LDNA, *A History*, 6.

<sup>51</sup> *Leicester Journal*, ‘LDNA Annual Meeting’ 1909; LDNA, *History*, 4.

<sup>52</sup> Fox, ‘DNAs’, 16.

<sup>53</sup> There would be an extensive list of reforming women, which would include Beatrice Webb, Mary Stopes, Louisa Twining, Eleanor Rathbone; Purvis, *Women’s History*, 1- 23; Vickery, *Women, Privilege and Power*, Introduction; Rowbotham, S, *Hidden from History: 300 Years of Women’s Oppression and the Fight Against it* (London 1973), passim.

<sup>54</sup> Merry and Irven, *District Nursing*, 13, 21 and 45; See also Appendix 1 to this chapter ‘LDNA Organisational Structure’.

<sup>55</sup> Prochaska, F. *Women and Philanthropy in Nineteenth Century England* (Oxford), 105 – 6.



nursing staff. To some extent the situation continued the long-standing ethos of women's work in the voluntary sector whilst introducing a fundamental distinction between 'lay' and 'professional' control.

Miss Hardman was appointed Superintendent at the Central Home in 1909. During her three years in post, Leicester was approved as a QNI training centre and her role was combined with that of district nurse tutor.<sup>56</sup> She resigned in 1912 to become a QNI Inspector (see Appendix 2).<sup>57</sup> The Inspector's reports show that a superintendent was expected to be of good social and intellectual calibre, robust in health and temperament, with sound management skills, and the ability to create a happy and loyal staff – Miss Richardson, appointed as Superintendent in 1937, was known affectionately by her staff as 'mother'.<sup>58</sup>

During almost two decades the Central Home responded to numerous changes and demands single-handedly. The population of Leicester expanded from 27,222 in 1911 to 234,134 in 1921; city boundaries were extended and the population redistributed.<sup>59</sup> From 1918, the electorate included women over thirty years of age.<sup>60</sup> The Great War meant that the city had to deal with the aftermath of disrupted family units, unemployment and a means-tested Poor Law on the one hand, and structural adjustments caused by economic decline, innovations in industry and vocational and academic education on the other.<sup>61</sup> The demand for district nursing escalated and placed a tremendous burden on the informal gifted funding arrangements. By 1928 the number of nursing staff had expanded from 12 in 1909 to 18, the number of cases attended had risen from 1,973 to 2,407, and the one Central Home was no longer appropriate.<sup>62</sup>

In 1928 the informal gifted funding system, by which the LDNA and its predecessor had operated from 1866 (see Chapter 5), was reviewed in favour of a collective Provident

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<sup>56</sup> NA, 30/63/264 QNI Contract of Appointment for Emily Richardson as Superintendent (1937).

<sup>57</sup> LDNA, *A History*, 5; NA, 30/63/264. Edith Bond, Correspondence Secretary, LDNA regarding Application for Approval at a QNI Training Home. (February 1910). Approval was awarded.

<sup>58</sup> Cuthbert, B, widow of a Leicester QN. (Interview 1998); Cuthbert, D, 'Those were the Days!', *Journal of Community Nursing*, May 1982, 6-7. The article included a picture of Miss Richardson with a group of district nurses in 1950.

<sup>59</sup> Simmons, J, *Leicester Past and Present 1860 – 1974* (London 1974), Vol. 2, 116–7 and 151.

<sup>60</sup> Simmons, *Leicester Past and Present*, 65.

<sup>61</sup> Nash, D and Reeder, D, eds., *Leicester in the Twentieth Century* (Leicester 1993, passim.)

<sup>62</sup> LDNA, *A History*, 5 – 6.



Contributory Scheme (PCS).<sup>63</sup> The scheme, under the control of a full-time secretary, operated primarily in the work place, where subscriptions were extracted at source and ensured comprehensive coverage; other groups were also formed whose subscriptions were paid to LDNA approved collectors (Appendix 3).

The success of the PCS enabled the establishment of four other Homes, each housing a superintendent, nurses and domestic staff to serve the developing neighbourhoods on the edge of the city (Appendices 1 and 4). The Homes, large family-style residences, reflected the status and esteem of Leicester's district nursing service. Aylestone Home was purchased for £1125 in 1928.<sup>64</sup> The following year the Committee ambitiously established Belgrave Home purchased for £2000, the Trustees having borrowed £1000 from the Leicester Permanent Building Society.<sup>65</sup> The building of a fourth Home at 14-16 Valence Road was aided by an appeal from a LDNA committee member, then Lady Mayoress, who raised £2862 towards the cost. The fifth, a branch Home at 272 Uppingham Road, which accommodated a Senior Nurse in Charge and three nurses under the superintendence of the Central Home, opened in 1938 to serve the growing north Evington and Humberstone areas.<sup>66</sup> In 1938, anticipating future demand for nursing to serve the New Parks Housing Estate to the north of the City, a site near the 'bus terminus on Groby Road' was purchased for a sixth Home but the plan never came to fruition. The growth of the LDNA's capital investment was a phenomenal achievement of professional management and partnership with the local community, but one that possibly put a strain on resources.

### **Assessment, affirmation and censure – the role of the QNI Inspector:**

The QNI Inspector made an annual inspection of the Homes, the work of the district nurses and the viability of the Association. The 'inspection' was a daunting experience and one that entailed endless preparation, but for the patient a visit from the Queen's Inspector assumed the revered status of a royal visit.<sup>67</sup> The QNI operated with military-like precision and ritual;

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<sup>63</sup> LDNA, *A History*, 7 – 8; WIHM, CMA/QNI Morris, S. G. *Progress and the Provident Contributory Scheme for District Nursing Associations (PCS)* (London 1930).

<sup>64</sup> LCC, Legal Department, Conveyance of land and messuage known as 346 Aylestone Road, Leicester.

<sup>65</sup> LCC, Legal Department, Abstract of the Title of LDNA to a messuage and dwelling house known as The Hawthorns, 129 Loughborough Road; LDNA, *A History*, 8.

<sup>66</sup> LDNA, *A History*, 9.

<sup>67</sup> Oral Histories - Pointon, G, retired Leicester QN. (Interview 1998); Smith, B L, retired Leicester QN and district nurse tutor (Interview (1998) reference is made to the QNI 'poke' hand-made paper bags for the collection of waste, newspaper carpeted sickrooms for the protection of cross infection and damage to the patients furnishing. The sickroom was prepared with a bowl, bucket and hot water to secure maximum time with the patient. The nurse's coat was folded outside out and placed on a hard chair. Nursing equipment was stored in a cardboard box or draw. These rituals of practice were maintained



exacting standards and rigid procedures were imposed, which frequently brought the QNI into conflict with the local association, and threatened the continuing commitment to affiliation.<sup>68</sup> The level and complexity of the Inspector's role was evident from its involvement at the bedside, in the management processes of the Nurses' Home and in the executive functions of the boardroom. The role extended across different socio-political settings from inner city to fringe suburban settings and the village context; the Inspector needed to be equally at ease in the drawing room of the local gentry, at the vicarage garden party, and at the village bazaar.<sup>69</sup> Periods were sometimes spent overseas to support the establishment of new DNAs and affiliates. The role was unique in women's work during the first half of the twentieth century for three reasons: firstly, its fluidity between discrete institutional boundaries and the social hierarchies it traversed; secondly, its requirement of competent professional knowledge, negotiating skills and personal resources of self-reliance and independence; thirdly, its emphasis on staff development by identifying district nurses for promotion and grooming superintendents for inspectorship and more advanced career development.

The Inspector's primary objective was to safeguard standards of care through effective management, a high calibre of practice, and adequate staffing (Appendix 5). The data suggested an expanding district nursing service in Leicester commensurate with, though not always proportionate to, the expanding population. The QNI made the first 'rough estimate' of the national requirement of district nursing in 1926 as one nurse per 10000 population.<sup>70</sup> The criteria were redefined in a Survey conducted by the QNI in 1934 based on the type of district nursing post held and the 1931 Population Census. In Leicester, and most other Midland urban areas, district nursing incorporated selected elements of health visiting - a service which, when fully combined, required a proportion of one nurse to 3000 population, compared with 1: 7-9000 for general nursing only. The provision of district nursing within the Midlands is compared in an extract from the survey (Table 1). The survey estimated a shortfall of two nurses in Northampton and nineteen in Nottingham; Leicester and Derby had no apparent shortfall. The survey clearly indicated that DNAs struggled to meet the needs of their respective areas. According to the QNI Inspector's report, the actual situation for

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long after domestic amenities were incorporated in modern houses and nursing provision was extended to the 'not so poor' whose silver backed hair brushes were removed from the dressing table and stored in the nurses box; Grove, G, *Blame Titchmarsh* (Market Harborough 2002), 46 for satire on QNI rituals.

<sup>68</sup> Sweet, H and Ferguson, R, 'District nursing history', in Lawson, S, Cantrell, J and Harris, J eds., *District Nursing. Providing Care in a Supportive Context* (London 2000), 81 – 98.

<sup>69</sup> Fox, 'DNAs', 152.

<sup>70</sup> ROLLR, DE 665/40 QNI *Survey of District Nursing in England and Wales* (QNI 1934), 5.



Leicester in 1934 was less favourable than the survey portrayed, with a proportion of one nurse to 8639 population, of which twenty-three were QNs and twelve under contract of training for the role (see Appendix 5). Before 1934, LDNA had a tradition of mixed-skill establishments and flexible contracts which, whilst less prevalent in the 1930s, gathered momentum thereafter. The survey arguably masked the true situation in district nursing by not differentiating between specifically qualified district nurses and others.

**TABLE 1: QNI SURVEY OF DISTRICT NURSE: POPULATION RATIOS FOR THE EAST MIDLANDS (1934).**

TOWN/CITY:	POPN:	No. NURSES:	No. NURSES:	TOTAL:	DN : POPn
		(Affil. Assn):	(Un-affil. Assn)	(Affil+ Un-affil.)	(approximation)
Derby	142000	0	24	24	1 nurse: 6000
Leicester	239000	32	0	32	1 nurse: 7500
Northampton	96000	17	0	17	1 nurse: 5700
Nottingham	269000	0	15	15	1 nurse: 18000

Source: QNI Survey of District Nursing in England and Wales (London 1934).  
Note. The Leicester PCS from 1928 aimed to provide 1 district nurse to 7000 population – a proportion estimated to provide for seventy five – ninety five percent of the population.

To examine more closely the pattern of district nursing employment in Leicester between 1909 and 1939, two factors will be considered: firstly, the length of district nursing service with the LDNA and the problem of staff turnover (Table 2); secondly, the reasons for leaving and the implications of employment policies, conditions of service and personal conflicts (Table 3) both of which reflected the national trend of high mobility, as identified in the analysis of the QNI database (see Chapter 4). The overall high rate of attrition before the fifth year of employment was one of the main features; between 1909 and 1928, 55% of nursing staff at Central Home left within the first five years, probably owing to the fact that there was a mobile student population. The provision of residential accommodation and other amenities made it easy for district nurses to move about the country and abroad.<sup>71</sup> Nevertheless, accepting that candidates may have been trained in Leicester for other areas, the size of the exodus suggests that either Leicester itself or district nursing had limited attraction for the nurses. Aylestone and Belgrave Homes between 1929 and 1933 were affected by high turnover rates within the first five years of employment, a pattern that continued between

<sup>71</sup> Pape, R, 'Touristry: A type of occupational mobility', in Dingwall, and McIntosh, *Sociology of Nursing*, 53 – 66 whilst acknowledging the value placed on travel and of wider experience for nurses claimed that it could also be a way of delaying occupational commitment, or a counterbalance to the job itself.



TABLE 2: LENGTH OF DISTRICT NURSING SERVICE WITH LDNA (1909 – 39)

YEAR/DURATION	LDNA NURSES HOME:				
	CENTRAL:	AYLESTONE:	BELGRAVE:	WEST END:	TOTALS:
	%	%	%	%	%
1909 – 27 Under 1 year	22.4				15.1
1 – under 5 years	32.7				22.0
5 – under 10 years	0.5				0.3
10 – under 20 years	1.5				1.0
20years +	1.0				0.7
Internal transfer	0.0				0.0
NK	0.5				0.3
1928 Under 1 year	1.0	0			0.7
1 – under 5 years	4.1	12.1			4.1
5 – under 10 years	1.0	0.0			0.7
10 – under 20 years	0.0	0.0			0.0
20 years +	0.0	0.0			0.0
Internal transfer	1.0	0.0			0.7
NK	0.0	0.0			0.0
1929 – 33 Under 1 year	4.1	27.3	4.9		6.5
1 – under 5 years	11.7	30.3	24.4		14.8
5 – under 10 years	1.5	3.0	2.4		1.7
10 – under 20 years	0.0	0.0	0.0		0.0
20 years +	0.0	0.0	0.0		0.0
Internal transfer	1.0	0.0	0.0		0.7
NK	0.0	0.0	0.0		0.0
1934 – 9 Under 1 year	3.6	6.1	29.3	19.0	8.6
1 – under 5 years	9.2	12.1	36.6	57.1	16.8
5 – under 10 years	0.0	0.0	0.0	0.0	0.0
10 – under 20 years	0.0	0.0	0.0	0.0	0.0
Internal transfer	0.0	0.0	0.0	0.0	0.0
NK	3.1	9.1	2.4	23.8	5.2
TOTALS	100.0	100.0	100.0	100.0	100.0

Sources: WIML SA/QNI O/S 69 Q6/9 QNI Register of Affiliated Associations England 1909 – 39.  
Note: LDNA Nurses Homes year opened, Central 1909, Aylestone 1928, Belgrave 1929, West End 1934.

1934 and 1939 for Belgrave and West End, while the staffing situation at Central seemed more stable - a situation arguably influenced by changes of superintendent (see Appendix 4).

The Inspector also questioned the comfort and amenities of the Homes and the attitude of House Committees, which demonstrated a lack of consideration for the district nurses they employed. Administrative policies based on expediency arguably resulted in the issuing of short-term temporary contracts. The termination of temporary contracts was, in most instances, the primary cause of nurses leaving the LDNA, (see Table 3) – a national problem identified from the analysis of the QNI data base in Chapter 4.



TABLE 3: LDNA NURSES REASONS FOR LEAVING (1909 – 39)

YEAR/REASON:	LDNA NURSES HOME:				
	CENTRAL:	AYLESTONE:	BELGRAVE:	WEST END:	TOTALS:
	%	%	%	%	%
1909 – 28: Marriage	3.6				2.4
Other work/promotion	13.3				8.9
Missionary/abroad	0.5				0.3
Other training	6.6				4.5
Military	0.5				0.3
Home duties	2.6				1.7
Temp contract	11.2				7.6
Released/term contract	1.5				1.0
Internal transfer	1.0				0.7
Health	2.6				1.7
Retirement	1.0				0.7
Unsuitable/misconduct	1.5				1.0
NK/left	20.4	12.1			15.1
Remaining in post	1.0	0.0			0.7
1929-33: Marriage	4.1	3.0	9.8		4.5
Other work/promotion	1.5	3.0	2.4		1.7
Missionary/abroad	0.0	0.0	0.0		0.0
Other training	0.0	3.0	0.0		0.3
Military	0.0	0.0	0.0		0.0
Home duties	0.5	3.0	0.0		0.7
Temp contract	2.6	12.1	7.3		4.1
Released/term contract	0.0	6.1	2.4		1.0
Internal transfer	1.5	0.0	0.0		1.0
Health	1.0	3.0	2.4		1.4
Retirement	0.0	0.0	0.0		0.0
Unsuitable/misconduct	0.0	0.0	0.0		0.0
NK/left	5.6	27.3	7.3		7.9
Remaining in post	0.0	0.0	0.0		0.0
1934-9: Marriage	1.0	0.0	2.4	14.3	2.1
Other work/promotion	1.0	3.0	7.3	19.0	3.4
Missionary/abroad	0.0	0.0	0.0	0.0	0.0
Other training	0.5	0.0	2.4	4.8	1.0
Military	0.0	0.0	0.0	0.0	0.0
Home duties	0.5	0.0	0.0	0.0	0.3
Temp contract	2.6	0.0	0.0	9.5	2.4
Released/term contract	0.0	0.0	7.3	4.8	1.4
Internal transfer	0.5	0.0	2.4	0.0	0.7
Health	0.5	0.0	2.4	0.0	0.7
Retirement	0.0	0.0	0.0	0.0	0.0
Unsuitable/misconduct	0.0	0.0	0.0	0.0	0.0
NK/left	5.6	15.2	36.6	23.8	12.4
Remaining in post	3.6	9.1	7.3	23.8	6.2
TOTALS:	100.0	100.0	100.0	100.0	100.0

Sources: WIML SA/QNI O/S 69 Q6/9 QNI Register of Affiliated Associations England.



The reasons given for leaving the employment of the LDNA can be summarised as administrative, professional and personal. A full analysis has been included to facilitate comparison between the LDNA and the national trends in attrition examined in Chapter 4. It can be seen that home commitments frequently resulted in the nurse leaving the district nursing service in Leicester.

The need for professional development, or merely change of employment, was frequently the second greatest influence, as nurses left for 'other work' in district nursing posts elsewhere - sometimes for promotion, occasionally to return to hospital, and sometimes for appointment to public health posts. 'Other training', mainly midwifery and occasionally health visiting, usually sponsored by the QNI, were prerequisites for promotion to Superintendent and higher posts. Personal factors included marriage, the third most common reason for leaving, and 'home duties' for which many nurses were given leave of absence or resigned. In addition, health crises, both mental and physical, often curtailed a nurse's ability to continue the physically, professionally and intellectually demanding role of the district nurse.

After the First World War, men entered nursing in greater numbers when unemployment was high; a second influx occurred in the 1940s following wartime service in the armed forces medical corps.<sup>72</sup> Men in nursing were discriminated against from the time of the Nurses Act in 1919 when the names of male nurses were entered on a 'supplementary' part of the register. Amalgamation with the 'general' part of the register did not occur until 1943.<sup>73</sup> By 1924, the GNC had only approved two general hospitals to train male nurses; thus a valuable resource was lost as the vast majority of men trained as attendants in the mental hospitals under the auspices of the Medico-Psychological Association.<sup>74</sup> Prejudice and short-sighted policies also resulted in similar obstacles for men seeking employment as district nurses, and membership of the QNI was withheld until 1947 when the first four male nurses successfully completed training. Even then, however, only seven associations, including LDNA, agreed to offer employment.<sup>75</sup> The archives, along with recent oral histories, reveal claims of 'unfairness'

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<sup>72</sup> Savage, J, *Nurses, Gender and Sexuality* (London 1987), 66 – 7.

<sup>73</sup> Abel-Smith, *The Nursing Profession*, 96 –7 and 217.

<sup>74</sup> Greene, J, 'Men in nursing and the Royal College of Nursing', *History of Nursing Journal* (1992-3), 4-9. for significance of The Medico-psychological Association (See Chapter 4 of this study).

<sup>75</sup> Sweet and Ferguson, 'District nursing', in Lawton, Cantrell and Harris, *District Nursing in a Supportive Context*, 81 – 9; Savage, *Nurses, Gender and Sexuality*, 67 and 75 – 6 both men and women nurses are objects of sexual curiosity but the gender status of male nurses is dubious being 'less of a man', homosexual or Casanova. WIHM, SA. QNI/H.28 Male Nurses Box 84 Newspaper articles and QNI correspondence.



and discrimination against male nurses who were required to ‘jump through many more hoops than the women’ to succeed in nursing.<sup>76</sup> In the first instance, acceptance for general nurse training was difficult; after qualification, QNI regulations then stipulated a seven months’ course compared with that of six months undertaken by female nurses; men also had to complete a probationary period following training. Men were precluded from qualifying as midwives and health visitors, both qualifications necessary for promotion to the senior ranks of the QNI. The experience of men, until the situation was rectified in the late twentieth century, underlined the caution with which they were received into the traditional female domain of nursing. Would the history books have told a different story if this had not been the case?

As in other spheres of work, married women had been discriminated against from the inception of the QNI. In 1947, however, a declaration was made by the QNI that ‘all barriers to the training and employment of married women shall be removed’.<sup>77</sup> This signified a move away from the traditional belief that a married woman’s place was in the home. The first married woman was employed in Leicester as a QN in 1948 at Central Home. QNs had previously been excluded on marriage and, when the rules changed, they were required to re-enrol with QNI on the payment of a fee; many did not and were classified as Ex-QNs (see Appendix 5). A candidate and a QN with the civil title of Mrs, appearing in the LDNA records for 1934 and 1936 respectively, were probably widows. The rejection of married women and of men (the first male district nurse was employed by the QNI in 1948) was an unnecessary waste of finite resources that the QNI could ill afford (see Chapter 4).

### **Partnerships in care:**

The relationship between district nurses, the LDNA, the community and local agencies was important for both the financial security of the LDNA and the patient’s access to quality nursing care. In addition, accountability to the GNC, the QNI, and the patient was a primary responsibility for the nurse and her employer. Trustworthiness, obligation and reciprocity were central to this possibly unequal partnership, in which quality of care, optimum staffing levels, the welfare of personnel and staff development were arguably common goals. The circumstances surrounding the 1918-19 influenza epidemic, nick-named ‘the Spanish Flu’,

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<sup>76</sup> Cuthbert, B, widow of a Leicester QN.(Interview 1998); Pointon, G, retired Leicester QN, whose husband was a QN. (Interview 1998); Swyers, E, widow of a Leicester QN. (Interview 1999).

<sup>77</sup> Morris, P, *Power a Philosophical Analysis* (Manchester 1987), 40 – 5; WIHM, SA/QNI H. 28, ‘Married District Nurses and Male District Nurses’, QNI Correspondence (22.11.1947).



although not mentioned in the Inspector’s reports, are summarised as a vignette to illustrate the concept of partnership between health-care and welfare and the local community.

The MOH suspended School Medical Inspections and Infant Welfare work; nurses were placed at the disposal of the Superintendent District Nurse. Women with nursing experience were recruited to work for as many hours as they were able; one of the most distressing nursing needs was assistance at night - several men also came forward on a voluntary basis to render service.<sup>78</sup>

The employer’s commitment to its employees and to society is paramount. In this regard, the period from the late 1920s to the 1940s might be justifiably argued as one of both re-generation and decline. By the late 1920s, LDNA had already secured a range of effective inter-agency contracts (see Table 4) for the procurement of revenue, but opinions within the

TABLE 4: LDNA PRINCIPAL SOURCES OF INCOME 1928 - 47

SOURCES OF INCOME:	£ (decimal):					
	1928	1934	1938	1940	1944	1947
LA notifiable diseases & tuberculosis (1/- per visit)	356	320	255	217	126	194
LA Pneumonia – block grant				60	30	30
Public assistance – block grant		100	150	150	150	150
Subscriptions		760	642	602	524	504
Donations and fees		322	280	278	414	328
Insured patients	207	148	109	91	34	68
Provident Scheme (PCS)		7189	8493	8477	10100	15517
QNI candidates grant				108		204
Association: Balance in hand (previous year)		825	510	797	-489	2188
Legacies/Investments		1132		678		{10000
Interest on temporary investments				175		{
Dividends/Cash in bank – various funds		4141			303	363

Sources: NA 30/63/263/264  
Note: The Irvin legacy is not cited.

LDNA were divided about the wisdom of statutory involvement and loss of control in the face of public accountability.<sup>79</sup> But, even with the rudiments of a welfare safety net in place

<sup>78</sup> ROLLR, L614 84/64 Leicester Corporation Health Reports (LCHR), (1918 and 1919; ROLLR L614. 518 Wilshire, J. *Leicester’s Great Influenza Epidemic* (Leicester 1986).

<sup>79</sup> Fox, ‘DNAs’, 60 refers to the Royal Commission on the Poor Law (1909) recommended the provision of district nursing through subscriptions as shown in the LCHR.; Morton, P. M, ‘Developments in the Organisation of Primary Health 1900 – 1977’, University of Nottingham MPhil thesis, 1997, 63, cites the Local Government Act (1929) and the permissive powers to contribute to district nursing, mainly for the elderly and chronically sick.



for the old, sick and unemployed, the optimum level of district nursing could not be guaranteed without access to a wider range of financial support through the PCS..<sup>80</sup>

Whilst retaining the essential principles of a ‘Trust’ economy, the Leicester PCS led the field in innovative practices which changed the fortunes of the LDNA from annual losses of up to £800 in the early 1920s to a viable enterprise, spearheading a system that revived the flagging economies of other DNAs (see Table 5). The benefits were claimed to be threefold: firstly, the ‘workers had immediate access to a trained nurse in the home, which meant that recovery was not prolonged; secondly, the livelihood of the ‘employers’ was not impeded by protracted periods of absenteeism through ill health; thirdly, the health and integrity of the City and Nation was enhanced through early diagnosis and treatment at the curable stages of illness.

**TABLE 5: GROWTH OF PROVIDENT CONTRIBUTORY SCHEMES IN DISTRICT NURSING (1936 –39)**

DNA	YEAR	POPULATION SIZE	NUMBER OF CONTRIBUTORS	% DNA INCOME FROM PCS	TOTAL INCOME (£)
Dover	*1936	40,000	4,210	80.5	950
	1939	40,000	4,337	91.1	950
Ewell	*1934	15,000	900	44.0	450
	1939	29,000	1350	37.8	773
Gateshead	*1934	125,000	NA	25.3	3,080
	1939	116,000	11,710	44.4	5,650
Greater Harrow	*1934	130,000	3,720	27.4	1,755
	1939	178,000	9,657	41.0	4,576
Leicester	1929	260,000	60,000	64.6	7,953
	1934	260,000	95,205	81.5	119,555
St Helens	*1933	107,000	18,000	58.8	3,382
	1934	107,000	25,000	60.7	4,581

Source: WIML CM SA/QNI H. 131712 QNI Council’s submission of evidence to the Interdepartmental Committee of Social Insurance and Allied Services

These claims, whilst laudable, were not systematically evaluated and, as a consequence, there is no official evidence that these benefits were achieved. During the inter-war years, many people still lived in overcrowded unsanitary conditions; wages frequently remained below subsistence level whilst occupational and fiscal welfare systems through pension provision and other subsidies and concessions were of far more benefit to the more wealthy taxpayers than to the poor.<sup>81</sup> Added to which, the depression in the 1930s affected the financial solvency

<sup>80</sup> Morris, *PCS*, 1.

<sup>81</sup> Donnison, D, *The Politics of Poverty* (Oxford 1982), 12 – 26; Simmons, *Leicester Past and Present*, 75 – 81; Brown, C, *Wharf Street Revisited: A History of the Wharf Street Area of Leicester* (Leicester 1995), passim observing Leicester’s position as the second wealthiest city in Europe (1936 League of



of local authorities – then responsible for the poor law institutions following the abolition of the Board of Guardians - and often prohibited a greater measure of non-mandatory sponsorship for voluntary services such as the LDNA, which, prior to the introduction of the National Health service (NHS) in 1948, provided a vital safety net for the sick and needy citizen.

The PCS created a significant change in the management culture of the LDNA, as the family firm altruism of the ruling classes was replaced by a corporate ideology under the control of professional management with strong business acumen. Methods of achieving financial efficiency and determining priorities, however, were arguably less influenced by best professional practice than expediency or the most economic commodity, thus prompting the question whether the interests of the patient or the nurse were being served. For example, in 1928, the staffing establishment numbered 21 nurses and 18 ‘others’, compared with the position in 1948, when 50 nurses and 38 ‘others’ were employed. Although the changes represented a phenomenal increase in nurses of 138%, the efforts of the PCs do not look so impressive when a comparison is made with the 111% increase in ‘other staff’. To some extent the increase in ‘other staff’, presumably mainly clerical and administrative, could have been justifiable in view of the increase in the nursing establishment, but the increase could also include non-trained, or minimally trained, care workers, perhaps reflecting the attempts revealed in the Inspector’s report to offset the shortfall in QNs by other staff employed to attend ‘washing cases’. The practice was censured by the Inspector when an analysis of patient needs revealed that ‘washing’ was inevitably accompanied by the need for skilled nursing care and therefore the LDNA was offering a sub-standard quality of care – and that to the most vulnerable groups in society, the frail elderly and the long-term sick.

The LDNA was not unique in its unanswered appeal for nurses; evidence suggests a long-standing national shortage - and the fluctuating and somewhat unstable nature of the district nursing service became increasingly evident.<sup>82</sup> The problems of demand exceeding supply, low pay, and exacting conditions of employment were arguably not exclusively to blame. It is difficult to define the extent to which the root of the LDNA’s staffing problems were externally imposed or internally created. Throughout the 1930s, inspectors repeatedly expressed concerns about the heavy workload carried by the nurses, coupled with the

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Nation’s Report) but decrying that little of its wealth filtered through to Wharf Stree; Nash and Reeder, *Leicester* Chapter 2.

<sup>82</sup> Baly, *Nursing and Social Change*, passim; Abel-Smith, *The Nursing Profession*, passim; Political and Economic Planning (PEP), *Report on the British Health Services* (London 1937), 166 – 80.



increasing demands on the service. With the onset of the War in 1939 the demand for nurses seemed insatiable.<sup>83</sup> But in 1937, the LDNA was well satisfied with the service provided and the growth in membership. Branch Homes had been opened to reduce the nurses' travelling time, a delivery and collection service of appliances to the patients' homes had been introduced, and a course of training negotiated with Leicester's University College.<sup>84</sup> Superintendents, however, were rather more cautious, as they reported a problem of nurse shortages compounded by high levels of sickness.

Fundamental changes in the demand for trained nurses occurred with the onset of war in 1939, resulting in a shortage that gave rise to continual concern and a trend towards a more complex division of labour and skill-mix, which continued throughout the war years (see Appendix 5). The balance of QNs to other staff may have been a matter of expediency or planned cost-effectiveness, but it was a trend that came to stay and one that arguably contributed towards a dilution in the service.

Whilst the achievements of the LDNA were usually commended in terms of business management and general standards of nursing, there were some sources of discontent, including cost-cutting; conflict also arose over the suggested discontinuation of House Committees, but in 1934 a successful attempt was made by the Inspector to convince the LDNA of their importance to the respective superintendents and the value of members' local knowledge and commitment. It seems too that, once established, the Homes assumed a low priority; by 1937, Aylestone Home had reached capacity, Central Home was quickly becoming 'out of date', and the newly purpose-built West End Home lacked essential amenities. The Inspector made known her dissatisfaction with the bleak conditions to which some nurses were exposed, but the Chairman objected to unnecessary expenditure and quashed the recommended improvements. Conditions gradually improved in the 1940s but heating and lighting were a continual problem, partly due to wartime fuel restrictions, and partly to financial stringency - some Homes were without fires in the bedrooms. Wartime restrictions or LDNA policy also contributed to the poor quality of the nurses' uniforms, which the Inspector sought to improve by offering to supply patterns of approved material. An added problem was the lack of adequate drying facilities for out-door clothes in the Homes.

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<sup>83</sup> NA, 30/63/264 LDNA QNI Inspector's Reports 1909 – 1948.

<sup>84</sup> ROLLR, L610.63 LDNA Annual Report (1937).



Successive inspectors, particularly from the mid-1940s, observed the work to be interesting and varied but fluctuations in workload were a concern. A number of factors may have contributed to variations in the up-take of services – not least the standard of care. For example, during the blackout evening visits were made in the late afternoon, thus leaving terminally ill and very sick patients unsupported by district nursing for long hours until the next morning. Some nurses were criticised for not paying attention to the patients' welfare needs and environmental problems, whilst others were accused of lacking interest other than in their own pursuits. Doctors were observed to be making less use of the service and hospital care had become a greater attraction. The criticisms culminated in a report of condemnation to the LDNA with expressions of concern from the QNI.<sup>85</sup> The LDNA responded with alacrity and alarm, as the debate towards the formation of a National Health Service (NHS) began to have implications for the future of district nursing.

In the 1940s, the Inspector repeatedly noted with satisfaction the healthy financial situation of the LDNA; although there was a financial deficit in 1944, due to excess expenditure over ordinary income, the situation was quickly rectified by an increase in subscription from 4/4d to 6/-. In 1946, a reticence to divulge 'Invested Funds' was experienced, but they were eventually declared as £10,000. Two years later, the same non-disclosing reaction was encountered; the secretary stated the LDNA did not print a balance sheet and had not done so for years so the exact amount of invested capital was unknown. The impression of a scorched earth policy in anticipation of nationalisation arguably accounts for the absence of primary data from which to conduct this research.

The partnership between the district nurse and her patient was a high priority for the Inspector, followed by the triage with the doctor in a range of circumstances (Table 6). The data suggests a great variety of work involving a balance of general nursing care and surgical nursing including health visiting type work, and conditions with a more precise medical diagnosis than hitherto, as discussed in Chapter 3.<sup>86</sup>

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<sup>85</sup> NA, 30/63/264 LDNA QNI Inspector's Report and subsequent correspondence (1941).

<sup>86</sup> Dingwall, Rafferty and Webster, *Social History of Nursing*, 198 – 9. the overlap is claimed to create confusion for health visiting statistic; WIHM, SMA/QNI Minutes of the Nursing Sub-Committee 21.01.1930, 7, DNAs requested 'instruction in Health Visiting and Infant Welfare' to enable district nurses to meet the needs of the community. On other occasions QNI attempted to secure greater integration between the two roles to no avail. It was a political controversy that remained, whilst in practice role boundaries were blurred.



TABLE 6: LDNA DISTRICT NURSING TREATMENTS (1913 – 39)\*

Type of cases:	General nursing care:							Surgical nursing care										
	Cancer/Tumours (all organs/bones).	Stroke/Hemi/paraplegia/coma.	Cardiac and circulation.	Senility/degenerative disorders	Chest infections and TB - organs/bones.	Arthritis/rheumatic fever.	Orthopaedic injury/infection	Other.	Leg ulcer/injury. Scald/burn. Skin infection/gangrene	Diabetes injection insulin.	Tuberculosis (organs and bones).	Tumours/Carcinoma	Glands/abscesses/sinuses.	Appendectomy/hernia/excision rectom.	Supra-pubic catheter.	Amputation/circumcision/mastoidectomy.	Other surgical nursing procedures.	GRAND TOTAL.
HOMES:																		
Aylestone	0.6	1.1	2.4	0.7	1.1	1.3	0.0	0.7	1.7	0.9	0.6	1	0.9	0.4	1.1	0.4	0.7	15.9
West End	0.6	0.7	0.9	0.9	0.9	1.5	0.7	0.7	1.7	0.2	0.2	1	1.1	0.0	0.0	0.7	0.2	12.2
Central/Humberstone	0.6	6.9	5.2	4.1	6.6	3.7	0.9	1.5	6.9	3.0	0.9	3	3.6	3.4	0.4	0.9	2.1	55.4
Belgrave	0.6	0.9	1.1	0.9	2.1	0.9	0.2	0.2	3.6	0.9	0.6	1	1.5	0.2	0.4	0.6	0.9	16.5
TOTAL	0.6	9.7	9.7	6.7	10.7	7.5	1.9	3.2	13.9	5.1	2.2	6	7.1	3.9	1.9	2.6	3.9	100.0

Note: \*Sample of nurses' work as selected by Inspector for annual sssessment.  
Source: NA. 30/63 263/264/265 QNI Inspectors' Reports LDNA 1913 – 1948.

The effects of ageing, life style and personal behaviour are represented amongst the main groups of conditions requiring general nursing care, whilst surgical nursing reflected the absence of antibiotics, conditions symptomatic of the type of household environment and the management of risk, extensive surgery for cancer, and wartime casualties. Insulin, administered by injection from the 1920s, revolutionised the treatment of diabetes, improved the quality of life for diabetics, and changed the demands on district nursing both in the short and long term, particularly by reducing the chronic illness that occurred as complications of diabetes. Nursing care demanded inter-personal and practical reciprocity between nurse and patient; for example, the patient prepared sterile dressings and baked them in an airtight tin in the domestic oven while culinary utensils were also adapted for use.<sup>87</sup>

Of particular interest is the circumcision of infants, usually performed for clinical reasons but also as a ritual within the Jewish tradition; the district nurse, uniquely as a woman, was often

<sup>87</sup> Merry and Irven, *District Nursing*, 110.



in attendance, which reflects the asexual stereotype of nurses whose 'humanity is denied' because they are ignored as 'real people' and become an extension of a socially constructed category.<sup>88</sup>

Comments by the Inspector confirmed the complex and distressing effects of irreversible chronic illness and protracted terminal illness, where limited mobility was often compounded by functional and behavioural changes and environmental constraints. Patients in this category were physically difficult, 'trying' for the nurses, and demanding on the resources of informal carers.<sup>89</sup> The 'burden' of long-term care in the home had an emotional and social impact on the family and neighbourhood network, but the economic implications of indirect costs such as extra comforts and household wear and tear were frequently hidden factors shared only with the nurse.<sup>90</sup> Clearly, the term 'supervision' was undervalued, as was the true extent of the supportive and counselling role of the Inspector and the Home Superintendent. By the same token, the paucity of the 'nursing notes' both in design and usage failed to reveal the skilled management process of assessment, planning and evaluation on which the nurse had exercised such judgements as the frequency and timing of her visits, when to consult with the doctor or draw on external resources. The lack of such written evidence was the 'Achilles' heel' of district nursing within the historical context and the political debates of mid-twentieth century health-care and welfare.<sup>91</sup>

The Inspector's reports identified the partnership that existed between district nurses and the community, when being a district nurse was as important as doing district nursing. For instance, during the war district nurses were not isolated from the physical traumas of war; some joined the Territorial Army, others manned first aid posts and fire watching, while part of each Nurses' Home was converted into an air raid shelter. District nurses clearly played an important part in maintaining social solidarity during the war – a period when, some scholars argue, 'social solidarity was limited' by divisive policies such as conscription into the forces and evacuation on the home front.<sup>92</sup> District nurses were regarded as ambassadors for the

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<sup>88</sup> Lester, P. M, ed., *Images that Injure; Pictorial Stereotypes in the Media* (London 1996), 10; Watkins, P. G, 'Women in the work force; Gender stereotypes', in Lester, *Images that Injure*, 69 – 85.

<sup>89</sup> Field, D, *Nursing the Dying* (London 1989), 99, 105 – 6. A Leicester study which identified the effect for district nurses of the 'long duration' of contact, together with conflict of 'disclosure' and its resolve.

<sup>90</sup> Carver, V and Liddiard, P. eds., *An Ageing Population* (Kent 1978), the Reader includes a wider range of perspectives on the challenges of ageing.

<sup>91</sup> McIntosh, J. B, 'District nursing: a case of political marginality', in White, R, ed., *Political Issues in Nursing. Past, Present and Future* (Chichester 1985), Vol. 1, 45 – 66; McIntosh, *Work Study of District Nursing*, 20 –4.

<sup>92</sup> Berridge, V, *Health and Society in Britain since 1939* (Cambridge 1999), 10 –22.



LDNA, part of an income generating strategy, their distinctive uniform making them immediately recognisable and accessible within the community.<sup>93</sup> In 1944, the White Paper on the NHS acknowledged the importance of a 'full home nursing service' to the success of the NHS.<sup>94</sup>

The forthcoming NHS involved more than a change of employer. The nurse-patient relationship underwent change, as all citizens were to be insured from the cradle to the grave for every eventuality.<sup>95</sup> It was a time of uncertainty laced by optimism, a state of mind that is arguably reflected in the cavalier attitude of some nurses and their apparent loss of motivation, criticised by the Inspector and included in her report of condemnation cited above.

### Conclusions:

During the period between 1909 and 1947 the development of district nursing in Leicester is shown to have resulted from three major initiatives taken by the LDNA. Firstly, the restructuring of the organisation and the establishment of 'Trust' status, which was a form of socially embedded trust, yielded an economic by-product and ensured public accountability and local autonomy (see also Chapter 8). Secondly, affiliation of the LDNA to the QNI in 1909 secured for the people of Leicester a professional district nursing service based on set standards of training and nursing practices, and brought about the replacement of lay management by professionally trained and highly experienced QNs; acknowledgement of Leicester's standing nationally and the commitment of the local community was further endorsed in 1910 when it received QNI approval as a training centre for QNs. Thirdly, Leicester launched a nationally acclaimed workers' provident contributory scheme (PCS) in 1930; this collective funding system, which replaced the individual gifted arrangement for district nursing service, is another example of the way in which the LDNA exercised its autonomy by utilising economic strategy combined with social cohesion to meet local need. The PCS changed the fortunes of the LDNA and removed the stigma of charity for the poorer working classes when they needed district nursing services.

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<sup>93</sup> Stocks, *100 Years of District Nursing*, 181 where a more general view of the district nurses ambassadorial role is described; Pointon, G, Leicester District Nurse (Interview 1989), felt that 'your uniform spoke for you'.

<sup>94</sup> White, R, *The Effects of the NHS on the Nursing Profession 1948 – 1961* (London 1985), King's Fund History Series 3, 143 – 6.

<sup>95</sup> Lowe, R, *The Welfare State in Britain since 1945* (Basingstoke 1999), 13; Stocks, *100 Years of District Nursing*, 181 – 2; Robinson, K, 'Nurses and the welfare state', in Gaffin, J, ed., *The Nurse the Welfare State* (Aylesbury 1981), 147 – 59.



The chapter highlights the way in which women as a group were restricted by legislative and socio-economic controls, while as individuals they created their own opportunities for freedom in a very specific and subtle way. District nursing played a significant role in this process by empowering women as carers and offering them an opportunity for emancipation through involvement in a profession. District nursing paralleled the emancipation of women at the boundaries of the traditional male preserves of medicine, the church and politics - a process that accelerated during the life of the LDNA. During peacetime, war and fluctuations in the economy, district nurses in Leicester engaged with the local community to promote health-care and welfare, a safe environment and a supportive neighbourhood spirit. The uniqueness of these achievements earns district nursing a place in women's history.

This chapter also shows how, from the 1930s, the shortage of nurses generally gave rise to great concern, and how, in Leicester, a limited understanding of the district nurse's role and function was particularly noticeable at times of recruitment difficulties. At such times, the district nursing establishment was often augmented by lesser-trained staff and lay assistants, with a detrimental effect on the assessment of patients' needs.

The LDNA, in spite of some short-comings, presented a rich dowry to the NHS in 1948 in the form of a thriving district nursing service, well-equipped District Homes and a successful QNI training scheme. Chapter 7 evaluates the transition from voluntary status to statutory control, and examines the extent to which district nursing consolidated its position in home-based nursing and community health-care, maintained and adjusted its relationships within a wider health-care and welfare system, and sustained its standing in the local community.



APPENDICES

1: LDNA ORGANISATIONAL STRUCTURE.

\* GENERAL COUNCIL

President  
Trustees  
Chairman/Vice-chairman  
Hon. Treasurer



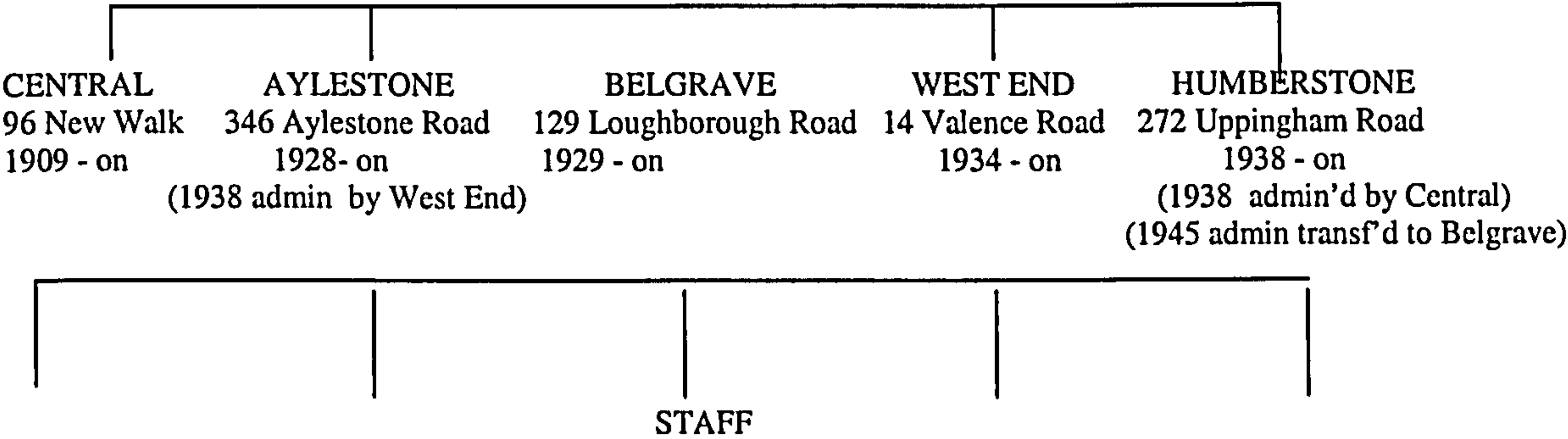
\*EXECUTIVE COMMITTEE

Chairman/Vice chairman  
Secretary and support staff  
Hon. Financial secretary  
Home Superintendent (s)  
PCS works /home subscribers representation  
(from 1928)



\*\*HOUSE COMMITTEES

Chairman  
Members – appointed from local community  
Home Superintendent



Superintendent and or Assistant Superintendent  
Senior Nurse: QNs and other trained nurses/candidates  
Domestic staff

Sources: PRO 30/63/263/264/265/266 QNI Inspectors' Reports; LDNA, *A History*.  
WIML. CMA. SA/QNI Morris, Provident Contributory Scheme.  
Key: \* Male leaders of Leicester's business, religious and medical communities.



APPENDICES

2: LDNA SUPERINTENDENTS 1909 – 1948.

NURSES HOME:	PERIOD:	SUPERINTENDENT:	QNI TRAINING COURSE:
Central	1909 - 1912	Miss Hardman	NK
	1912 - 1916	Miss Bacon	Bloomsbury
	1916 - 1937	Miss Mearns	Hull
	1937 - on	Miss Richardson	Paddington
Aylestone	1928 - 1931	Miss Swan	Brighton
	1931 - 1937	Miss Richardson	as above
Belgrave	1932 - 1938	Miss Ruddock	Liverpool
	1938 - 1940	Miss Grimes	Blackburn
	1940 - 1941	Miss Duff	Hammersmith
	1941 - on	Miss Lee	Bath
West End	1934 - on	Miss Jepson	Paddington



## APPENDICES

### 3: LEICESTER PROVIDENT CONTRIBUTORY SCHEME (PCS)

#### INITIAL ADVERTISEMENT:

Join the

LEICESTER DISTRICT NURSING ASSOCIATION'S WORKS  
CONTRIBUTORY SCHEME.

*A SOUND INVESTMENT*

By paying 1d per fortnight the worker receives: Trained Home Nursing  
care **FREE** of charge for self and non-wage-earning , and **PRESERVES**  
Independence and Self Respect.

Form a Subscribing Group where you are employed.

Nurses' Home, 96 New Walk, Leicester.

#### FOUR SUBSCRIBING GROUPS:

1. **Works Group** - for all workers to contribute at their place of employment – subscriptions collected, or deducted at source.
2. **Women's Organisations Group** – for people not employed at a large works e.g., small shopkeepers, domestic servants, gardeners, the retired.
3. **Public Medical services Group** supported the scheme and their collectors obtained the subscriptions for district nursing in their districts for a commission of 20%.
4. **Home Scheme Group** – for those who are not weekly wage-earners and able to afford a higher subscription but not the cost of private nursing. Paid collectors service this group at a commission of 12% and 6d for every new subscriber.

Sources: Leicester District Nursing Association (LDNA), *History of the LDNA 1867 – 1953* (Leicester 1953), 7. WIHM, SA/QNI, Morris, S. G, *Progress and the Provident Contributory Scheme for District Nursing Associations* (London not dated), 4 – 6.



APPENDICIES

4: LDNA NURSES HOMES AND HEADQUARTERS.



← LDNA/PCS headquarters  
2 University Road.

CENTRAL HOME  
96 New Walk.  
↓



← AYLESTONE HOME  
346 Aylestone Road



BELGRAVE HOME  
129 Loughborough Road. →







WEST END HOME 14 – 16 Valence Road.



HUMBERSTONE (Branch) HOME 272 Uppingham Road



## 5: PATTERNS OF DISTRICT NURSING IN LEICESTER 1913 - 1948

[illegible]

KEY: Yellow shaded area - Years when a complete set of Inspectors' reports are available for all Nurses Homes.

**(Bold)** - Queen's Nurses (QN).

c - candidates undertaking QNI training

p/t - part-time trained nurses (rarely QN)

- temporary nurses (could be QNs)

- relief staff (could be QN)

other - hospital and partially trained nurses

v - vacancy

\* - Male District Nurse in employment - first appearance in available records

SOURCE: NA. 30/63 263/264/265 QNI Inspectors' Reports LDNA 1909 - 1948



**5 (cont'd): PATTERNS OF DISTRICT NURSING IN LEICESTER (1913 - 1948)**

[illegible]



## 7

## FROM VOLUNTARISM TO STATE CONTROL -LEICESTER 1948 - 1974

'If all schemes were as fully developed as the Leicester Provident Contributory Scheme (PCS), there would not be the need to change the present system ... (for a National Health Service (NHS))... except to regionalise District Nursing Associations (DNA)'.<sup>1</sup>

Leicester, although weak in some areas, displayed considerable vision and enterprise in its approach to providing a district nursing service and to resolving problems associated with the fragile funding mechanism of a voluntary organisation. The principle of the Provident Contributory Scheme was similar to that on which Beveridge based his concept of funding the inclusive National Health Service, and this no doubt accounts for his glowing comments on the Leicester situation.<sup>2</sup>

This chapter examines the first phase of the NHS from 1948 to 1974, almost 30 years of continuing socio-economic, political and scientific change that brought district nursing into a different relationship with society. Leicester will be used as a case study of that relationship. When the NHS was implemented in 1948, Leicester, like the rest of Britain, was a city recovering from the destabilising effects of war.<sup>3</sup> Its citizens had expectations of health-care and the relief of want, based on principles of need rather than selection.<sup>4</sup> The world of work was evolving around new technology, and the nature of the workforce, like the risks inherent within the workplace, was changing, as people adapted their skills to accommodate the merging of 'hand and brainpower', and menial tasks were often assigned to immigrant

<sup>1</sup> Beveridge, W, Secret Document: Report of Interdepartmental Committee on Social Services and Allied Services Meeting 8 July 1942, Wellcome Institute for the History of Medicine (WIHM) Contemporary Medical Archives (CMA) Supplementary Archives (SA)/ Queen's Nursing Institute (QNI) H.13/712, above quote from Lord Beveridge's, observation after taking the Queen's Nursing (QNI) evidence during which Morris' gave an exposition of the PCS in Leicester.

<sup>2</sup> Gaffin, J. ed., *The Nurse and the Welfare State* (Aylesbury 1981); Klein, R, *The Politics of the National Health Service (NHS)* (London 1983), vii; Berridge, V, *Health and Society in Britain Since 1939* (Cambridge 1999), 13 – 15 the welfare debate, principles and plan citing, Beveridge, W (Chairman) Report of the Royal Commission on Social Insurance and Allied Social Services. Cmd 6404 (London 1942).

<sup>3</sup> Simmons, J, *Leicester Past and Present 1860 – 1974* (London 1974), Vol. 2, 81 – 2; Berridge, *Health and Society*, 2 – 21.



workers.<sup>5</sup> Consequently, many people enjoyed a higher standard of living and commercialised pleasures, but the casualties of post-war Britain were often trapped in inner-city areas, living in small, substandard dwellings and houses of multiple occupation – a situation further aggravated by the influx of immigrant communities in the 1950s.<sup>6</sup> The NHS was affected by swings in the economy, and its varying performance at home and abroad had a major effect on welfare policies. For instance, in the early days of the NHS, the economic climate allowed the expansion and diversification of welfare provision in relation to need, but during the 1970s the position changed and inflation imposed significant constraints on welfare policies resulting in a cycle of public expenditure cuts.<sup>7</sup> In addition, demographic factors such as the birth-rate, increasing longevity and immigration influenced demand for health-care and the supply of human resources. So, whereas the LDNA had its funding problems locally, the NHS introduced other funding restrictions on a macro-level.

It was within this climate of continuity and change that the NHS between 1948 and 1974 embraced three interacting elements: consumer needs; the skills of providers of care; and management tools and resources.<sup>8</sup> It would be unproductive to explore the three elements independently of one another; instead they will be looked at together in order to examine how district nursing adjusted to the NHS, and to compare aspects of district nursing with health visiting (HV) as a way of understanding the relationship between the two largest nursing services in the community (see Chapter 3).

One of the main features of the NHS was that it did not begin in post-war Britain; earlier chapters have shown that the origins of the NHS could be detected throughout the nineteenth and early decades of the twentieth century (see Chapter 3).<sup>9</sup> A number of building blocks can be identified in which district nursing played an important part and often gave a lead to future development, as the introductory quotation suggests.<sup>10</sup> Throughout the NHS debates of the

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<sup>4</sup> Titmuss, R, *Problems of Social Policy* (London 1950); Thane, P, *Old Age in English History: Past Experiences and Present Issues* ((Oxford 2000), 355 –364.

<sup>5</sup> Royle, E, *Modern Britain. A Social History 1970 – 1985* (London 1988), 149 – 50, 206 – 7.

<sup>6</sup> Royle, *Modern Britain*, 265 – 9; Simmonds, *Leicester Past and Present*, 104 – 5; Brown, A. E, ed., *The Growth of Leicester* (Leicester 1972), 100; Nash, D and Reeder, D, *Leicester in the Twentieth Century* (Leicester 1993), Chapter 4.

<sup>7</sup> Lowe, R, *The Welfare State in Britain since 1945* (Basingstoke 1999), 68 – 73.

<sup>8</sup> Rivett, G, *From Cradle to Grave, Fifty Years of the NHS* (London 1997), Preface.

<sup>9</sup> Illiffe, S, *The NHS: A Picture of Health?* (London 1983), 11 – 25.

<sup>10</sup> McEwen, M, *Health Visiting* (London 1960), 189; Charley, I. H, *The Birth of Industrial Nursing* (London 1978), 49 and 82 – 4 examines the role played by district nurses from the late nineteenth and early twentieth century in factory and school health care; Morton, P, 'Developments in the Organisation of primary Health Care 1900 - 1977', University of Nottingham M. Phil. Thesis, 1978, 41 – 2 and 45 –



late 1930s and early 1940s, district nurses sent out mixed messages; campaigns to improve the provision of district nursing showed a growing commitment towards government action, but there was an equally aggressive lobby to retain a voluntary district nursing service. It is probably true to say that both sides won.

The NHS had two main aims: firstly, to provide a comprehensive health-care system free at the point of delivery; and secondly, to afford to the prevention of illness and the promotion of health, rehabilitation and after-care the same priority as the traditionally medically orientated spheres of diagnosis and treatment.<sup>11</sup> District nursing could easily identify with these aims, but their realisation was a challenge because of the extent to which the full range of skills and potential of district nursing was not sufficiently recognised and was even damaged by attitudes within the medical and nursing professions.<sup>12</sup>

The success of the NHS clearly depended upon the confrontation of two major forces. Firstly, the conflicting values of voluntarism and state welfarism which remained at the root of much unease. Welfarism, in the form of informal voluntarism (see Chapter 2), was often regarded as the function of 'natural' channels which included family support and the market economy, whilst the obligation of the state was to intervene and take collective responsibility for problems beyond the control of the individual.<sup>13</sup> Secondly, the tensions within and between the professions caused by inclusive collectivism, or imposed control, were a threat to the optimum use of resources and clinical freedom - the latter presenting hurdles for the medical profession in particular.<sup>14</sup> From this investigation it will be seen

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the 1908 Old Age pensions Act off-set the impending disaster of pauperism and enabled the elderly sick and handicapped to remain in their own homes, often under the care of the district nurse; the 1911 National Insurance Act, likewise encouraged workers to seek medical advice and treatment at an earlier stage of their illness – usually involving the district nurse, a service not included in the act.; Thane, *Old Age in English History*, 436 – 57, examined the way in which, between the wars, the needs of the elderly sick and handicapped were brought into sharper focus with the Local Government Act (1929) and the transfer of the responsibilities of the Poor Law to the local authorities. The desirability of closer links with the preventive, curative and palliative care role of district nurses became increasingly marked; Fox, E. N, *District nursing and the work of district nursing associations (DNAs) in England and Wales: 1900 - 48*, University of London Ph.D. thesis, 1993, the 1936 Domiciliary Services Bill was seen as an important attempt to secure an adequate number of specially trained district nurses. The Bill failed but the 1936 Public Health Act included permissive powers for local authorities to develop agency arrangements with local DNAs.

<sup>11</sup> Lowe, *The Welfare State*, 167 – 97; Merry, E. J and Irven, I. D, *District Nursing* (London 1948) 255; Stocks, M, *A Hundred Years of District Nursing* (London 1960), 171.

<sup>12</sup> Hockey, L, *Feeling the Pulse* (London 1966); Hockey, L and Potter, A, *Co-operation in Patient Care* (London 1970).

<sup>13</sup> Allsop, 'Welfare state', 20 -32

<sup>14</sup> Berridge, V, 'Health and Medicine' in Thompson, F. M. L, *The Cambridge Social History of Britain 1750 – 1950: Social Agencies and Institutions* (Cambridge 1990), Vol 13, 171 – 24 2; Records Office for Leicester, Leicestershire and Rutland (ROLLR), British Medical Association (BMA) Meeting



that welfare by its very nature was a dynamic two-way process through which policies and practices affecting district nursing were constantly reviewed and amended in the light of the changes taking place in 'modern society', and district nursing proved itself responsive to new circumstances and not set in a pre-NHS mould.<sup>15</sup>

### **NHS – structure and organisation in Leicester:**

The NHS was based on a local tripartite structure accountable to central government: Executive Councils administered the general practitioner (GP) services; Hospital Management Committees, under the auspices of Regional Hospital Boards, governed consultants and hospital facilities; and the personal health services became the responsibility of the local authorities (LHA) (see Appendix 1). To some extent the structure attempted to appease the particular interests of the different disciplines, whilst creating a cost-effective, responsive system of health-care, but in other ways it was seen as a ploy by government to divide and rule. Bridging the divide was a major concern, possibly resolved in the 1960s by the introduction of the health centre as a focal point in Leicester for the delivery of comprehensive health-care. The under-investment in nursing staff was another major concern; the national shortage well documented since the 1930s was aggravated by competition between the three divisions of the NHS, and external sources caused conflict and leverage, as hospital personnel often considered that it was wasteful to use trained nurses as district nurses.<sup>16</sup>

Large local government authorities such as the County Councils and County Borough Councils were designated Local Health Authorities (LHA) and charged with the responsibility of implementing and administering Section 3 of the NHS Act, a range of services known collectively as the personal health services, which included district nursing under the new and ambiguous designation of 'home nursing'.<sup>17</sup> Whilst local government was familiar with its former role of safeguarding public health through environmental controls and the administration of specialist hospital and ex-poor law institutions, the imposition of personal

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'Doctors applaud 'Stay out' speech', *Leicester Mercury*, 17 March 1948, 1; ROLLR, BMA Leicester Branch Meeting 'Doctors to stay out until health Act is amended', *Leicester Mercury* 8 March 1948, 6.

<sup>15</sup> Jones, L. J. C, 'Re-shaping welfare: voices from the debate' in Davies, C, Finlay, L and Bullman, A, eds. *Changing Practices in Health and Social Care* (London 2000), 8 – 16.

<sup>16</sup> Abel-Smith, B, *A History of the Nursing Profession* (London 1960), 114 –29; Formal interviews and informal discussion with health care personnel; Pascall, C 'Health' in Marsh, D. C, *Introducing Social Policy* (London 1979) 141 – 64.

<sup>17</sup> Home Nurses a designation that includes district nurses will only be used in points of accurate interpretation, otherwise the term district nurses and district nursing will continue to be used throughout the thesis.



health duties was a new and untested experience. Numerous factors militated against the success of this arrangement. For instance, the rigorous subjection of local government in Britain to state control frequently weakened the primary objective of the welfare state which aimed to secure uniform health-care provision throughout the country, unlike the situation on the continent where the investment in local empowerment and decision-making promoted freedom and accountability at consumer level.<sup>18</sup> In addition, although the personal health and social services were central to the evolution of the welfare state, their lack of a coherent professional identity was a major weakness; employees were drawn from a variety of professional and occupational sources between which there was frequently an uneasy relationship (see Chapter 3). Within this uncertain situation, the political strength of the consumer groups was an asset but, even though self-help and politically-motivated organisations evolved, the personal health services themselves lacked a strong political presence because of the impoverished and vulnerable position of the majority of clients.<sup>19</sup>

The Medical Officer of Health (MOH), the chief officer of the LHA, had to steer this enterprising but often unstable ship through times of under-funding, low staffing levels and political unrest.<sup>20</sup> In Leicester, the MOH, probably recognising the vulnerability of his position, regarded the changes introduced by the 'new' legislation as 'devastating'; the loss of hospitals and TB and venereal disease (VD) clinics to the Regional Hospital Boards was described as 'severe', but the 'gains', such as district nursing, were regarded as 'not insignificant'.<sup>21</sup> The major concerns of the MOH in taking on this responsibility were threefold: building restrictions that would delay the development of clinics and health centres; the unknown financial implications of increasing health-care demands; and the shortage of nurses to provide skilled care. It was in such a climate that district nursing hoped to strengthen its well-established role within the community and more fully utilise its expertise. Instead, district nursing seemed to have jumped out of the frying pan of the unstable and undervalued position of voluntarism into the fire of professional and political incompatibility and discrimination in the newly created NHS world post-1948.

As is often the case, legislators incorporated controlled discretionary powers to meet local need in acknowledgement of the perceived wisdom of consumer organisations, the 'street level' governance of local councillors, and the expertise of clinical professionals and

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<sup>18</sup> Niemi, M, 'Health, Experts and the Politics of Knowledge', University of Leicester Ph. D. thesis, 1999.

<sup>19</sup> Lowe, *The Welfare State*, 263 – 5; Rivett, *From Cradle to Grave*. Introduction.

<sup>20</sup> Lewis, J, *What Price Community Medicine?* (Brighton 1986), 1 – 14.



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technocrats. As a consequence of this 'bottom-up approach', national policy varied between areas, and indeed was sometimes at variance with the intention of the primary legislation.<sup>22</sup> District nursing was an example of the way in which a community could benefit from the discretionary powers contained within the NHS legislation, which allowed LHA to provide, or arrange for others to provide, a 'home nursing service'.<sup>23</sup> In 1948 various arrangements for the management of a district nursing service developed throughout the country, ranging from comprehensive agency accountability and affiliation to the Queen's Nursing Institute (QNI) – as in the case of the Leicester District Nursing Association (LDNA) – to the assumption of direct control by the LHA with the discontinuation of the local district nursing voluntary committee and membership of the QNI.<sup>24</sup> But the transition from voluntarism to state control, even with broadly similar contexts of health and welfare, involved more than organisational restructuring and different sources of income and accountability. The process represented a change of culture from diversity and flexibility to conformity and uniformity, and from informal collectivism to bureaucratic universalism and from local to national norms. Nevertheless such changes were not necessarily irreconcilable, given the subtle changes that had taken place in the voluntary sector during the twentieth century as its autonomy was gradually eroded by government (see Chapter 6).<sup>25</sup> This study concentrates mainly on how the transition affected the role and position of district nursing within society between 1948 and 1974 rather than the politics of structural change, although the two are not mutually exclusive.

The appointment of a Health Committee (HC) in 1948 to manage the disparate strands of health-care assigned to the LHA was a statutory obligation. In Leicester, co-options were made from members of the Executive Council, Hospital Management Committee and Local Medical Committee; reciprocal co-options between the HC and LDNA were also agreed. This emphasised the importance of co-operation in the fragmented health service and the attempts made to preserve the local autonomy of district nursing within the NHS framework.<sup>26</sup> Sub-committees were established by the HC to undertake delegated duties for planning,

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<sup>21</sup> ROLLR L614 84/64, Leicester Corporation Health Report (LCHR) (1949).

<sup>22</sup> Lowe, *The Welfare State*, 48 –50.

<sup>23</sup> Merry and Irvén, *District Nursing*, 17 – 8, referenced Ministry of Health Circular 18/47.

<sup>24</sup> Stocks, *100 Years of District Nursing*, 178.

<sup>25</sup> Harris, J, 'Society and the state in twentieth century Britain', in Thompson, *Cambridge Social History*, Vol. 13, 63 – 118; Sherrington, C. A, 'The National Society for the Prevention of Cruelty to Children (NSPCC) in transition 1884 – 1983. A study of organisational survival', London School of Economics and Political Sciences Ph.D. thesis, 1984.

<sup>26</sup> ROLLR, DE 3277/117 Leicester Health Committee Minutes (LHCM) and Leicester District Nursing Association Report (1952). A Superintendent appointed to the Executive Council.



monitoring and expediting the day-to-day workings of a specific group or groups of services.<sup>27</sup> A comprehensive range of sub-committees was established, with the potential benefit to district nursing of being part of a system of health-care that covered all facets of human need, particularly those of the most vulnerable members of society. Initially district nursing was assigned to the General Welfare Sub-committee, which included health education, convalescent homes, tuberculosis (TB) services, home-helps and the health and welfare of families and children. Other sub-committees represented aspects of health-care of importance to the role of district nursing, such as the Health Inspection Sub-Committee whose remit covered all matters related to Public Health legislation, including defective property, food and drugs standards, and public and environmental nuisance. Likewise, the newly established Mental Health services sub-committee developed a range of services for the care of mentally ill and handicapped people which complemented the work of the district nurse. District nurses themselves, however, were not represented on any of these sub-committees, in contrast to the previous situation where full representation had been the standard practice. District nurses who were in post at the time recalled feelings of uncertainty and insecurity but, were 'glad to see the end of the collection of fees' and 'welcomed the benefits we thought it would bring to our patients'- quite the opposite to the experience of the district nurses in Dougall's Scottish study who 'did not notice much change'.<sup>28</sup>

In 1953, the LDNA suddenly withdrew from its agency arrangement with the LHA after a period described by the MOH as 'the happiest of relationships'.<sup>29</sup> The establishment of a new agency was then considered but preference was given to the full take-over of district nursing by the LHA, mainly for reasons of legal status and financial control.<sup>30</sup> To ensure continuity of district nursing and to safeguard its interests, four main steps were taken by the LHA in 1954: firstly, a Home Nursing Sub-Committee was established; secondly, two ex-members of the discontinued LDNA were co-opted to represent the interests of district nursing until 1974; thirdly, the LHA purchased the properties and land owned by the LDNA and took over the lease of its headquarters' office accommodation; and fourthly, the LHA continued with the

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<sup>27</sup> ROLLR, DE 3277/ 115 LHCM.

<sup>28</sup> Fraser, E. C, QN Superintendent and later Division Nursing officer Community Nursing Service, Leicester (Personal testimony, 1998); Pointon, QN Leicester; Wells, G, District Nurse Leicester (Interview 1999); Dougall, R. E, 'Perceptions of change: an oral history of district nursing in Scotland, 1940 – 99', Glasgow Caledonian University Ph.D. thesis, 2002, 158.

<sup>29</sup> ROLLR DE 3277/119 LHCM 15 May 1953.

<sup>30</sup> ROLLR DE 3277/119 LHCM 16 October 1953 - account is not given of the reasons for the sudden withdrawal; LDNA, *A History of the LDNA 1867 – 1953* (Leicester 1953), 12, records that the 'Leicester Corporation was notified .... that the LDNA would cease to exist and could no longer act as Agents' and that the 'City Council ...decided not to delegate work to another voluntary body formed from members of the old Association'.



affiliation agreement with the QNI which had been negotiated by the former LDNA. The LDNA had accumulated assets of £83,000 that were transferred to a new trust fund – ‘The Leicester Aid in Sickness Fund’ - approved by the Charity Commission, to continue to help the sick and suffering of the City.<sup>31</sup>

Between 1957 and 1973, the HC structure continued to change to accommodate the expanding responsibilities of the LHA. One of the main growth areas was the development of prevention, care and after-care priorities under the terms of the NHS Act, which had considerable implications for district nursing and created scope for new services.<sup>32</sup> The HC structure thus represented a comprehensive and interactive forum for debate and the potential development of district nursing but, as the complexity of the committees grew, district nursing was in danger of being overwhelmed by different priorities. Ordinary men and women undertaking civic duties within the Leicester Corporation gave a continuing commitment to the personal health services sub-committees which included regular visits to the District Nursing Homes to assess standards and identify new needs.<sup>33</sup> Thus, after all the anxiety about the position of district nursing in the NHS, the Minister of Health had endorsed the nation’s confidence in the competence of local associations and established a place for district nursing, however ambiguous, within a statutory framework.

### **Demand and supply:**

The post-war environment into which the NHS was introduced was one of limited financial and human resources. In addition, the housing stock was seen as ‘a severe blow to health progress’ for a population whose health risks reflected the experience of wartime; it was an environment that had far-reaching effects over the next quarter of a century.<sup>34</sup>

For district nursing, this meant an ever-increasing volume and complexity of work in the provision of care to vulnerable groups,<sup>35</sup> particularly the elderly with their multiple pathology,

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<sup>31</sup> LDNA, *A History*, 12. The Trust Fund came into operation in March 1954 and remains active at the time of writing this thesis.

<sup>32</sup> ROLLR L614 Leicester Corporation Health Reports (LCHR), (1948).

<sup>33</sup> ROLLR DE 3277 LHCM – membership comprised between 9 and 12 member of Council who averaged a 50% attendance – and 3 – 4 co-opted members (2 from former LDNA) who averaged a 70% attendance rate.

<sup>34</sup> ROLLR L614 84/64, LCHR, (1944).

<sup>35</sup> ROLLR L614 84/64, LCHR, (1954).



and an expanding professional role which combined nursing with social welfare.<sup>36</sup> The situation, which in some ways was not new to district nursing, created the need for a systematic and disciplined examination of both the social and clinical world of the district nurse. For citizens, access to free professional services at the point of need had implications for their contribution to the local rating system and general taxation – full employment was the lynch-pin of the welfare economy. Many benefited from the removal of barriers to health-care and welfare services but the needs of others were sidelined and some slipped through the net completely in spite of the existence of powers of compulsory intervention.<sup>37</sup> The demand and supply of health-care was influenced by three main factors: government policy; consumer needs, and available resources. Individually and collectively these influences promoted new methods of working for the district nurse - at the bedside, in the boardroom and in academic institutions.<sup>38</sup> Government funding was not always available to facilitate implementation, however, with the result that a time-lag arose between demand and supply.

Between 1948 and 1955, district nursing continued to change in terms of the volume and pattern of visiting: the number of new patients doubled; each year there was an average 80% increase in the number of cases brought forward from the previous year; the ratio of visits per patient gradually declined from an average of 24 to 17; the average case-load per nurse remained fairly constant at 19 in 1954/5 but the overall visits per nurse showed a significant 9% decline.<sup>39</sup> During the next decade, by contrast, there was a 30% decrease in the number of cases but an overall 3% increase in the number of visits per patient with an average increase from 18 to 27. The factors that provoked these patterns were complex. Some were those identified pre-NHS (see Chapter 6), but in general four influences were particularly significant: firstly, the unprecedented volume of unmet need following the introduction of the NHS; secondly, population fluctuations and spatial changes within the city;<sup>40</sup> thirdly, the re-emergence of moderately-well-stabilised health problems such as an increase in the incidence of TB and the morbidity of diabetes, together with a rising proportion of older and handicapped people needing help; and fourthly, scientific advances and changing practices,

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<sup>36</sup> ROLLR L614 84/64, LCHR, (1955). Multiple pathology refers to an inter-related process of physical, social, emotional and spiritual dysfunction, which can affect a patient of any age but most commonly the elderly.

<sup>37</sup> ROLLR L614 84/64, LCHR, (1954 – 1972) on the casualties re-claimed by the National Assistance Act (1948) and LRO L614 84/64, LCHR, (1951) – on children neglected or treated in their own homes.

<sup>38</sup> The emergence of district nursing scholars and the increasing portfolio of research (See Chapter 3).

<sup>39</sup> ROLLR L614 LCHR, Home Nursing Section (1955).

<sup>40</sup> Simmonds, *Leicester Past and Present*, 151; ROLLR L614 LCHR (1961, 1967 and 1971), 4% decrease in population by 1961 recorded as people migrated to housing estates beyond the LHA boundaries and slum clearance was replaced by office building



such as doctors requiring some forms of medication to be administered by mouth rather than by injection, and alternative resources being provided by HV and home-help services during the final stages of recovery when skilled nursing-care was not required.<sup>41</sup>

The increasing complexity of district nursing in Leicester stimulated the introduction of more comprehensive records in 1956, which included sociological and additional clinical indicators of health needs.<sup>42</sup> This data had the potential to demonstrate the significance of environmental and sociological evidence for district nursing when competing against other services for finite HA resources – an important adjustment that district nursing had to make. As a point of reference, however, for important decisions about staffing levels and skill-mix, it was incomplete when compared with later projects.<sup>43</sup> A brief analysis of the information collected between 1956 and 1962 demonstrates several important features of district nursing. For instance, a prime factor and critical resource indicator was the patient's self-care ability and the availability of carers.<sup>44</sup> Over 86% of patients had access to help from family and 6% from neighbours, but many elderly people were supported by elderly and often weary partners,<sup>45</sup> 2-3% received support from the Home Help Service, and over 3% had no-one. In spite of NHS provision, resources were augmented by a number of voluntary, charitable and statutory agencies. For instance, the Marie Curie Memorial Foundation's day and night nursing/sitting service for cancer patients, introduced in the 1950s, was invaluable. In 1962, 93 patients received help from the Foundation, 68 of whom received nursing services and 25 received nourishment, fuel, nursing necessities, and domestic help. It is significant, however, that, according to the district nursing records, there were more than 380 patients suffering from cancer - over 6% of the overall case load. This raises questions about the patients' and carers' perception of their needs, the accuracy of need assessment by the district nurse and the extent

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<sup>41</sup> ROLLR L614 LCHR, Home Nursing Section (1955).

<sup>42</sup> ROLLR L614 LCHR – Home Nursing Section (1956 – on).

<sup>43</sup> McIntosh, J. B, *Work Study of District Nursing Staff* (Edinburgh 1976 Scottish Health Services Studies No. 37), 23 –24. Provides evidence of how variable a single category like 'bed bath' can be; the mistaken understanding that visiting categories are homogeneous when in reality they vary widely in time and content; the importance of nurse-patient communication which accounts for over one third of visiting time; the high level of nursing skill, up-to-date knowledge, ability to make responsible decisions and execute them, professional judgement, the definition and solution of clinical and psychological problems, and a considerable insight into human behaviour; the potential misuse of district nursing skills in the surgery, for instance the 'withdrawing blood and completing laboratory forms'; and the value of shared problem solving based learning between GPs and district nurses.

<sup>44</sup> Oral histories and personal testimonies identified 'the family' and 'neighbours' as being amongst the district nurses greatest allies.

<sup>45</sup> ROLLR L614 LCHR – Home Nursing (1961); Oral history interviewees and informal respondents (1998 – 2002), frequently observed that it was 'difficult at times to know who was the carer and who was the patient'.



to which the ordering of priorities was affected by available resources.<sup>46</sup> Three case studies are presented to illustrate the value of the Foundation's contribution to the quality of life for patients and their carers, and the collaboration between statutory and voluntary enterprise:

Case Study 1. 'A female patient aged 38, suffering from sarcoma of the hip, married with one child, refused hospital treatment. She lived in a comfortable working class home, well cared-for by relatives and by her husband, who worked full-time. Owing to the patient's condition it was impossible for the family to give continuous nursing care. The district nurse visited four times daily and, to cover other periods during the day, a Marie Curie nurse was engaged during the day and a second nurse from 10 p.m. to 7 a.m. The patient was able to remain in her home and her husband to continue at work until the end of her illness thanks to strenuous nursing-care and family devotion.'

Case Study 2. 'A youth of 15 years, suffering from sarcoma of the hip, well cared-for by his parents and nurses upstairs in a pleasant bedroom, was asked by a male district nurse what he missed most. He said "the television". Arrangements were made to rent a television set which was delivered within twenty-four hours. The youth enjoyed many hours viewing, particularly sports and western programmes. His mind was kept occupied, his body relaxed, and the pain was easier to bear.'

Case study 3: 'A male patient aged 53, diagnosed with cancer of the lung, married to a SRN with two teenaged children, bed-bound for several weeks and nursed by his wife. A male district nurse, called to give specialised treatment, reported that the wife found it difficult to do the shopping, was not getting enough rest, and appeared harassed. A Marie Curie nurse was engaged for three hours each afternoon to allow time for the wife to do her shopping, have a change of surroundings, enjoy her own space and rest for a short while. The wife insisted upon caring for her husband during the night until the later part of the illness when she accepted night help on two nights a week before the illness terminated. (In appreciation the relatives and friends gave a donation of £17 to the Foundation).'<sup>47</sup>

The facilities available in the home were another important factor for the district nurse, and in the 1950s there is a sense of *déjà vu* with the late nineteenth and early twentieth centuries. District nursing records show that, in 1957, over half of patients relied on a kettle as the main source of hot water but the situation in 1962 improved to over one-third; nearly a half of patients had no bathrooms; over a half used outside toilets and a third shared facilities. Whilst housing stock was being up-graded or new units built for the elderly and handicapped, the long wait or the prospect of moving was too daunting for many, even though they were left behind and isolated in run-down inner city areas.<sup>48</sup> Problems for the district nurse were exacerbated in the late 1960s by difficulties of access to high rise buildings; the situation was time-consuming and risky, particularly for night nurses who, though working in pairs with mobile radio facilities, were still apprehensive.<sup>49</sup> The overcrowded and limited amenities of houses of multiple occupation were also problematic, particularly when combined with difficulties of communication and differences in culture arising from the influx of immigrants

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<sup>46</sup> ROLLR L614 LCHR – Home Nursing (1962)

<sup>47</sup> ROLLR L614, LCHR - Home Nursing Reports (1959 and 1962).

<sup>48</sup> Anon, 'The uncertainty of it all: A view from outside – a health workers reflection', in Hyde, C, *Walnut Street Past, Present and Future* (Leicester 1996) 79 – 81.

<sup>49</sup> Pointon, G, Leicester QN. (Interview 1998); Gill, R, *The Book of Leicester* (Buckingham 1985), 99 – 100; Anon, 'The uncertainty of it all', Hyde, *Walnut Street*, 79 – 81.



in 1962; one district nurse treating 11 Asian patients suffering from tuberculosis in one household felt forced to identify them by number.<sup>50</sup>

Towards the end of the 1960s and early 1970s, the attachment of district nurses to general practice began as a local innovation that was eventually formalised within a code of practice by central government and set within the broader concept of Primary Health Care Teams (PHCT).<sup>51</sup> PHCTs brought together the rich mixture of holistic and reductionist perspectives of care (see Chapter 3). The concept was not new; it lay at the heart of Lord Dawson's health centre proposals in the 1920s; and the close working relationship between GPs and district nurses was an ideal promoted by the QNI since its inception in the nineteenth century.<sup>52</sup> The adjustment for district nursing in the 1960s involved contributing in a wider professional arena and accepting the potential of less central control. The process was affected by professional challenges and conflicts, such as the national crisis in general practice when GPs threatened to withdraw from the NHS - a situation saved only by the 'GPs Charter' introduced in 1965 which aimed to reverse the mounting dissatisfaction amongst GPs and the decline in their numbers (see Appendix 3).<sup>53</sup> The introduction of attachment schemes, therefore, was as much politically motivated as clinically inspired, and provoked questions about the relationship both between professional colleagues and between the professionals and the consumer that was not always in the best interests of either group.<sup>54</sup> Hockey's research in the late 1960s showed that doctors in general knew very little about the expertise and role of the district nurse and this ignorance had a serious effect on the quality of GP referrals.<sup>55</sup> Wilson, about the same time, began to identify the sensation of a loss of power by professionals when involved in shared decision-making, to the detriment of patient care and inter-

<sup>50</sup> ROLLR L614 84/64, LCHR (1962 on); Gill, *The Book of Leicester*, 99; Anon, 'The uncertainty of it all: A view from the outside - A health workers reflection' in Hyde, *Walnut Street*, 79 - 81.

<sup>51</sup> Baly, M. E, ed., *A New Approach to District Nursing* (London 1981), 78 with reference to the influence of the Harvard Davis Report *The Organisation of Group Practice* (1971); Gilmore, M, Bruce, N and Hunt, M, *The Work of the Nursing Team in General Practice* (London 1974); British Medical Association (BMA), *Primary Health Care Teams: A Report by a Panel of the Board of Education and Science* (London 1974); Department of Health and Social Security (DHSS) (London 1977) (CNO (77) 8), *Nursing in Primary Health Care*.

<sup>52</sup> Rivett, *From Cradle to Grave*, 1- 2, referred to the Dawson Report and its three important principles of PHC namely: patient accessibility; a common base for doctors and nurses with easy availability of specialist help; comprehensive in nature -cure, prevention, and containment.

<sup>53</sup> Lowe, *The Welfare State*, 190 - 3.

<sup>54</sup> Deakin, retired QN Leicester and Rolley, retired QN/Midwife/Health Visitor, Parsons retired QN/HV and Senior Nursing officer and other respondents recalled such factors as the excessive travelling involved where GPs did not circumscribe their catchment area (64 different GPs visited patients in one street), and for nurses attached to more than one single-handed GP; attitude - "personality more important than policy"... "in some situations it was like a shot-gun marriage"... "we were used"

<sup>55</sup> Hockey and Potter, *Co-operation in Patient Care*, passim.



organisation/professional relationships;<sup>56</sup> and Griffiths' and Luker's study claimed that steps to avoid conflict between team members resulted in collusion and militated against patients' choice.<sup>57</sup> As a consequence, a new dimension of professional education in the 1970s to address these issues was stimulated, and experiments culminated in a generally-accepted national policy of inter-professional training.<sup>58</sup> It could be argued that this was just papering over the cracks and that there were more fundamental issues to address, such as those of structure and resource-allocation.

Contributors to the attachment schemes valued the arrangement for a range of reasons; GPs gained access to additional resources which saved their time and increased the scope (and income) of the practice; patients were seen to receive more timely intervention and benefited from access to different sources of health-care;<sup>59</sup> and some district nurses achieved greater job satisfaction although others felt used.<sup>60</sup> At the same time, however, DNs experienced conflict from divided loyalties between the practice and employment policies, and between the needs of mobile patients and the housebound. As can be seen from Figure 1, following the introduction of the attachment schemes in the 1960s, a striking change occurred in the work of the district nurse. From 1967, the number of home-treatment cases increased dramatically but there was a significant drop in the number of visits to patients' homes. By contrast, however, the number of surgery-based treatments increased in line with the rise in the number of cases.<sup>61</sup> In one sense, the trend demonstrates the valuable contribution made by district nursing to the practice community but, in another sense, the 400% increase in the number of patients treated in the surgery in 1968 compared with the 12% increase in patients treated at home, indicates that home-care was being sacrificed in favour of GP surgery-based treatments, which usually engaged the expertise of a trained district nurse and left lesser trained personnel to provide care in the home.<sup>62</sup> The situation caused alarm, given evidence

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<sup>56</sup> Wilson, P, 'Linkages among organisations: consideration and consequences', *Health and Social Work*, 134, 2, 1978, 13 –33.

<sup>57</sup> Griffiths, J. M and Luker, K. A, Intraprofessional teamwork in district nursing: in whose interest?' *Journal of Advanced Nursing*, 20, 6, 1994, 1038 – 45.

<sup>58</sup> England, H, 'Education for co-operation in health and social work' Papers from a Symposium on Interprofessional Learning. *Journal of the Royal College of General Practitioners*, 1979, Occasional Paper 14; Damant, M, 'A comparative study of shared learning between health visitors and district nurses in England, Plymouth Polytechnic M.Phil. thesis, 1991.

<sup>59</sup> ROLLR L614 LCHR (1970).

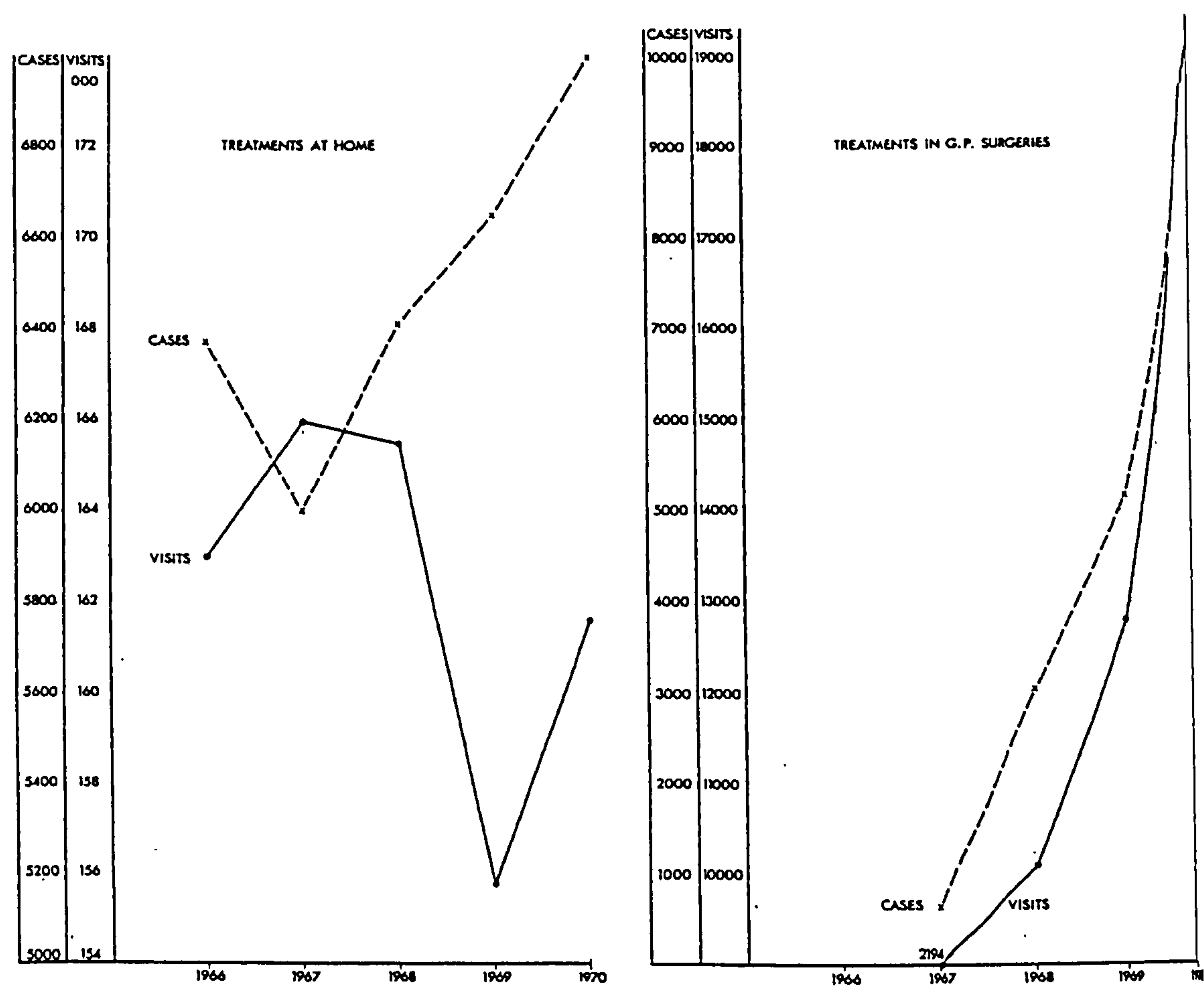
<sup>60</sup> Oral histories and personal testimonies Leicester District Nurses (Recorded 1998 – 2002).

<sup>61</sup> ROLLR L614 LCHR (1969) – declared that the increase in the number of patients treated by the district nurse in the doctors' surgeries meant an unreasonable curtailment of the nursing care needed by other patients.

<sup>62</sup> Lesser trained staff refers to; non district trained State Register Nurses (SRN), State Enrolled Nurses (SEN) and nursing auxiliaries (NA) - lay people who had usually gained hospital experience.



FIG.1: DISTRICT NURSING GP SURGERY: HOME CARE (1968)



Source: ROLLR L616 84/64 Leicester Health Report (1970).

of the number of increasingly frail and elderly patients in the care of the district nurse (a 7% increase from 1967, accounting for 50% of the total cases and 64% of visits); the high number of housebound chronically sick (with a 4% increase in those requiring heavy nursing from 1967); and the dying who relied on the skills of the trained district nurse.<sup>63</sup> One district nurse recalled that because of her distress and anxiety at the plight of the most needy patients, she felt forced to visit them in her off-duty hours – “and I was not the only one,” she added.<sup>64</sup> The main classifications of conditions nursed at home almost exactly mirrored those cited by the MOH as the major causes of death.<sup>65</sup> With slight variations from time to time, the general pattern of the major conditions nursed in the 1960s was fairly typical, with heart and circulatory disorders in the region of 15%, digestive conditions 13%, respiratory illnesses 12%, generative organs (male and female) 9 %, and cancer 7%. The majority of patients

<sup>63</sup> ROLLR L614 84/64, LCHR (1967 and 19690.

<sup>64</sup> Hughes, B, District Nurse and later District Nurse Tutor, Leicester (Interview and written response 2000); Rollie, J, District nurse midwife, health visitor, (Written response 2000), together with 5 other respondents, felt that GP attachment did not necessarily improve the service.



(60%) were female, nearly 30% were men, and 10% children. This pattern is not unusual and does not necessarily reflect the standard of women's health or the inability of men to provide care in the home. It does, perhaps, reveal the stoicism of women, their greater life expectancy, and the way in which they used their role as a basis for empowerment and assertion.<sup>66</sup> Orr states that district nurses have a major role to play in the nursing of women at home and in the support of women carers.<sup>67</sup>

Concern for the needs of the number of high-dependency patients nursed in their own homes prompted a small-scale survey undertaken by the Leicester district nursing service in 1971.<sup>68</sup> The aim of the survey was to review the extent of the problems experienced by paraplegic patients and their need for skilled nursing care.<sup>69</sup> The care by that time was provided by an increasing number of lesser skilled staff compared with specifically qualified district nurses.<sup>70</sup> A sample of 14 paraplegic patients receiving care from the district nurse was selected; of these, 10 patients were male, of whom 2 were aged 25, 5 were aged between 30 and 55, and 3 were over 60 years of age. By comparison only 4 females, aged between 45 and 55, were receiving nursing-care. The aetiology of the 14 cases showed that multiple sclerosis was a major factor (36%), followed by accidents (33%), of which some were industrial injuries but most were road traffic accidents, viral infections such as poliomyelitis (21.4%), and cancer (14.2%). Furthermore, the survey showed that the patients and their carers required extensive care over long periods of time; 2 patients for six months, 5 patients for between eighteen months and 2 years, 5 patients (36%) for between 5 and 7 years, and 2 patients for more than ten years (14.2%).

The findings of the survey revealed a constant fear of electrical power failure and the effect of the loss of essential equipment on the patient's welfare and survival; it was a concern the respondents to the survey shared with at least 40 other patients in Leicester whose care was

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<sup>65</sup> ROLLR L614 84/64, LHCR (1948 on).

<sup>66</sup> D'Cruze, S, 'Women and the family' in Purvis, I, ed. *Women's History: Britain 1850 – 1945* (London 1995), 51 0- 83

<sup>67</sup> Orr, J, 'Women's health: a nursing perspective', in White, R, ed. *Political Issues in Nursing: Past, Present and Future* (Chichester 1988), Vol. 3, 121 – 38.

<sup>68</sup> ROLLR L614 84/64 LCHR Home Nursing Section (1971).

<sup>69</sup> Paraplegic – a person suffering from paralysis of that half of the body below which the spinal injury has occurred, usually the lower half including the legs.

<sup>70</sup> ROLLR L614 84/64 LCHR and LHCM (1965 and 1967) - 'Differently trained' refers to nursing auxiliaries, none nursing trained staff who were prepared by in-service training, State Enrolled Nurses (SEN), second level nurses who worked under the direction of a State Registered Nurse (SRN), and SRNs without district nurse training. HVs were assisted by clinic nurses in reception and other routine tasks, and audio typists relieved clerical duties associated with the HVs role.



maintained by the use of such aids.<sup>71</sup> Patients and their carers were also faced with the constant threat of the 'breakdown of skin surfaces', respiratory and urinary infections, hypothermia, and the effects of low morale. Spicer's study, although completed in 1993, examined a similar range of nursing problems as those encountered by the district nurse.<sup>72</sup> For instance, she demonstrated that patients nursed in their own homes exhibited multiple problems – a mean number of 6 was calculated from nursing records. Her study also identified the psychological effects of long-term illness; 'loneliness' was reported by 68% of home respondents (in contrast to 12% of hospital patients); a correlation was observed between increasing feelings of 'aloneness', whether or not support and companionship was present in the home, and the increasing length of time over which care was given. The responsibilities of this work underlined the significance of the analysis of the QNI database in terms of the experience and qualifications some district nurses brought to their role (see Chapter 4) - a system of professional preparation that was a too hit-and-miss process for district nursing. The survey, although only a bird's-eye view of some of the professional and personal complexities and demands faced by district nurses and their long-term patients, confirmed the importance of professional vigilance and skill, together with teaching, support and counselling, as the main priorities for the LHA.<sup>73</sup> There is no evidence to suggest the review had any influence on policy making, although an increase in district nursing establishment was made in early 1973 – purportedly following the 'norms of good practice' issued by the Minister.<sup>74</sup>

In addition to the provision of district nursing services in the patients' home, the District Home also provided a stable and continuing oasis of support in the community. A survey, carried out over a period of one week in 1954, provides a relevant example (see Table 1).<sup>75</sup> The Home played a co-ordinating role between the patients and various services. The peak times for telephone calls coincided with the start of the district nurses' rounds in the morning and evening, and during the mid-morning when referrals were made by the GPs at the end of their surgery. The local population used the Home as a call-in centre for unplanned treatments and advice throughout the day, while the peak of treatments in the evenings

<sup>71</sup> ROLLR DE 3277/126 LHCM 15 January 1971 concern expressed about the interruption of power supplies to home renal dialysis units.

<sup>72</sup> Spicer, J. E, 'District Nursing: its focus through a comparative analysis of nursing problems', University of Surrey, 1993, 269 – 71.

<sup>73</sup> McIntosh, 'Work study of district nursing staff', conclusions; ROLLR 614 LCHR Home Nursing Reports (1965 – 72).

<sup>74</sup> ROLLR DE 3277/126 LHCM 17 November 1972 and 19 January 1973. DHSS Circular 13/72 refers.

<sup>75</sup> ROLLR DE 3277/119 LHCM Home Nursing Sub-Committee May 1954.



**TABLE 1: CALLS AT BELGRAVE DISTRICT NURSING HOME OVER A PERIOD OF ONE WEEK (1954).**

Tme:	Phone:	Door:	Treatment:	Loans:	Misc:	TOTAL:
8:00 AM	11	11				22
9:00 AM	31	15		4	3	53
10:00 AM	25	25		7	9	66
11:00 AM	30	24			4	58
12 noon	14	15	4	6	5	42
1:00 PM	12	7	1	1	2	23
2:00 PM	27	19	2	2	3	53
3:00 PM	24	27	1	2	3	57
4:00 PM	27	14	13	1	2	57
5:00 PM	15	17	16	2	1	51
6:00 PM	18	18	30	2	3	71
7:00 PM	20	11	30	1		62
8:00 PM	23	10	14			47
9:00 PM	7		1			8
10:00 PM	2					2
TOTALS:	286	213	112	28	35	672

Source: ROLLR DE 3277/119 LHCM: Home Nursing Sub-Committee Minutes June 1954

reflects the work undertaken in the clinic at the Home operated by district nurses. Over a decade later, statistics showed the continuing use made of the evening clinics; in some Homes the demand was considerable, with over 70,000 treatments per annum, compared with nearly 9,000 in others; Central Home in New Walk was one of the busiest clinics and the one with the greatest increase in treatments (21% between 1967 and 1971), suggesting that it provided a convenient facility for people working in the City.<sup>76</sup>

In spite of an integrated network of care and a range of services that provided personal social services across the life span, there were gaps through which some people slipped. For example, there were 3 to 10 cases referred annually to the MOH for the compulsory removal from their own homes of individuals ‘suffering from grave or chronic illness, or being aged and incapacitated, or living in unsanitary conditions and unable to devote to themselves, or not receiving from other persons, proper care and attention’.<sup>77</sup> Such cases were most frequently ‘found’ by GPs, neighbours and relatives, and LHA staff. Compulsory removal by court order was a last resort, and the investigation of such situations caused the personnel involved great distress. All efforts were made to obtain voluntary admission to an appropriate place such as hospital, or to live with a relative. Alternatively, intensive support was provided

<sup>76</sup> ROLLR L614 LCHR – Home Nursing Report( 1971).



by the LHA domiciliary services. The following case study illustrates a fairly typical situation and the efforts required to safeguard the welfare of staff:

‘An elderly lady, living alone for several years and suffering from chronic ill-health, had been unable to keep her house clean. There were large accumulations of dirt throughout the house and numerous colonies of fleas in inhabited rooms. It took many days to clean the house and, during that time, in spite of Sanitary Department staff having sprayed the rooms and contents with insecticide, the home helps, district nurses and others who went in to help, and their friends at home, suffered severely from flea bites. As a result of this case special protective clothing has been provided for the District Nursing and Home Help Departments.’<sup>78</sup>

In the face of the escalating cost of the NHS, fluctuating staffing levels, particularly in the 1960s (see Appendices 2 and 3) and the multiple factors associated with ill health, action was taken to secure a more effective health-care system for patients in their own homes by stimulating closer collaboration between different professional groups and agencies. Two main forms of collaboration will be assessed in relation to informal and formal arrangements. The following case studies from the late 1950s show that in the relatively early days of the NHS informal collaboration between different occupational groups and agencies benefited home-based care.

Case study 1: ‘An elderly male patient was living alone and receiving injections from the district nurse, prescribed by GP following hospital consultation, for deficiency disease resulting from nutritional complications. The district nurse, realising the importance of establishing good eating habits and routines, referred the patient to the home help service to provide meals to a specified standard – the delegated responsibility was shared between the Meals on Wheels Service of the Old Peoples’ Welfare Committee and a neighbour. The patient’s condition improved, nursing treatment was discontinued, the patient was referred to the HV for supervision, and the support from the home help continued.

Case study 2: The HV reported to the Home Nursing service an old lady living alone and requiring attention in a house that was dirty. Two home-helps cleaned the house and the nurse concentrated on the lady’s health problems. After one month’s treatment, the lady was much improved and referred back to the HV for supervision with home-help support.<sup>79</sup>

This pattern of rotational care provided fresh perspectives which prevented complacency<sup>80</sup> and ensured that input was matched to needs, thus enabling resources to be concentrated at all times on those who required the special skills of the district nurse. The disadvantages may have been twofold: firstly, practitioners occasionally resisted the withdrawal of their services, either through possessiveness or a genuine fear of fragmentation and the risk of distancing the

<sup>77</sup> ROLLR L614 LCHR most years between (1950 – 70).

<sup>78</sup> ROLLR L614 LCHR – Home Nursing Report (1954).

<sup>79</sup> ROLLR L614 LCHR - Home Nursing Report( 1957).

<sup>80</sup> One district nurse explained, ‘You too can forget the hole in the carpet and learn to step over it.’



patient from the key-worker;<sup>81</sup> secondly, duplication of services sometimes caused the patient to be overwhelmed and confused by the number of different agencies visiting the home.

Formalised inter-professional collaboration and networking in Leicester accelerated in the late 1960s and took different forms, particularly when Section 28 of the 1946 NHS Act (Prevention Care and After Care), arguably one of the most important initiatives in the legislation, began to have an effect. One of the earliest initiatives was the after-care and care of diabetic patients. Dr Joan Walker, Consultant in Diabetes, at Leicester Royal infirmary, observed that 'in 1921, no one considered diabetes to be a community problem, thirty years later longevity has given rise to a problem of some magnitude...in Leicester we have relied on district nurses and specialist HVs to carry out the initial training of all new diabetics in their own home...the district nurse takes full responsibility for the management of new and sick diabetics in the home', the specialist HV is the key worker who liaises between the clinic and home based care..<sup>82</sup> A second development was in the field of presymptomatic services during the late 1960s which included the testing of infants' urine for phenylketonuria, the result of a genetically determined metabolic disorder, and cervical cytology and examination of the breast for the early detection of cancer.<sup>83</sup> Again, both services were important collaborative enterprises in bridging the tripartite division of the NHS; tests were taken and health education was provided by LHA HV/district nursing staff, laboratory assessment was performed by the hospital sector, the results and treatment were the joint responsibility of the GP and hospital consultant, and the process then completed the circle back to the district nurse (or HV), who administered and managed the treatment which ensued. District nurses were challenged to adjust to the potential for good and the ethical dilemmas of pre-symptomatic diagnosis, which in turn strengthened the underlying principles of anticipatory care in the home and in the GP's surgery.

Hospital liaison was an issue that had bedevilled district nursing and interfered with best practice since the 1950s. The under-use of district nurses for patients discharged from hospital

<sup>81</sup> Bradshaw, J, 'The mythology of modern medicine' *Now*, 33, 1980, 5 – 6.

<sup>82</sup> The Joan Walker Collection, Leicester Medical Society Special Collection, Clinical Science Library, Leicester University extracts from the following papers included in the collection – Baxter, D and Walker, J, 'International Diabetes Federation Congress, Toronto July 1964', *Balance*, March 1965, 11, 1, 17 – 9. Walker, J. B, 'The First Yugoslav Symposium on Diabetes, Zagreb, 1967'. Walker, J.B, '17<sup>th</sup> Banting Memorial Lecture, 1966: The Natural History of Diabetes', *Balance*, March 1967, 11, 9, 243 – 52. Walker, J. B, 'The medico-social aspects of bringing up a diabetic child', (British Diabetic Association 1969).

<sup>83</sup> ROLLR DE 3277/125 LHCM 17. 6. 1966 reference to the establishment of the screening service and the collaborative arrangement between the LHA and the Leicester Royal Infirmary pathology department.



wards, out-patient clinics and accident and emergency units, reflected a lack of appreciation and negative attitudes towards district nursing by other health practitioners, and a failure in the working of the comprehensive provision of the NHS (see Chapter 3).<sup>84</sup> Discharge home was not always a positive experience for the patient or the district nurse, as patients were frequently discharged without adequate provision for continuing care or having been inappropriately assessed for discharge.<sup>85</sup> Several initiatives were established to redress a gap that had both cost and consumer-satisfaction implications for health-care management. For instance, in 1961 a 5-day surgical ward opened at the Leicester Royal Infirmary (LRI), and in the first three months the district nurse treated 65 patients after discharge. Four years later, in 1966, hospital liaison schemes for geriatric and orthopaedic patients involving the district nurse were introduced.<sup>86</sup>

The geriatric patients' liaison scheme was initiated in the 1960s by Dr Alvarez, the first geriatric consultant to be appointed in Leicester in 1963.<sup>87</sup> He discovered a large number of elderly frail and sick 'dumped'<sup>88</sup> in the redundant sanatoria and cottage hospitals throughout the city and county of Leicester, and he worked to create the space, understanding and networking needed in the community for their rehabilitation and discharge.<sup>89</sup> Like others working with the elderly, he found that their health-care often suffered at the hands of practitioners with negative attitudes towards older people; poor drug-management skills, and lack of knowledge or its application to geriatric care, could result in missed diagnoses of conditions such as diabetes, hypothermia, hypothyroidism, and even abuse and the effects of poverty and deprivation.<sup>90</sup> The geriatric liaison scheme, which operated from Hillcrest

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<sup>84</sup> Hockey and Potter, *Co-operation in Patient Care*, passim; Pascall, G, 'Health', in Scambler, G, *Sociology as Applied to Medicine* (London 1991), 141 – 64, noting the gradually declining length of stay in hospital from 49.3 days in 1949 to 21.6 days in 1976 and highlighting the implications for the domiciliary services.

<sup>85</sup> Gay, P and Keathley, P, '*When I went home*': a study of patients' discharge from hospital, (Kings Fund Study, London 1979); Skeet, M, *Home from Hospital* (London 1968).

<sup>86</sup> Geriatrics is a speciality concerned with the needs of the sick elderly person.

<sup>87</sup> Alvarez, A, Geriatric consultant in Leicester from 1963 - 1992. Interview 1999.

<sup>88</sup> Marsh, D. C. *Introducing Social Policy* (London 1979), 150 – 2 sees the situation known as 'dumping' and 'bed-blocking' by the elderly as a means by which they are excluded from the real world of care for the sick by the over-concentration on 'interesting cases'.

<sup>89</sup> Alvarez, Geriatric consultant: Thane, P, *Old Age in English History. Past experiences, Present Issues* (Oxford 2000), 436 – 57; Warren, M, 'Geriatrics: A medical, social and economic problem', *Practitioner*, 157, 1946, 384 – 90.

<sup>90</sup> Informal discussion with QNs practising in the late 1960s and 1970s; Blane, D, 'Health professions', in Scambler, *Sociology*, 221 – 35, quotes evidence from two cases studies in 1957 which show the negative effect of professional socialisation: the first involved medical students who saw the clinical importance of the disease and not the patient as central to the care give; the second involved nurses who were divided their patients into 'real nursing cases requiring technical care' and 'just basic care of helpless patient'; Stockwell, F, *The Unpopular Patient* (London 1972) passim; Kratz, C. R, *Care of the Long-*



hospital revolutionised the care, after-care and quality of life for the elderly sick and handicapped, and was an important development for district nursing.<sup>91</sup> The essence of Alvarez' approach was based on the first principles of geriatric care: health and the promotion of patient morale as primary values; a holistic approach, 'of which the practitioner must need lose sight'; rehabilitation as a central process; and teamwork in which the patient, relatives/supporters, and personal and social services were involved as equal partners.<sup>92</sup> The whole approach challenged traditional values of control and authority in favour of autonomy and empowerment. It encouraged a new way of thinking about older people, their problems and their future, and of using different types of expertise to bring a holistic perspective to clinical decision making – 'a patient's pet dog was always an interesting problem'. These principles were not new; they had been part of professional consciousness since the eighteenth century.<sup>93</sup> Although few systematic studies have been undertaken on the effectiveness of district nurses in meeting the needs of the elderly sick and frail, evidence suggests that they were in the frontline of prevention and restitution through the early recognition of need, care and after-care during acute and long-term episodes.<sup>94</sup> Alvarez recalled the district nursing service as being an important part of the team; he commented that on occasions the district nurse would put a very strong case for or against a patient's discharge and it would be well worth listening to her.<sup>95</sup> Kratz' small-scale study of the long-term sick, however, suggested that, without improvements in district nurse training, professional intervention was unlikely to continue to meet the observed needs of the patient and his family.<sup>96</sup>

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*term Sick in the Community* (Edinburgh 1978), passim; Perlmutter, M and Hall, E, *Adult Development and Aging* (Chichester 1985), passim; Mackintosh, J. M, *Topics in Public Health* (London 1965), 52 – 8 – the increasing importance of 'social diagnosis'.

<sup>91</sup> ROLLR 614 84/64 LCHR 1962 – the elderly comprised 50% of the district nursing case load and accounted for 64% of all visits.

<sup>92</sup> Warren, M. W, 'Clinical aspects', *The British Journal of Physical Medicine*, March – April 1947 36 – 8; Royal Society of Medicine Library (RSML), WT 11. 1, Liv. Livesley, B, 'The Osler Lecture of 1975: Galen, George 111 and Geriatrics', Paper to *The Faculty of the History and Philosophy of Medicine and Pharmacy of The Worshipful Society of Apothecaries of London*; RSML, Tr. 144478. Burstein, S. R, 'Papers on the historical background of gerontology: first series', *Reprint from Geriatrics*, 10, 1955, 189 – 93, 328 – 32, 536 – 40; Seaton, D, retired Leicester social worker. (Interview 2000); Swire, E, widow of a Leicester QN district nurse officer (Interview 1999); Smith, B. L retired Leicester QN and district nurse tutor. (Interview 1999).

<sup>93</sup> Cornaro, L, *Discourses on a Sober and Temperate Life: The method of Preserving Health to Extreme Old Age* (London 1779).

<sup>94</sup> Spicer, 'Analysis of nursing problems', 267 – 9; ROLLR L614 84/64 LCHR the reports regularly documented the heavy and demanding nursing problems of the elderly to which the district nursing service responded.

<sup>95</sup> Alvarez found that in Leicester HVs, in contrast to other areas of the country in which he had worked, had minimal involvement with the elderly patients in his care.

<sup>96</sup> Kratz, *Care of the Long-term Sick*, 90 – 2; Poulton, K, R, 'Perception of wants and needs by nurses and their patients', University of Surrey Ph.D. thesis , 1981, 20.



Team-work and inter-agency collaboration became a high priority in the 1960s in all health-care and welfare settings, and the formal involvement of both district nurses and HVs in a range of hospital liaison schemes from 1968 tended to blur the boundaries between the two disciplines. The opportunity was missed, however, to combine specific roles in the interests of best practice and to address the extreme staff shortages continually reported in HC minutes and reflected at national level (see Appendix 3). Instead, in Leicester named district nurses were assigned to integrate care between the community and the orthopaedic and geriatric hospital specialities; specified HVs were likewise assigned to liaise with a variety of hospital departments to prepare for planned transfer in the interests of continuity of care, patient safety, the control of infection, and the assurance of relatives. Such focused clinical liaison was a questionable development for HVs, who voiced concern when faced with attachment to GPs. Many found the situation challenging because their clinical skills and knowledge had fallen out of use in their preoccupation with child development, health-education and social advice. Specialist in-service programmes were arranged to accommodate the anxiety of HV and other nurses who expressed the need for clinical updating.<sup>97</sup> The future implications for HV, and indeed district nursing, of the implementation of the Local Authority Social Services Act (1970) and the transfer of selected children's and welfare services for the elderly and handicapped from the LHA to the new Social Services Department were under review, but the implementation of the new approach which emerged is beyond the time-scale of this research.<sup>98</sup>

### **Service planning and management:**

The adjustment made by district nurse superintendents (managers) from the inception of the NHS in 1948 was perhaps even more striking than that made by district nurses. Firstly, they transferred from the cause-focused, self-directed administration of voluntarism to a multi-dimensional statutory organisation directed by political ideology and bureaucratic universalism. Secondly, the superintendents lost the professional pre-eminence that was the hallmark of the QNI (see Chapter 6) by relinquishing the local governance of district nursing to the MOH and the lay committees of the LHA, except for the preparation and submission of periodic reports. This was a new situation for district nursing, unlike that of HVs and midwives who had been part of the public health administration prior to the NHS. No longer were district nurses represented by district nurses, although GPs had GP representatives on

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<sup>97</sup> ROLLR L614 84/64 LCHR (1970); District nurses (QN) attended refresher courses every 5 years – these were usually residential courses hosted by Universities and other highly rated educational establishments.

<sup>98</sup> ROLLR DE 3277/126 LHCM 18 September 1970.



the Executive Council, and consultants had representation on the Hospital Management Committee and Regional Hospital Board. In 1964, however, the appointment of a Chief Administrative Nursing Office, previously a HV tutor in Leicester, who completed her QNI training during the course of her appointment, relieved the situation to some extent.<sup>99</sup> Thirdly, development and flexibility in district nursing continued to be impeded by the control imposed by doctors, which required the district nurse to work under the clinical direction of the 'medical man' (see Chapter 6). By contrast, HVs, who practised relatively independently of such controls, were governed only by local policy in relation to the obligatory visits to vulnerable groups. Furthermore, the HV service provided for the whole population in a given area and it was easy to identify under-served need in times of HV shortfall.<sup>100</sup> District nursing was heavily dependent on referrals, however, and the recognition by individuals of their need for medical help;<sup>101</sup> like the iceberg, it was impossible to assess the full extent of the unmet health-care needs that lay beneath the surface of a relatively superficial auditing system.

Fourthly, district nurse superintendents were not necessarily more inept and unpractised than managers in other disciplines, as inferred by McIntosh, but to some extent they were disempowered by the adjustments required in the process of transition to state control and by the limitations of LHA policy formation and decision-making.<sup>102</sup> They were disempowered not only by structural boundaries and cultural and ideological conflicts but also by their inability to sustain pressure to ensure that the district nursing needs of the local community were adequately met in areas such as skill-mix and district nurse training policy. Fifthly, the management of the district nursing service changed dramatically between 1948 and 1972, with the transition from an approach which was almost parental in style to that of professional management. Some of the transitional changes were evolutionary and in keeping with the developing nature of the profession and its relationship with wider networks; other changes were imposed by the government both directly and indirectly through the agency of local government or the professions; further changes were the result of influences from the world of commerce and production, such as task hierarchy, the division of labour and 'shop-floor' training inherent within the concept of Fordism;<sup>103</sup> a selection of district nurses, together with

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<sup>99</sup> ROLLR L614 84/64 LCHR (1964).

<sup>100</sup> ROLLR L614 LCHR (1969) – identify HV shortfall in terms of 4000 population.

<sup>101</sup> Pounlton 'Perception of wants and needs', 18 – 20 sites Robinson's important findings that 'chronicity became part of an old person's way of life' which 'they accepted as a fact of life'.

<sup>102</sup> McIntosh, J. B, 'District Nursing: a case of political marginality', in White, R, ed. *Political Issues in Nursing. Past, Present and Future* (Chichester, 1985), Vol. 1, 45 - 66

<sup>103</sup> Fordism – a system of social reconstruction in the workplace which dates back to the 1930s and changes in precept and concept over the next forty years; Clarke, S, 'What in the F...'s name is



other LA staff were even required to attend task analysis training provided by the Ministry of Labour in 1963.<sup>104</sup>

District nurse managers had practised some principles of the new professional management almost intuitively, and it was important that these skills should not be sacrificed but should be transferred to new circumstances. For example, at the inception of the NHS, the Superintendent Queen's Nurse fulfilled a range of administrative functions in relation to patient-care and the welfare of both the district nurses and as manager/bursar of the District Nursing Home. The centre superintendent knew all the patients in her area through her supervisory position as administrator and her practice of periodic visiting with the district nurses during their rounds. Record-keeping was always a major priority in district nursing, seemingly rooted in the accountability of voluntary agencies to their subscribers. Patient-care records, grounded in a commitment to patient sovereignty and shared care, had been the only patient-held documentation of care in use until the 1960s when similar records were introduced in midwifery. In addition, statistical data collected by district nurses was used by superintendents to provide a system of quality control, patient advocacy, staff development, and future planning.<sup>105</sup> The introduction of computerised records in 1972 was designed to be timesaving and provide greater accuracy and a collaborative planning mechanism; it was a projected development in which Leicester was one of the leaders in the field.<sup>106</sup>

The crucial issue of adequate district nursing staffing levels and resources was a permanent feature of the Home Nursing Reports to the HC. Five main impressions are gained from the district nursing staffing statistics. Firstly, there is difficulty in interpreting the proportion of trained to untrained district nurses due to lack of definition, with the result that the quality of the service is unclear. Complementary sources, however, such as continuing affiliation to the QNI, training records (see Appendix 4), and the oral histories and personal testimonies of Leicester district nurses suggest that appropriately trained district nurses were employed.<sup>107</sup>

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Fordism?' in Gilbert, N, Burrows, R and Pollert, A, *Fordism and Flexibility: Divisions and Change* (Basingstoke 1992), 13 – 30; Jessop, B, Post-Fordism and the State', in Amin, A, *Post-Fordism* (Oxford 1994), 251 – 279.

<sup>104</sup> ROLLR DE 3277/124 LHCM.(1963; One QN recalls how she was inspired to produce a 'Practical Procedures Manual' and in retrospect felt that "Florence Lees (Mrs Dacre Craven) would have turned in her grave".

<sup>105</sup> Segesten, K, 'Patient advocacy – An important part of the daily work of the expert nurse', *Scholarly Inquiry for Nursing Practice: An International Journal*, 7, 2, 1993, 129 – 136.

<sup>106</sup> ROLLR L614 LCHR (1971).

<sup>107</sup> Oral histories and personal testimonies reveal that the majority of respondents commenced training on the day of employment, or within 6 months, others, some of whom were part-time, delayed taking the



Secondly, there is an impression of a growth orientated service in keeping with national trends (see Appendix 3); in Leicester, an establishment of 45 nurses in 1953 (31 full-time, including 5 male nurses and 17 part-time staff) served a population of 285181 (1 nurse to 6337 head of population); by 1972, the establishment had increased to 113 (1 nurse to 2515) to provide the City with a 24-hour district nursing service which included GP attachments, hospital liaison commitments, and pre-symptomatic detection activities.<sup>108</sup> Thirdly, sustained growth was impeded by difficulties in maintaining staffing levels, either in the recruitment of staff to fill new posts or the frequent replacement needs created by staff mobility – a situation reflected nationally (see Chapter 4). In the 1960s district nursing was assessed as ‘fighting a losing battle to cover mounting case loads’, and recruitment was thought to be hampered by the level of remuneration and conditions of service.<sup>109</sup> District nurses felt neglected by their professional association the RCN, particularly following the cessation of the QNI in 1968, and they begin to show a marked interest in the Leicester branch of the RCN.<sup>110</sup> Fourthly, a division of labour and skill-mix arrangement was introduced on a seemingly fragile basis of cost-cutting and expediency. For example, in 1961, to meet the requirement of improved national conditions of service for district nurses, 5 additional QNs were recommended by district nursing managers but preference was given by the HC to 5 State Enrolled Nurse (SEN) posts ‘to reduce the cost’ by £1300 per annum.<sup>111</sup> By comparison, extending the night nursing service to 24 hour cover required 5 extra nurses, and preference was given to the appointment of 3 QNs and 2 SENs instead of 5 SENs, with the reduction in the cost of the day staff appointments meeting the cost of the additional night nursing provision. A district nursing team attached to general practice in 1968 often consisted of 1 Senior District Nurse, 1 SRN full-time, 2 SRNs part-time, 1 SEN part-time, and 1 NA part-time. This was a fairly typical establishment, containing only one fully-trained district nurse.<sup>112</sup> The employment of lesser trained staff was not always welcomed by trained staff and managers; rather than relieving staff shortages, it may have aggravated the situation through the perceived dilution

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course for other reasons. All respondent recalled that it was accepted policy that training was a condition of employment,

<sup>108</sup> ROLLR DE 3277/119 LHCM 20 November 1953, and DE 3277/126 LHCM 17 November 1972.

<sup>109</sup> ROLLR L614 84/64 LCHR (1969)

<sup>110</sup> Rose, H, *Royal College of Nursing The Leicestershire Branch* (Private publication 1991), 51: Fraser, E, C, QN Superintendent, Leicester (Personal testimony 1998); Smith, B. L QN and later District Nurse Tutor, Leicester (Interview 1998); See also Davies, C, Four events in nursing history: a new look’, *Nursing Times*, June 1978, Occasional Papers 2, 69 –71 on the exclusion of district nursing from RCN interests.

<sup>111</sup> ROLLR DE 32778/12, LHCM Midwifery, Child Welfare and Nursing Sub-Committee Minutes 11.10.1961.

<sup>112</sup> ROLLR L614 84/64 LCHR (1967).



of the service and the feeling that 'the poor push the good ones out'.<sup>113</sup> Poor recruitment and retention of staff could be as much self-induced as due to external forces, but there were no obvious plans to reverse the process. The under-valuing of district nursing may be attributed in part to similar causes. It is arguable that a more imaginative and flexible style of management and a less controlling climate could have yielded a more stable work force. Fifthly, in 1967, as part of decentralisation policies, a Senior (trained) District Nurse management grade was established; nine were appointed to supervise a mixed-skill team of 4 – 8 nurses, including a male nurse, to visit delegated patients once each week, and to undertake the practical teaching of student district nurses.<sup>114</sup> Each team was an autonomous unit; referrals were made by direct contact with GP surgeries and the Home, and work was no longer allocated or referred centrally but by each senior district nurse to the group. The development was positively evaluated the following year; it was an expression of sapiential authority and gave a boost to the position of district nursing. By contrast, the criteria applied to the delegation of nursing duties were as vague as those informing skill-mix decisions. In Leicester, delegation seemed to be based on a 1953 arbitrary division of nursing into 'basic' and 'technical' work, disregarding the concern which McFarlane expressed in 1970, 'What is basic about basic nursing?', and that of others who commented on the apparent simplicity of the complex task of nursing.<sup>115</sup> But the die was cast, and 'bathing' became the easy divide between skilled and non-skilled nursing.<sup>116</sup> Sixthly, a positive commitment to training was demonstrated insofar as the LHA provided a district nurse training-course supported by students from other authorities (see Appendix 4); following the appointment of a tutor in 1969, training opportunities expanded to include the needs of all spheres of district nursing. This may be seen, however, as another example of papering over the cracks for two reasons: firstly, the absence of a mandatory, systematic programme of education; and secondly, the apparent lack of a clear local policy on staffing structure and role definition.

In the presence of a continuing battle to maintain cost-effective staffing levels throughout the 1960s and early 1970s, advances in technology and new methods of working were introduced to augment human resources. For instance, a telephone recording machine (Telstor) was

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<sup>113</sup> Stocks, *100 Years of District Nursing*, 203 referring to 'Gresham's Law'.

<sup>114</sup> ROLLR DE3277/125 LHCM 17 February 1967.

<sup>115</sup> Baly, M. E, *Nursing and Social Change* (Bath 1980), *The Work of Nurses in Hospital Wards – The Goddard Report*, 436 7; Bradshaw, A, *The Nurse Apprentice* (Aldershot 2001), 116 – 22; McFarlane, J, *The Proper Study of a Nurse* (London 1970), *passim* focussed on the issue of what is basic about basic nursing?; Kratz, *Long-term Sick*, *passim*.

<sup>116</sup> Griffiths, J, *An ethnographic study of district nursing work*, University of Liverpool Ph.D. thesis, 81 – 9, *passim*.



installed in 1966, which relieved professional time for more appropriate duties but ran the risk of distancing the patient from the district nursing service and creating communication barriers.<sup>117</sup> In addition, nursing techniques were improved in 1968 by the introduction of pre-sterilised and disposable items of equipment as well as pre-sterilised dressings which became available on prescription; previously, the 'boil-up and bake' method had been used. The advantages of time-saving, however, reduced quality time with the patient and threatened to put holistic care at risk.

Management also held a responsibility to facilitate best practice throughout all areas of district nursing, and intra- and inter-professional collaboration was a high priority. The diminishing number of residents in the District Nursing Homes from the 1950s provided an opportunity to decentralise health-care and welfare staff, and form multidisciplinary bases. HVs, home-helps and other staff such as social workers and therapists moved into the Homes to work alongside the district nurses. This was the beginning of the health-centre development, which expanded rapidly from the mid-1960s.

In 1969 a government enquiry into nursing management structures in the community resulted in the extension of decentralisation and the introduction of three levels of administration; each level merged the three strands of community nursing – district nursing, HV and MW.<sup>118</sup> In many respects, the new managerialism constituted a second, possibly welcome, cultural revolution for district nursing;<sup>119</sup> in practice, however, the different strands of nursing experienced a loss of identity and a confusion of accountability, while male nurses emerged to compete with their female counterparts; in Leicester, two of the three first-level posts were filled by male district nurses, and another was appointed at senior level.<sup>120</sup> It seems regrettable that the principle of combined practice and transferable skills in management practices was not followed through in fieldwork.

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<sup>117</sup> Bradshaw, 'Mythology of modern medicine', concerns about the effects of the new technology and ways of working on the quality of the GP – patient relationship can be applied to district nursing.

<sup>118</sup> Baly, ed., *A New Approach to District Nursing*, 273 – 4, new management structures initiated by the Salmon Report on Senior Nursing Staff Structure in hospital (1966), and the Mayston Report on the Management Structure in the Local Authority Nursing service (1969).

<sup>119</sup> Davidson, N, *A Question of Care. The Changing Face of the National Health Service* (Suffolk 1987), 22.

<sup>120</sup> Carpenter, M, 'Managerialism and the division of labour in nursing', in Dingwall and McIntosh, *Sociology of Nursing*, 87 – 105; Hardy, L. K, 'Career politics: the case of the career histories of selected leading female and male nurses in England and Scotland', in White, *Political Issues in Nursing*, Vol. 2, 69 – 82; ROLLR DE 3277/125 LHCM 17 March 1967.



Although in some ways management facilitated the development of district nursing by exploring new methods of working that brought together the GP and the district nurse, in other ways this created serious difficulties. Numerous organisational and administrative problems were associated with GP attachments: the areas of GP practices were not limited, resulting in excessive travelling time and expenditure; many GPs worked in single-handed practices; and some areas, particular inner-city areas, were designated 'under-doctored' by the Executive Council, creating problems of access for the nurse and the patient. The sharing of surgery accommodation, services and expenses undermined the proper working of the enterprise; and divided loyalties often compromised the position of the district nurse and jeopardised her professional autonomy and credibility in multi-disciplinary settings.<sup>121</sup>

Management also relied on collaboration with the voluntary sector. As Beveridge predicted, the need for voluntary service did not go away with the introduction of the NHS.<sup>122</sup> Indeed, Lowe described voluntary provision as 'the shadow welfare state', particularly from an historical perspective.<sup>123</sup> The Archbishop of Canterbury, in 1941, cautioned against the totalitarianism of the Welfare State, and argued for the involvement of non-state agencies.<sup>124</sup> In 1963 and 1970 Titmuss, an ardent collectivist, perceived the role of the state to be less threatening and believed that the welfare state helped to draw together disparate groups in society for the common good.<sup>125</sup> In Leicester, collaboration between the statutory and voluntary services made a significant contribution to the quality of district nursing care and patient satisfaction. Voluntary initiatives, such as the British Red Cross Medical Loans Department which took over and developed the loans service previously organised by the District Nursing Homes in the City, all began as small enterprises which eventually reached a point of insolvency owing to increasing demand, and were then helped by substantial grants from the LHA and the judicious use of resources by district nurses. Some district nurses were personally involved in fund-raising activities - the days of the LDNA bazaar stood them in good stead. The LHA demonstrated a strong commitment to the social health and welfare of families and the prevention of break-up, and to this end financial support was given to the

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<sup>121</sup> District nurse occasional contacts; Pointon, G, retired Leicester QN (Interview 1998); Beales, G. *The Sick Health Centre* (London 1978), passim. Includes a description of the nurse manager's visit to a health centre and the ruffled feathers she leaves behind.

<sup>122</sup> Beveridge, W, *Voluntary Action. A Report on methods of Social Advance* (London 1984), 306 – 8.

<sup>123</sup> Lowe, *The Welfare State*, 33.

<sup>124</sup> Lowe, *The Welfare State*, 10 refers to Archbishop of Canterbury's publication *Citizen and Churchman* (1944) and the warning it contained about the power being assumed by the benevolent state.

<sup>125</sup> Allsop, 'Nurses and the Welfare State', 20 – 32, here Titmuss' collectivist arguments in his *Essays on the Welfare State* (1963) and *The Gift Relationship* (1970) which explores 'altruistic giving', such as blood donors, as a dimension of state welfarism.



Leicester branches of a range of voluntary services such as the Family Service Unit, Family Planning Association, Marriage Guidance Council and the Samaritans, to augment the work of the statutory body. The contribution of the QNI to the development of district nursing was also acknowledged through a continued affiliation agreement. Individual district nurses, encouraged by management, also made a unique personal contribution that was beyond the call of duty, often showing significant skills of inventiveness and enterprise. One QN, with the help of the Chief Ambulance Officer, designed and constructed a lifting apparatus for a young immobile patient with a severely painful condition; another started a social club for stroke patients in conjunction with the St John Ambulance, which provided transport, and a Scout Group, which offered accommodation;<sup>126</sup> a third founded a local branch of the Parkinson's Association; a fourth served on the committee of the Multiple Sclerosis Society;<sup>127</sup> while others combined professional, civic and military duties as members of various bodies such as the QNI Council and the Territorial Army.<sup>128</sup>

### **The position of district nursing:**

The distinctive contribution of district nursing was central to the ethos of non-discriminatory health-care within the framework of the NHS, and for the first time in history its contribution was formally recognised in official records – no longer was district nursing hidden from history. Within the overall political, organisational and professional structure of health-care and welfare, however, district nursing was disadvantaged from the outset in comparison with health visiting. Historically district nursing and HV had always pursued different trajectories and this was reinforced by the NHS Act, in spite of opportunities to work towards a closer relationship in the interests of an integrated public health/community nursing speciality. The wording of the NHS Act gave statutory status to health visiting, but district nursing was re-designated as 'home nursing' (arguably a ploy to avoid the contentious designation of district nurse), and this gave cause for concern with regard to both training and practice. Two working parties were subsequently established by government in the 1950s, one for HV (The Jameson Committee) and the other for district nursing (The Armer Committee), whose reports had far-reaching and irreversible consequences (see Chapter 3). In the 1960s statutory safeguards were established for health visiting, the training course was lengthened and re-located in higher education under the control of a qualified HV tutor who, together with the

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<sup>126</sup> Swire, E, widow of Leicester QN. (Interview 1999).

<sup>127</sup> Smith, B. L, retired Leicester QN and district nurse tutor. (Interview 1998).

<sup>128</sup> Oral histories and personal testimonies of Leicester district nurses reveal a continuing commitment to a wide range of voluntary activities in their retirement.



students, benefited from the facilities of an inter-professional academic environment. In the case of district nursing, however, the course was shortened and continued as an in-service type of learning experience under the control of management, while the lead role of the QNI was replaced by a government department in spite of the QNI offering to re-adjust to fulfil this role. In 1960, the 6 month course that was long over-due for upgrading, was reduced to four months (with the course being reduced from four months to three months for MW, HV and tutors, without a corresponding reduction for district nurses undertaking the HV course). The shortened district nurse course was accepted by the HC without any apparent contest, neither did the lack of concession for district nurses undertaking the HV course seem to raise any objections<sup>129</sup>

Prior to and from the outset of the NHS, attempts were made to set up some collaboration between the training of HVs and district nurses, but it was a limited experience based simply on the sharing of lectures. In 1965, however, the district nursing course was transferred to accommodation near the HV course at Vaughan College, within the Adult Education Department of the University of Leicester.<sup>130</sup> This speculative move incurred a small additional cost of £40 per annum for the QNI course. It was a visionary step, however, in keeping with national trends towards shared learning and joint HV/district nurse courses. To facilitate the development, a QN with HV qualification, who had been actively involved with the QNI course in Leicester, was sponsored for the HV Tutors' Course 1968-69, funded from the national pooling arrangement for HV. The purpose of the sponsorship was to provide cross-boundary teaching, with the result that the designation of the new tutor was that of Public Health Nurse Tutor. During the year, however, negotiations took place to validate the HV Course within higher education, and in 1969 the HV course was located within Leicester Polytechnic. The QNI course was transferred into hospital teaching accommodation at the LRI. This move was contrary to the trends taking place in district nursing education in the rest of the country, and Leicester, which had once been a trail-blazer (see Chapter 5), lagged behind developments (see Chapter 6).<sup>131</sup>

There are numerous other instances in which the distinction between district nurses and HVs was evident, such as division of labour and the employment of lesser-trained staff. From

<sup>129</sup> ROLLR DE 3277/120 LHCM Home Nursing Sub-Committee 16 November 1955.

<sup>130</sup> ROLLR DE3277/124 LHCM 17 September 1965.

<sup>131</sup> Gibson, S. R, 'A history of the Panel of Assessors for District Nurse Training (PADNT) 1959 – 83', University of Surrey, Ph.D. thesis, 1993, most district nurse courses were validated in higher education by 1980 – Leicester was one of the last courses to be transferred in the mid-1980s.



1961, HVs were assisted by state registered nurses (SRN) employed as school/clinic nurses who undertook specially delegated duties without compromising the statutory status of health visiting. For district nursing however, without a statutory qualification or mandatory sphere of practice, the term district nursing (or 'home nursing') was misleading and did not distinguish between the special sub-set of QNs and district nurses without training. The confusion was such that the Minister of Health in 1965 attempted to clarify the position by stating quite clearly and helpfully that 'The home nurse must retain responsibility for all her patients and should only delegate after assessing the needs and conditions of individual patients', but followed this by claiming that up to 50% of the work might be delegated to SENs, nursing auxiliaries, or lay assistants. It is little wonder that QNI training was seen as a low priority.<sup>132</sup>

The ambiguous and disadvantaged position of the district nurse brought discredit to district nursing, its managers and administrators generally (see Chapters 3 and 5).<sup>133</sup> The extent to which such disadvantage occurred in Leicester is often inconclusive but a rather telling example was the exclusion of the district nurses from the official opening of Westcotes Health centre in 1973, whereupon the district nurses sent a letter of complaint to the HC.<sup>134</sup> In response to the district nurses' letter the Chief Administrative Nursing Officer gave her reasons as the lack of space and argued that there was sufficient HA representation. The situation caused discomfort amongst the members of the committee and a letter of apology was sent to the district nurses expressing the HC's regret. Other rather glaring examples include the relative cost of the district nursing and HV services. Bearing in mind that on average the HV establishment was half to two-thirds lower than district nursing, serious anomalies are revealed: firstly, the unit cost per visit for district nursing in 1948-50 was 3s.6d (130568 visits) and in 1950 - 51, 4s.2d (133151 visits), but for HV in the same periods, it was 5s.2d (48065 visits) and 6s.1d (49994 visits) respectively, thus indicating a salary differential between HV and district nurses, the employment of lesser-trained, low-paid workers in district nursing or less time-consuming visits; secondly, HV training course expenditure is itemised separately in the accounts but district nursing training is included within the general accounts, suggesting an in-service training cost; and thirdly, HVs were full-time students during their course and the cost of training attracted money from the national pooling

<sup>132</sup> Merry and Irlen, *District Nursing*, 59 referenced Ministry of Health Circular 12/65, 12.

<sup>133</sup> Hockey, *Feeling the Pulse*; Hockey, L, *Use or Abuse?* (London 1972); Stocks, 100 Years and District Nursing 193 - 205; and Gibson, 'PADNT', 88 - 90 for evidence to the Armer Report on the training of district nurses (1955).

<sup>134</sup> ROLLR DE 3277/126 LHCM 21.9.73.



arrangement subscribed to by LHAs; by contrast, district nurse students were regarded as apprentices, rated as the equivalent of two thirds of a full-time post.<sup>135</sup>

Finally, different ways of providing training for community nursing were being explored throughout the country (see Chapter 3). In Leicester, although various initiatives were suggested, little happened and, if anything, Leicester slipped back. An integrated diploma scheme between the LRI/QNI and Leicester University, supported by the Regional Hospital Boards and Leicester Corporation HC was under consideration in the early 1960s. The scheme was agreed in principle at the meeting of the Midwifery, Nursing and General Welfare Sub Committee in February 1964, and in May 1967 definitive financial estimates were presented for approval; joint ownership of the course was negotiated with an anticipated starting date of November 1968.<sup>136</sup> This scheme of nurse training, which would have given both general and district nurse training diploma status and enhanced their academic skills and clinical potential, was never implemented. Instead, a lower level integrated hospital and QNI training scheme for enrolled nurses (SEN) was introduced in 1970 (see Appendix 4).<sup>137</sup> Particularly surprising was the fact that the LHA seems to have ignored a strongly worded recommendation from the Minister of Health for LHAs to set up specialised mandatory training for district nurses in line with that of HV and midwives. Although no funding was provided for this, Leicester had already prepared the ground and was in a position to move forward in line with the recommendation. Worst of all, from the point of view of district nursing, was the LHA's decision to set up a group school of nursing which brought district nursing under the administrative control of basic nurse training and isolated to the higher education sector – an inappropriate position and against the national trend.<sup>138</sup> The re-thinking behind the MOH's recommendation to combine HV and district nurse education passed unheeded.<sup>139</sup> The potential of district nursing was undervalued and the need for an appropriate educational foundation passed unrecognised, with the prospect of a permanent severance from higher education facilities and inter-professional learning with HVs and other members of the PHCT. The future of district nurse training and the status of a mandatory qualification for a

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<sup>135</sup> ROLLR 352 City, Leicester's Finances 1950 – 51; 1960 – 61 and 1970 – 71.

<sup>136</sup> ROLLR DE 3277/124 LHCR.

<sup>137</sup> ROLLR DE 3277/126 LHCM 16 January 1970.

<sup>138</sup> ROLLR L614 84/64 LCMR (1971), membership of the Group School Project Committee comprised; Regional Health Authority and Leicester Hospital management Committee representatives, CANO, MOH Leicester and MOH Leicestershire, Principal Tutor LRI and Leicester General Hospital and Leicester Public Health Nurse Tutor.

<sup>139</sup> ROLLR L614 84/64 LCHR (1962).



specialised area of professional practice were yet to be written following consideration of the recommendations of the 1972 Royal Commission on Nursing.

### **Conclusion:**

This chapter has illustrated the transition in Leicester from a socially embedded form of trust engendered by voluntarism, to a form of institutionally constructed trust that was inherent in the structures and approaches established by legislation and government policies. It has also shown that, in addition to the difficulties that inevitably arise during a period of change, district nurses had to face other challenges which were created by the contradictory attitudes of society towards district nursing. Such difficulties threatened to compromise and diminish the role of the district nurse, particularly in the face of the fringe role of district nursing in policy making and executive decisions. Nevertheless, the evidence has shown how the resilience of district nurses, and the feel-good factor their work engendered, enabled them to continue to build on their strengths and keep at least some part of their mission intact.

Unlike Chapters 5 and 6, this chapter has been unable to produce a detailed account of the clinical work undertaken by the district nurses in Leicester but simply an insight into their role and its challenges. What has been revealed is the district nurses ability to work constructively within a climate of finite resources and competing priorities both in relative isolation from, and in collaboration with, peers and colleagues. These qualities were frequently undervalued, not least in the limited perception of the training needs of district nurses.

Throughout the chapter evidence highlights the influence of an expansionist policy and innovative practices where new initiatives were introduced in the face of severe staff shortages. In many respects, the use made by new technology and systems of care such as pre-sterilised disposable commodities, office technology and management strategies were of benefit to an over-stretched service. In other respects, policies were introduced often to the detriment of both existing services and individual district nurses. For instance, the citywide introduction of GP attachment schemes is arguably one example of induced conformity between different professions where attitudes and commitment are central to effective partnerships that are in the best interest of the service, the professionals and the patients. A second was evidence of a nucleus for growth and development for district nursing within a comprehensive framework of the 'Prevention, care and after care' facility within the NHS Act 1946 but in which the HV was often selected by management to take the lead role in clinical specialities. A third was the imposition of a division of labour within the district nursing



service to meet expansionist policies and new needs of a changing population, which suggested an undervaluing of the true range of skills and responsibilities of the district nurse.

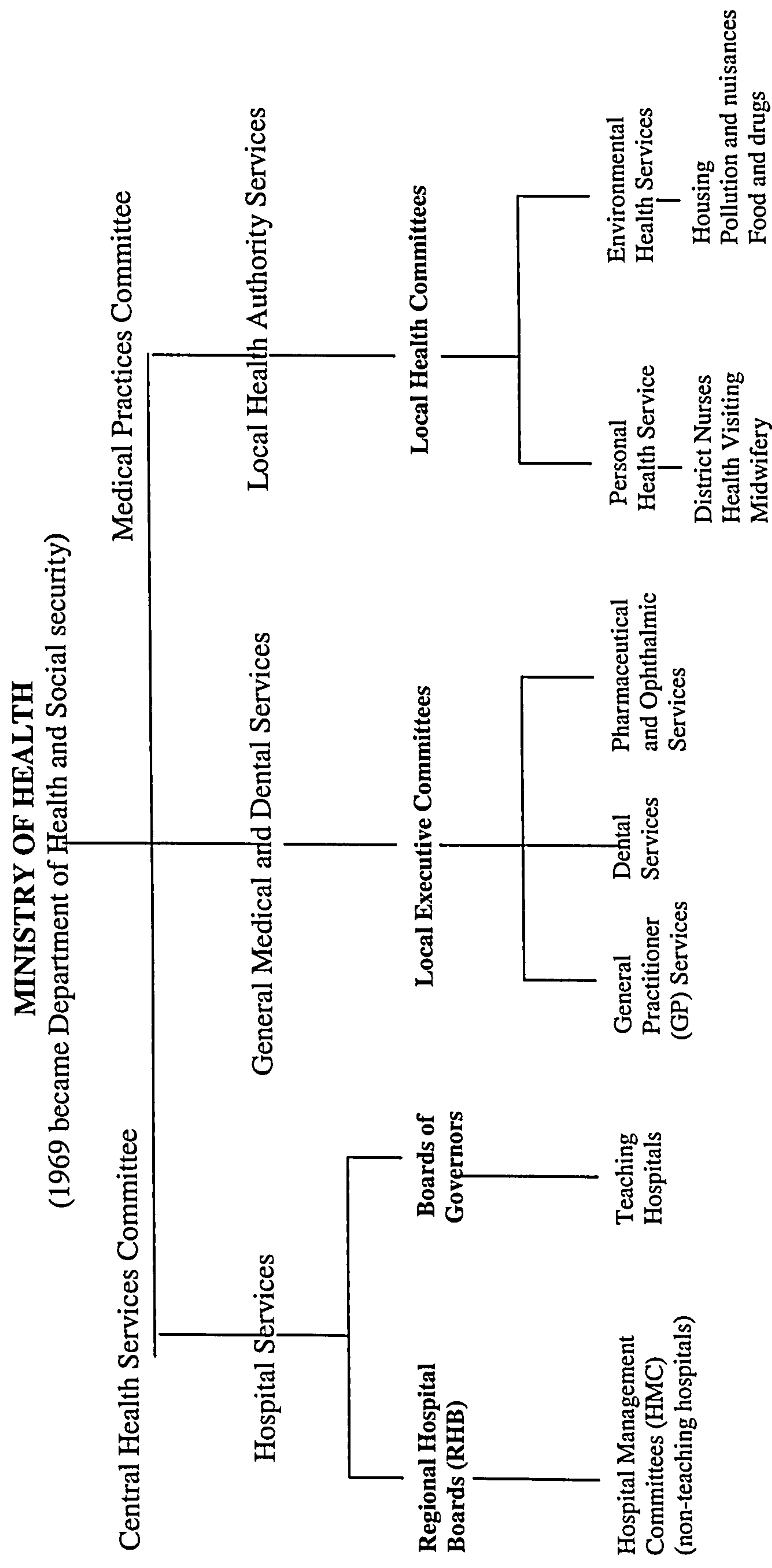
The evidence shows that Beveridge's assumption about the promising situation which existed in Leicester prior to 1948 was understandable but unrealistic, given the unstable employment situation in the country as a whole – an important factor for a health and welfare system that relied on full employment. Furthermore, whilst monetary resources, obtained by effective means, and efficient accounting were crucial for the NHS, the quest for financial solvency often undermined the pursuit of clinical excellence.

The chapter closes at the end of a period of unprecedented structural and functional change in the NHS, throughout which district nurses demonstrated their ability to adjust in new working environments and to respond to the changing health-care needs of society. It was the dawn of a new era for health-care and welfare provision in which hospital and community care would be integrated within a single administration, and the social work disciplines would be combined and administered by a new Social Services Department of the Local Authority. The future of district nursing and its struggle for appropriate, mandatory training also hung in the balance. For Leicester, however, at the conclusion of this research, the future looked bleak.



# APPENDICES

# 1: STRUCTURE OF THE NATIONAL HEALTH SERVICE 1948 -72



Source: Merry, E. J, and Irlen, I. D, *District Nursing* (London 1948), 255 – 6; Baly, M. E, *Nursing and Social Change* (Bath 1980), 196 – 7



**APPENDIX 2: COST OF LOCAL AUTHORITY (LHA) HEALTH AND WELFARE SERVICE (England and Wales)  
YEAR ENDING 31 MARCH 1962 – 71.**

YEARS:	1962-3	62/3	1963-4	63/4	1964-5	64/5	1965-6	65/6	1966-7	66/7	1967-8	67/8	1968-9	68/9	1969-70	69/70	1970-1*
SERVICE:	£	% >	£	%>	£	%>	£	%>	£	%>	£	%>	£	%>	£	%>	£
Home Nursing	9011	10.3	9939	7.0	10635	12.5	11965	6.1	12698	14.0	14491	8.7	15752	5.4	16598	21.2	20130
Health Visiting	5022	13.9	5722	9.2	6247	12.1	7003	7.5	7526	12.9	8497	13.2	9616	6.9	10277	24.1	12759
TOTAL LHA STAFF	85038	9.7	93293	8.9	101640	13.5	115418	9.0	125917	9.5	137947	8.0	149006	8.4	161543	18.9	192019

Source: DHSS Health and Personal Social services Statistics for England and Wales - Cost of Local Authority Health and Welfare Service  
Years ending 31 March 1958-7 and 193-71, (1972), 24.

**APPENDIX 3: MANPOWER SUMMARY – GENERAL PRACTITIONER, HOME NURSING AND HEALTH VISITING  
(Great Britain) 1963 – 71**

YEARS:	1963		1964		1965		1966		1967		1968		1969		1970		1971
SERVICE:	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.
All General Practitioners*	25024	-1.2	24723	-0.4	24620	-2.5	24010	-0.02	24005	0.4	24107	0.5	24239	0.9	24458	0.85	24668
WTE Home Nursing**	8332	4.0	8665	2.6	8892	2.7 +	9146	2.4	9369	3.0	9656	1.8	9828	4.1	10234	5.2	10769
WTE Health Visiting	6064	2.7	6227	2.3	6369	0.9 +	6427	-0.4	6403	1.4	6495	1.6	6602	5.7	6982	4.2	7279
WTE Other general nurses	2186	6.9	2336	14.4	2672	8.4 +	2919	11.0	3229	4.8	3385	6.7	3612	3.4	3736	12.9	4218

Source: DHSS Health and Personal Social services Statistics - Manpower Summary Great Britain Table 111, 26 - 7.

Note: \* includes trainees and assistants.

\*\* there is no mandatory definition of 'Home Nurse' the category could include trained nurses with and without district nurse training

- unlike health visitors whose qualification is mandatory for practice.



#### 4: DISTRICT NURSING COURSES LEICESTER 1949 - 72

YEAR and SIGNIFICANT EVENTS:	TYPE OF COURSE:			
	POST BASIC SRN:	POST BASIC SEN:	SEN INTEGRATED:	PRACTICAL WORK TEACHER:
1949: QNI approved course	Leic: 12: Other 0			
1951	Leic. 9: Other 0			
1952	Leic. 10: Other 3			
1953: LDNA ceased	Leic. 8: Other 6			
1954	Leic. 9: Other 0			
1955: Armer Report	Leic. 6: Other 6			
1956	Leic. 5: Other 6			
1957	Leic. 3: Other 4			
1958	Leic. 4: Other 1			
1959: PADNT established	Leic. 5: Other 4			
1960: Course shortened	Leic. 4: Other 1			
1961: HV course lengthened	Leic. 5: Other 3			
1962	Leic. 5: Other 2			
1963	Leic: 5: Other 7			
1964	Leic. 6: Other 9			
1965: Transfer to Vaughan College	Leic. 7: Other 8			
1966	Leic. 7: Other 8			
1967	Leic. 12: Other 8			
1968: QNI withdrew from training	Leic. 16: Other 6			
1969: PH Nurse Tutor appointed	Leic + others 23			
1970: HV to polytechnic	Leic + others 19	7	12	Leic. 11: Other 14
1971: Group School Project	Leic + others 18	8	8	Leic + others 24
1972: Briggs Report/ NHS reorganization	Leic + others 24	8	8	Leic. 13: Other 13*

##### Notes:

Post-basic SRN Courses 'Other' includes seconding authorities Leicestershire, Northamptonshire, Nottinghamshire, Warwickshire, Derbyshire, Rutland, Cheshire and 'Independent candidates' - self funding.

\* Practical work teacher course included teaching midwives.

Source: ROLLR L614 84/64 Leicester Corporation Health reports, from 1969: An active programme of in-service training for nursing auxiliaries and clinical updating, staff development for all community nurses was introduced.



# SECTION 3

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## CONCLUSIONS AND RECOMMENDATIONS



# 8

## CONCLUSIONS

### 'Belgrave mourns its angel'.

'On behalf of all the people of Belgrave I would be glad if you would give me the opportunity of saying through your column that we have all sustained a loss which is impossible to put into words. I refer to the death of Miss Edith May Kelly, Superintendent in charge of the District Nursing Home in Belgrave. Her job was her life and countless scores of old people and the sick not surprisingly gave her the name of 'Angel'. I have gone to the bedside of a dying person at 2 a.m. and found her already there. Although off duty, she was there again at 8 a.m. She used her own money to buy things needed by the badly off or those incapable of managing their own affairs – she went the extra mile and kept on going. Edith Kelly was a Christian and a jewel in the diadem of her Maker, and the devoted servant of the people of this area.

This tiny tribute is totally inadequate and masks the tremendous gratitude we owe to her.'

Quine, E. K. I, Vicar of Belgrave, 'Belgrave mourns its angel' (1948)<sup>1</sup>

A recurring feature of this research has been the extent to which the district nurse is ingrained in the public mind with affection, esteem and sometimes awe; the public experienced a sense of the district nurse being there with them, sharing their lives, their homes and their community in times of adversity, as illustrated by the Rev Quine's tribute to Edith Kelly. Public imagery of the role of the district nurse is usually associated with the virtues of a calling; competence and reliability in times of need. The little black bag and its mystique are part of this imagery of district nursing; a container of secret powers and instruments of healing, and a badge of credibility which symbolically endorses the conventional links between the district nurse and the general practitioner (GP) in the public consciousness. The confusion that arises between such idealised preconceived ideas, cultural mores, and other conceptualisations of the reality of district nursing has produced a picture of district nursing as medical assistant, saint or servant.

This research clarifies the confusion by confronting the different realities of district nursing; in so doing it has revealed society's shifting and often contradictory attitudes to the service.

<sup>1</sup> Quine, E. K. L, 'Belgrave mourns its angel', *Leicester Mercury* 7 July 1948, 4.



The research, therefore, makes a unique two-fold contribution to the literature. Firstly, it has examined the biographical characteristics and career rhythms of the sub-set of district nurses known as Queen's Nurses (QN), thus providing the first, full picture of the diverse social and professional backgrounds from which QNs were drawn and their career profiles. Although the exclusive nature of the QNI database imposed some limitations on the research, it is argued that generalisation is possible because it has been shown that, in reality, district nursing did not function in watertight compartments. In its role as the sole national voice for district nursing, the QNI had an influence well beyond its formal boundaries, while the transfer of associations in and out of contracts of affiliation and the movement of QNs between affiliated and non-affiliated associations inevitably disseminated the principles of its approach. Secondly, the research has produced additional evidence of the distinctive nature and trajectory of the development of district nursing in provincial urban society through a focus on Leicester, thus broadening the scope of the research and presenting opportunities to explore the situation for district nurses in both non-affiliated and affiliated settings.

The process of analysing the development of a trained district nursing service in Leicester during the period 1866 – 1974 reveals three phases of development. The first phase (1866 – 1908) was the result of the transition from an *ad hoc* system of informal voluntarism and local handy-women to a locally organised response by lay, religious and medical communities in the form of the Institution of Trained Nurses for the Town and County of Leicester (ITNL), in which trained nurses were under the supervision of middle class ladies. The second phase (1909 – 1948) represented the professionalisation of district nursing through the formation of the Leicester District Nursing Association in 1908 and its subsequent affiliation to a system of structured voluntarism within a national network under the professional supervision of the QNI. The final phase (1948 – 1974) resulted from the transition to state control and universal collectivism. The picture is clearly not static, and district nursing cannot be assessed in isolation from other professions and institutions or the influences of internal and external forces.

The central hypothesis of this research argues that, although the work of district nursing was valued by all levels of society, the district nurse's full range of skills and potential for social benefit was not sufficiently recognised, and was even damaged by attitudes within the medical and nursing professions. Throughout the research a complex picture emerges of



continuity, change, subterfuge, conflict and manipulation on the one hand, and achievement, esteem and professional pride on the other.

### **Socially embedded trust:**

It has become clear that, although district nursing was valued by all levels of society, it was valued in different ways and for different reasons by different groups. Firstly, the recipients of district nursing and those closest to them held district nursing in high esteem and valued its contribution to the relief of suffering. It is evident that their trust in the district nurse was such that whilst the district nurse represented an authority figure, patients still felt able to retain their autonomy. District nurses renegotiated the normal boundaries and taboos that protected personal space and relationships between men and women; they were exempted from conventions of entry into the patient's home - the immobile, for instance, provided free access by a key on a string behind the letter box; they were trusted with personal and family secrets; and played a sensitive role in the nursing of terminally ill patients. This study shows that in the late nineteenth to early twentieth centuries district nursing care was often provided in places where other members of the public would not venture; unlike most people, district nurses were willing to work with and be part of what was sometimes irreversible human misery and distress. As environments improved and district nurses benefited from advances in science and technology, they remained at the forefront of home-based care for the sick, the handicapped, and the slowly dying. In spite of contemporary housing developments from the 1950s, many of society's elderly and under-privileged members lived in overcrowded environments and high-rise dwellings; even the better-off, when they were ill or frail, could become isolated and reduced to poverty. As is evident in the Leicester case study, district nurses responded to the trust people placed in them by themselves valuing and respecting the privilege of their role which, in turn, reinforced their commitment to the work they did.

Secondly, in the late nineteenth to mid-twentieth century, within the ethos of voluntarism, social reformers, religious societies, individuals who shared the mission of district nursing, and the business communities clearly regarded the work of the district nurse as very important. Chapters 5 and 6 demonstrate that, although these individuals and groups did not always fully understand the full range of skills and responsibilities of district nursing, they valued the outcomes, which they believed were of benefit to the sick and reduced the length



of absenteeism from work through sickness.<sup>2</sup> In the late nineteenth century it became clear that this group of differently motivated people, through its collective attributes of enthusiasm, altruism, financial and personal commitment, inspired the establishment of the ITNL, attracted public loyalty and support, respected public probity, and made a direct contribution to the local economy, from which the ITNL, in turn, also drew its own strength and stability. The need for a different approach and regulated form of provision in 1909 reflected the influence of nineteenth century professional society and the values of informed practice and accountability. The ITNL enjoyed its autonomy for over 40 years, and for the last 22 of these resisted the opportunity to integrate within the Queen's Nursing Institute's (QNI) national network of affiliation. Personal investment made by the ruling classes and the sense of fulfilment it provided for their wives and daughters may have contributed to this reluctance to change, as Gorsky found in his study of voluntary hospitals.<sup>3</sup> Local politics, personal interest and public esteem militated against the recognition of the growing body of knowledge and expertise in health-care and welfare.<sup>4</sup> It was no longer acceptable, however, for district nurses to be supervised in their work by middle class women whose skills in managing the servants in their own households were no longer appropriate or transferable to the professional setting. As a consequence, the change of name from the ITNL to the LDNA in 1908 and subsequent affiliation to the QNI represented a reappraisal of district nursing provision and reaffirmation by the local community of its worth and professional needs; there was a reaffirmation of socially embedded trust within a continuing culture of voluntarism in partnership with professional society. The true value of the voluntary provision of a district nursing service in Leicester and the enormity of the task undertaken for over 80 years, with minimal contribution from central exchequer funds, became startlingly clear with the transition to the statutory control of the welfare state in 1948. Even though local people still made a contribution to the continuation of a district nursing service indirectly through their rates, the intimate link and sense of trust between the local community and district nursing was diminished.

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<sup>2</sup> Haynes, Joseph Dare Reports, 24 – 5; Leicester District Nursing Association (LDNA), *A History of the LDNA 1867 – 1953* (Leicester 1953); The Wellcome Institute for the History of Medicine (WIHM), Contemporary Medical Archives (CMA), Queen's Nursing Institute (QNI) Collection P. 8/4 Morris S. G, Progress and the Provident Contributory Scheme for District Nursing (London 1930), 1 – 2.

<sup>3</sup> Gorsky, M, 'Voluntary and municipal hospitals: a 'joined-up' approach to British health care before the NHS', University of Leicester Centre for Urban History Seminar paper, 2000; Leicester Records office (LRO), *Leicester Journal*, 'District Nursing Association – Annual Meeting', March 1909.

<sup>4</sup> Niemi, M, 'Health Experts and the politics of knowledge: Britain and Sweden 1900 – 40', University of Leicester Ph. D. thesis (1999).



It is clear throughout the study that a third and influential perception of district nursing was held by the medical and related professional groupings. The GP, working in the community, was closer than any other group to the district nursing service - both attended the sick in their own homes and were almost natural partners. From the mid-nineteenth century, however, although united in a common cause, they were divided by organisational boundaries and in some cases by the hierarchical barriers instilled during hospital training. The research provides an insight into the ambiguity of this relationship that was often resolved by a shared professional commitment and by personal compatibility rather than by statutory intervention. But, as has been seen, this was a hit and miss affair. Throughout the research period it has become clear that the necessity to promote effective relationships between GPs and district nurses was in the best interests of the patient as much as of the professions, and this was addressed from the beginning of the twentieth century by the representation of GPs on the local district nursing committee, (see Chapter 6, Appendix 1) although half a century passed before reciprocal arrangements were made.

### **Institutionally constructed trust:**

In 1948, the relationship was institutionalised within the concept of the welfare state by the introduction of the NHS, but its tripartite administration did little to improve and in some ways caused further disintegration to the conventional way of working. The research highlights the way in which Leicester restructured the working relationship between district nurses and GPs in 1960 by the introduction of attachment schemes, endorsed by government policy. District nurses were removed from their geographical areas and attached to the non-circumscribed catchment areas of general practice, thus changing the ethos of district nursing from the home to the surgery and from a specific district to an amorphous community. This deflected the professional skills of the district nurse to a new cohort of patients – the walking wounded – and to hospital-like technical routines which compromised the care of the housebound and therefore the basic principles of district nursing. Encouragement at national level to pursue this policy can be seen as an attempt by government to appease the political unrest amongst GPs in the 1960s by exploiting the vulnerability of the district nursing service to become a form of general practice nursing, without considering the spin-off for other groups of patients or the misuse of highly-prized district nursing expertise.



Hospital doctors and nurses, separated from district nursing by organisational constraints which are indicated throughout the study, frequently expressed ignorance of the skills and knowledge base of district nurses and the nuances of their practice, with the result that their skills were under-used.<sup>5</sup> Paradoxically, in spite of this expressed ignorance, doctors showed a desire to control the practice of district nursing for fear of erosion of their medical role, and displayed intolerance of what they felt to be the inappropriate use of trained nurses to work with the elderly and chronically sick as district nurses. By the late 1960s, however, concern for both patient welfare and the problems of unnecessary bed occupancy in hospital brought district nursing to the fore, and highlighted the important role which could be played by district nurses in liaising between home and hospital.

After the NHS reconstruction of health-care services in 1948, district nursing formed part of a trio of community-based 'nursing' professions, which included midwifery and health visiting and from which other divisions evolved. The research highlights the uneasy relationship which existed between these groups, but also reveals the significance of their common attributes and the joint contribution which they made in shaping the visible and invisible contours of a community, particularly in the empowerment of women and health-care systems; they shared a common characteristic of being women and working on, and frequently overlapping, the boundaries of the male preserves of medicine and environmental engineering. Culturally, they each emerged from a similar nineteenth century background of voluntary enterprise and independent practice, but professionally, whilst they each possessed a different professional pedigree, a thread of generic features was common to all three. Professionally, in the second half of the nineteenth century, while district nursing consolidated its nursing expertise, the lay health visiting service developed its preventive role under the auspices of the public health service, and in 1919 a nursing qualification became a prerequisite for practice as an HV. The case of midwifery, rooted in the Anglo-Saxon translation 'helping woman', continued as an independent practice based on skills transmitted from generation to generation until legislation in 1902 made training and registration compulsory and in 1936 it consolidated its identity within the public health department. The shared characteristics, however, produced a common commitment to health promotion, empowerment and accountability, and gradually, as their pedigree adapted to the changing health needs of society, a stronger clinical and professional focus evolved, which not only

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<sup>5</sup> Hockey, L, *Co-operation in Patient Care* (London 1972).



enhanced the potential of the different roles but created opportunities for more collaborative educational enterprises and ways of working. There is convincing evidence from which to argue that, in Leicester, these opportunities passed almost unrecognised. Whilst the NHS brought the trio together within the same organisational structure under the umbrella of public health, they were uneasy bedfellows and conflict of interest militated against a truly effective partnership in care.

Tensions were shown to flow like an undercurrent both at the level of fieldwork and in management. There is evidence to suggest that, whilst the de-centralising of large functional units in the late 1960s brought HVs and district nurses in closer working proximity, it did little to change the restrictive practices that operated at field level. The research shows that separatist attitudes had always prevailed upon both groups to varying degrees, often due to a lack of flexibility at management level, with the result that highly skilled resources were misused, and staff transferred between district nursing and HV (and social work), or left the service altogether. Conflicting perceptions were also shown to have existed between the professions; for example, GPs and some hospital consultants did not always see the role of the HV and district nurse in such absolute terms. As has been shown, the Medical Officer of Health (MOH), in the late 1940s, saw prevention, care and after-care provision within the NHS as breaking new ground for the HV and suggested that she be called a 'domiciliary nurse adviser to the GP', thus ignoring the potential of the district nurse; whilst in 1962, he advocated the integration of district nurse and HV courses.<sup>6</sup> Likewise, GPs working with attached district nurses and HVs in the 1960s regarded flexible role boundaries as more cost-effective and sensible. In such situations, it could be argued that the role and full potential of both the district nurse and HV were undervalued.

Lastly, the research suggests that the government and civil service exercised considerable control over the agenda for change, and that this led to significant consequences for all medically based professions, but in particular for district nursing. Doctors had their own powerful political machinery to off-set or minimise the effects of the government's activities, and, because of the interest of hospital doctors in maintaining an effective nursing force, the wider profession of nursing was to some extent protected. District nursing, however, was

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<sup>6</sup> ROLLR 614 84/64 LCHR (1962), the MOH advocated more publicity about the work of the district nurse and the integration of district nurse and HV training.



hampered by three factors. Firstly, the image of district nursing arguably stemmed from the symbolic mantle of social and physical impoverishment it shared with the people it served, particularly at a time when health-care was segregated according to social class – it was also a practical activity with misleading associations with blue collar work. Secondly, it was a minority group within a wider nursing profession and one that was sidelined by its voluntary culture and by the isolation of its practice from the traditional sphere of the hospital. In spite of the kudos of the QNI, its association with the establishment was probably irksome to left wing politics. Thirdly, district nursing was divided within itself with one faction closely associated with the establishment through affiliation to the QNI and the other operating independently. The position of the QNI and its association with the establishment to some extent safeguarded the erosion of its powers by the government and the civil service. The status of the QNI's non-enforceable standards, however, was arguably the Achilles' heel of district nursing: local district nursing associations (DNAs) were not compelled to affiliate with the QNI; there was no statutory definition of the title 'district nurse'; the profession was in a continual state of flux as DNAs moved in and out of affiliation. It is interesting to note that at no time during the period was a 100% level of affiliation achieved. Divisions are often healthy: they can stimulate growth and the refinement of ideals and practices; in district nursing, however, although conflict was often a healthy part of the relationship between the QNI and DNAs, politics and personalities often got in the way, and the non-affiliated DNAs failed to offer an alternative conceptual basis for the professionalisation of district nursing. District nursing had become a controversial issue, particularly after the Second World War when the quest for greater autonomy and self-expression emerged, with some local authorities and DNA resenting the intrusive and expensive policies of the QNI, and others just as vehemently supporting affiliation.

The findings of the research suggest that the government and civil service capitalised on the weakness and general instability within district nursing. Firstly, the NHS Act (1946) introduced a new definition of district nursing in the form of 'Home Nursing', and by so doing created confusion and appeared to re-invent district nursing. The Government failed to endorse the QNI's established definition of a district nurse by statute or to justify the intended change, with the result that the district nursing service was open to abuse and misinterpretation - and none more so than in the identification of its training needs and conditions of service. This lack of commitment by government to establish a coherent



professional identity for district nursing, particularly when compared with the attention given to health visiting whose professional role was re-affirmed by statute in the NHS Act (1946), opened the way to continue the abuse of the role of the district nurse by the indiscriminate employment of lesser trained staff and by new working practices. It has been shown that subsequent government advice and directives failed to redeem the position; in fact, the increasing demands on district nursing without extra funding only served to aggravate the situation.

Secondly, the transfer of district nursing to the local health authority (LHA) in 1948 is shown to have had a very serious effect on nurse superintendents, as managers of the service. The LHA covered a wide range of services and did not allow for the kind of involvement in decision-making which the superintendents were accustomed to. As a consequence, district nurse managers were without a voice to sustain the position of district nursing. This undervaluing of the importance of district nursing had potentially serious implications, which demonstrate the effect of conflict between political, professional and ideological aims and the hindrance to meaningful change and best practice in the use of skilled resources in several ways. For instance, from the 1950s district nursing was caught between the competing financial priorities of capital building projects, such as health centres, and home-based personal health care, while repeated re-organisation and change created more and more uncertainty. One of the effects was the determining of establishments on the cheapest rather than the best buy principle. In Leicester, in the 1960s, this resulted in an average establishment of two-thirds state registered nurses – with no distinction between those without a district nursing qualification.

Thirdly, the research findings suggest that the government and the civil service, like many of the professional colleagues of district nurses, had a limited understanding and appreciation of district nursing because of two main factors. The first was the rise of professional society in the nineteenth century and the intense desire of doctors to own and control specific spheres of practice, which led to hierarchies of specialities and discriminatory practices. The twentieth century inherited a professional ideology of separatism and reductionism that quickly influenced nursing. It was a climate that gave little kudos to generalism and yet district nursing by its very nature in caring for the sick, handicapped and dying in their own homes, irrespective of age, diagnosis, or type of intervention, developed generalist expertise. The



QNI could perhaps have been seen as politically shrewd rather than inept by developing the speciality of district nursing as a generalist one, and thereby preventing the funnelling of its unique orientation into a narrow clinical-social domain. The study shows that specialities have appeared and disappeared; roles have been complemented and eroded in the interests of best practice or political leverage; for example, the creation of the geriatric speciality in the 1960s, and the erosion of the health visiting role in the 1970s as the result of developments in social work. The generalist nature of district nursing, however, undoubtedly affected its image.

The second factor was the lack of recognition of the outcomes of district nursing, mainly because the criteria that needed to be applied were different from those of the hospital setting. As can be seen, cure was not the main outcome of care for district nursing, because the elderly and slowly dying were its main patient group. District nursing achievements were clearly not dramatic in the same way as those associated with the hospital and therefore needed to be measured by a different yardstick that assessed the quality of life for the chronically ill, the peacefulness of the death, the counselling provided to the bereaved, and the integration of appropriate agencies to achieve these ends in the seclusion of the patient's home. It was clear from research findings that government and the local health authorities failed to appreciate the process and contribution of district nursing. The clearest evidence of this was the level of salary offered to the district nurse compared, say, with that of the health visitor and the midwife. Further evidence can be found in the decisions from the 1950s about skill mix and the employment of lesser qualified staff based on an industrial rather than a professional model where 'bathing' became almost the only criterion for delegation.

Finally, in 1955, following the Armer Report, the government made swingeing changes that undermined the whole ethos of district nursing by minimising training requirements and relegating the QNI to a role subordinate to a quango, the PADNT. In this way the government effectively took over control of district nursing while other branches of nursing and medicine were still answerable to their professional bodies, and for health visiting a statutory body was specially created in 1962.



### **Resilience, Re-assessment, and re-adjustment:**

The research has shown that district nursing demonstrated remarkable powers of adjustment and self-reinvention in response to changing circumstances and needs, throughout which the past retained its ideological authority while not providing an operational blue-print for the future. The standard set by the QNI, however, was often difficult for affiliated DNAs to achieve for several reasons: the difficulties of recruiting trained nurses from a limited pool of resources; the cost implications of employing highly skilled staff in the face of over-stretched budgets; and pre-1948, the arduous duty of fund raising and 'penny-pinching' to augment voluntary funding. This study and other sources show the extent to which QNI policy was not upheld, as district nursing appointments were filled by staff who were not specifically trained as district nurses and, in some cases, did not even hold a nursing qualification.

The adjustments made by district nursing not only reflect its inventiveness but also its remarkable resilience in the face of changing health needs, rising expectations, a developing scientific and professional community, fluctuations in the economy, the continually shifting contours of population and lack of appreciation shown by those in power. It has been seen that the three stages of transition in district nursing in Leicester each represented significant milestones and included phases of rise and decline, but the outcomes identified by the research were phenomenal and make an impressive contribution to the social policy and the social history of health-care in Britain. The service grew from an establishment of 4 trained nurses in 1866, to 12 by 1909, 45 in 1948 and 67 in 1970 of whom a substantial number were claimed to be QNs. A revolutionary funding mechanism was introduced in 1930 known as the Leicester Provident Contributory Scheme (PCS), and the capital assets realised on hand-over to the NHS supported a substantial aid and sickness fund for the nurses and sick poor of Leicester. Following the introduction of the NHS, and in the face of discriminatory policies, the service flourished and responded to a plethora of political, socio-economic, environmental and scientific changes. The contribution of district nursing to the health of the community, and therefore to the local economy, in peacetime and through two world wars, demonstrated an aptitude to engage with change and innovation. The final transition from voluntarism to state control, which resulted from the passing of the National Health Services Act (NHS) in 1946 and its subsequent implementation in 1948, produced major ideological, organisational and professional changes for district nursing.



Further resilience was shown when the system of skill mix was imposed; district nursing reacted by creating district nurse practice teams and by expanding the traditional clinical management role of the trained district nurse to accommodate a new dimension as leader of the team. It is also shown that, in sharp contrast to some GP attachment experiences, the revolutionary changes brought about in the care of the elderly sick, frail and handicapped in Leicester in the late 1960s – early 1970s had significant and positive input by district nursing. The positive effects of easier access to expert care for long-term, elderly patients and their relatives, whose needs were largely hidden from society and who constituted a low priority for GPs, given their commitment to surgery-based nursing, strengthened the position of district nursing. Geriatric medicine, with its focus on rehabilitation and patient empowerment, was far-reaching and had the potential to integrate the basic principles of district nursing whilst re-conceptualising its role and function. As district nurses responded to the challenge, they engaged in a new relationship with the hospital and allied professions, which had implications for best practice across all sections of the community.

The QNI gave women a special place and unique opportunities in the world of work, in which they were independent, informed, socially, and geographically mobile. One of the most surprising findings in the research was the freedom experienced by QNs and the extent to which they moved around the country and other parts of the world. The QNI also gave status to women's work, and prestige and a progressive career structure to district nurses; they were well educated, and many were also trained as midwives, HVs and tutors; a large number too had extensive experience in clinical and managerial posts at home and abroad. QNs were of a higher social class than most other working women, and, in addition to their nursing experience, some had held senior posts in a variety of other occupations. It is likely that the abilities and expertise which recruits had developed from other work situations masked the true training needs of district nurses.

District nursing was an empowering force for women. Through health education in the home, support for women carers and skilled nursing care for women who were sick or handicapped, the district nurse promoted the role of women and empowered their position within the local community and society in general. It also offered an opportunity for women to enter a profession. On the other hand, district nursing faced challenges in the late 1940s when married women were allowed to practise as district nurses. In a sense, marriage



disempowered women in the profession by imposing restrictions on geographical movement and career development. Analysis of the QNI database shows that after the 1950s district nurses were more likely to develop their careers through engaging in clinical specialities and less by upward mobility through management. Married women with children also had to adjust to the conflict of competing priorities and divided loyalties; evidence from the QNI database suggests that they did this by delaying their career development until the children became more independent. It is further surprising that historians failed to recognise the importance of these developments, firstly of district nursing in relation to the wider profession of nursing where there is an over emphasis on hospital and military nursing, and secondly the significance of district nursing in relation to the history of women's work.

As can be seen, at the same time as adjustments were made by district nurses to accommodate married women, the profession was opened to men. Male district nurses always constituted a small minority of the total district nursing population, with the majority entering nursing as a second career, unlike their female counterparts. The first male QN in Leicester was appointed in 1948, and, by 1959, seven were in post. In the 1940s men were required to take a longer course and were supervised more closely and for longer than women, and career opportunities in district nursing were few because of the exclusion of men from midwifery and HV training. Men had to re-invent the role of the district nurse to counter negative discrimination and prejudice, and to enable their full potential to be used for the benefit of patient care. The adjustment was complete by the 1970s when attitudes and practice were changing and male district nurses could be deployed, like their female counterparts, in all but the most sensitive situations. Indeed, by the 1970s, four of the nine lower, middle and senior management posts were held by men.

Looking at the evidence presented in this thesis, it is clear that the central hypothesis has been largely proved; it has been shown that, whilst the work of district nursing was valued by all levels of society in different ways and to different degrees, the district nurse's full range of skills and potential for social benefit was not fully recognised, and was even damaged by attitudes within the medical and nursing professions. In addition, however, it has become evident that the Government aggravated the situation by ignoring what had already been achieved in the field of district nursing when it established the NHS and then changed the training requirements in line with the Armer Report. In the aftermath, the QNI rallied to build



up a body of scholarly research and development as a means by which the position of district nursing, and the confidence of society as whole, could be restored. This is the picture presented by the research as district nursing entered the 1970s and faced three critical phases of transition: re-organisation within an integrated health service; the creation of a separate Social Services Department; and the recommendations of the Royal Commission on Nursing, in which district nursing was acknowledged as a specialist branch of nursing with specific training needs.

Hobsbawn believed that what each generation brings is more important than what has gone before,<sup>7</sup> but the past has undoubtedly cast long shadows on the development of district nursing, which are gradually clearing through the imaginative and unfettered contribution of each new generation. This is illustrated by Kelly and her co-authors in their appraisal of district nursing, which, although beyond the time boundaries of this research, is still clearly relevant:

‘The traditional elements of district nursing illustrate a breadth of role and function for the district nurse; they incorporate relatively complex, sophisticated assessment and evaluation skills as well as seemingly simple practical skills and tasks. The precise nature of the district nurse’s role is, however, currently subject to a number of forces including professional, social and political pressures which do not necessarily result in complimentary effects regarding professional status.’<sup>8</sup>

### **Implications for social policy and further research:**

First and foremost there is a need for further investigation into the reasons for the government and the civil service allowing district nursing to be downgraded professionally, politically, educationally, and at the interface of care. It is possible to speculate that the government feared the potential strength of a unified and highly trained district nursing force, bringing with it the support of social reformers and other people of influence; or that its actions may simply have been an expedient response to identified need which resulted from a lack of appropriate investigation. Further research would perhaps establish whether there is any evidence to support these ideas.

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<sup>7</sup> Hobsbawn, E, *On History* (London 1960), 89.

<sup>8</sup> Kelly, A. Mabbett, G and Thome, R. ‘Professions and Community Nursing’ in Symonds, A and Kelly, A, eds. *The Social Construction of Community Care* (London 1998), 157 – 175.



Secondly, further examination of the situation in Leicester would be useful to explore a number of issues: firstly, to assess service planning strategies and the priority given to district nursing, with particular emphasis on the validity of approaches adopted to assess skill mix and division of labour; secondly, to investigate how Leicester coped with the challenges facing them at the end of this research.

Thirdly, the QNI database provides further scope for analysis. There are several areas worthy of study; firstly, the relationship between education, social class, experience and achievements in district nursing as a way of informing manpower planning and education strategies; secondly, the height and weight measurements of QNs, which could form the basis for a health survey to assess changes in the body-mass index between yesterday's and today's district trained nurses, and perhaps provide an indicator of social change generally; and thirdly, the contents of the annual reports produced by the QNI inspectors for each QN, which would offer an insight into the attitudes of the Inspectors themselves, and the standards demanded by the QNI.

Finally, this study has highlighted both the importance of district nursing in the history of women's work, and also the need for further studies that investigate the wartime periods as a counter balance to historians' tendency to focus on military nursing service.



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Deakin, S, M, retired QN, Practical Work Instructor/Senior QN Leicester

Fraser, E. C, retired QN, midwife and HV. QN Superintendent Leicester and Senior Nursing Officer Carlisle

Hughes, B, retired QN, district nurse tutor Leicester

Hutchinson, D, retired QN/midwife Leicestershire and district nurse tutor Leicester

Jones, Margaret, retired QN, Nursing Officer Leicester

Pointon, G, retired Leicester QN, Senior Night Nurse.

Rimmington, W, retired Nursing Auxiliary.

Smiles, retired QN Leicestershire, district nurse tutor, Leicester and Coventry,

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Cawthorn, M. retired Leicester Health Visitor.

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## FICTIONAL CHARACTERISATION OF DISTRICT NURSING including:

- Feldman, M, 'District nurse Hargreaves', a popular sang of the 1970s
- BBC series, 'The District Nurse', characterising a QN with some accoutrements loaned from D. Cuthbert (see 'The Cuthbert Collection – district nursing', ROLLR DE 5505)