

# Lancashire and South Cumbria New Hospitals Programme: once in a generation or generation gap?

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## ABSTRACT

The Lancashire and South Cumbria New Hospitals Programme (NHP) contends that the region has a 'once in a generation opportunity' to transform hospitals for 1.8 million local people by 2030. The NHP is the central pillar of a regional strategy developed by Lancashire and South Cumbria Health and Care Partnership (HCP), one of 42 Integrated Care Systems (ICS) constituted by the Conservative Government's National Health Service (NHS) reform outlined in *Integration and Innovation* as the building block of services. The strategy envisions organising services as a 'network' comprising existing hospital sites and services as spokes which centre around a new world-leading hospital hub. However, rather than being 'once in a generation', this model mirrors exactly the intentions of the original architects of the NHS. The NHP is, in fact, a generation gap. The 2030 vision is the realisation of the model which planners conceived in 1948. This paper shows how the original 1948 model emerged and how, ultimately, it was rejected. The rejection was not due to clinical or service failings in the model, but to the rivalries and jealousies of hospitals, services, and universities. This history has several lessons for current health services leaders and the NHP.

## INTRODUCTION

The Lancashire and South Cumbria New Hospitals Programme (NHP) contends that the region has a 'once in a generation opportunity' to transform hospitals for 1.8 million local people by 2030.<sup>1</sup> The NHP is the central pillar of a regional strategy developed by Lancashire and South Cumbria Health and Care Partnership (HCP), one of 42 Integrated Care Systems (ICS) constituted by the Conservative Government's National Health Service (NHS) reform outlined in the *Integration and Innovation* White Paper as the building block of services.<sup>2</sup> Geographically, the ICS amalgamates seven Clinical Commissioning Group (CCG) footprints: Morecambe Bay; Chorley and South Ribble; Greater Preston; East Lancashire; Blackpool, Fylde and Wyre; Blackburn with Darwen; and West Lancashire. In terms of providers, the ICS encompasses seven trusts: Blackpool Teaching Hospitals NHS Foundation Trust (FT); East Lancashire Hospitals NHS Trust; Lancashire and South Cumbria NHS FT; University Hospitals of Morecambe Bay NHS FT; Southport and Ormskirk NHS Trust; the North West Ambulance Service NHS Trust; and Lancashire Teaching Hospitals NHS FT.

The strategy envisioned by the NHP sees services being reorganised as a 'network' which combines existing facilities with a new hospital which is intended to be an international centre of clinical excellence. This is effectively a hub-and-spoke approach within the regional territory: the hub of the new hospital at the heart of the

strategy and region at Garstang, and the spokes of existing health services and hospitals in peripheral sites. However, rather than being 'once in a generation', this model mirrors *exactly* the intentions of the original architects of the NHS during the 1940s. Rather than symbolising a bold new modern vision, the NHP is a return to the past. The NHP in fact represents a generation gap. The vision for 2030 is the realisation of the model which planners conceived at the very foundation of the NHS in 1948: a regional territorial blueprint exactly the same, except for West Lancashire, centred on a hub of clinical excellence and teaching in Preston which connects with hospitals in the towns and cities of Westmorland and Lancashire.

This paper shows how the original 1948 model emerged and how, ultimately, it was rejected. Lancashire and Westmorland hospitals were subsumed within a much larger region which incorporated the cotton towns of Greater Manchester, and whose centre of excellence was the University of Manchester Medical School. The rejection of the original model was not due to clinical or service considerations; it was due to the rivalries and jealousies of former private and public hospitals, the division of primary and secondary services, and universities and their medical schools. The aspirations of Lancashire and Westmorland became embroiled in a power struggle between Liverpool and Manchester umpired by the Ministry of Health. Drawing on archives from the Ministry of Health, the Universities of Liverpool and Manchester, this paper explores the history of health service organisation for the region which offers lessons for current health services leaders and the NHP.

## NATIONALISING HEALTH SERVICES

Welsh firebrand and the Labour Government's Minister of Health Nye Bevan was singularly significant in turning the idea of a National Health Service into a reality by 1948. His pragmatism, canny negotiations and commitment succeeded where previous attempts at reforming health services had failed.<sup>3</sup> One of his key decisions was to nationalise hospitals and take them out of the hands of both the private and public sectors. This left general practice and community services as separately organised in what constituted a tripartite division within the NHS. In many ways a National Hospital Service rather than National Health Service better described this outcome.

Prior to the NHS there was a 'mixed economy' of hospital services provided by the public and private sectors. Private voluntary hospitals offered acute secondary and tertiary services and were staffed by unpaid honorary consultants whose income was derived from private practice. They were financed by philanthropic bequests, public donations, and subscriptions by labour unions with decisions to admit patients decided at the largesse of the benefactors who ran them.<sup>4</sup> In large cities some voluntary

hospitals were also teaching hospitals and aligned with university medical schools where honorary consultants also held academic appointments.

Public hospitals were run by local authority public health departments and funded through local rates. They were largely relabelled workhouses and welfare institutions providing degrees of care rather than what are recognisable medical services, although many were modernised following the 1929 Local Government Act and began to employ clinicians.<sup>5</sup> There was not much love lost between the two sectors. Competition minimised planning and the integration of services despite successive attempts to encourage regional planning on a cooperative basis before 1939 by the Ministry of Health.<sup>6</sup> Accordingly health services remained incredibly localised, parochial, varied, and uneven.

Bevan's decision to nationalise hospital services was an attempt to transcend these historical tensions which had hindered earlier efforts at reform. The organising principle of combining hospital services within a tripartite NHS was that of hierarchical regionalism: territorial units centred on medical schools as centres of excellence which could educate clinicians, rationally plan and organise services at different scales, and disseminate modern medical advances.<sup>7</sup> The 1944 Goodenough report on medical education imagined 1000 bed teaching units as the beating heart of this new system, although the relationship of these units to the meeting the health needs of the population was subservient to the priorities of medical education.<sup>8</sup> Teaching requirements and their administration remained distinct from the provision of clinical health services.

Despite this neat teleology, hierarchical regionalism represented at best a compromise between conflicting vested interests simply to secure agreement for the creation of the NHS.<sup>9</sup> In practice regional administration – as the building block of unifying hospital services – was bifurcated between Regional Hospital Boards (RHBs) and Boards of Governors (BoGs). RHBs oversaw the activities of Hospital Management Committees (HMCs): organisational entities responsible for clusters of newly nationalised hospitals within areas which provided, for the first time, a full suite of hospital services to the local population free at the point of use. BoGs were separate from RHBs and were responsible only for running teaching hospitals in the interests of medical education, not serving the local population.

Charles Webster, in the official history of the NHS, summarises this contradiction neatly:

Paradoxically, although the whole philosophy of regionalisation was based on the idea of the undergraduate teaching hospital as the key hospital of the region, the teaching hospitals ... side-stepped integration in the regional framework, thinking of themselves as *dei ex machina*.<sup>10</sup>

Webster also notes that these teaching hospitals were former voluntaries, meaning this bifurcation effectively nationalised and perpetuated the existing public and private administration of hospitals from before the NHS: 'the elite corps of ex-voluntary hospitals were granted privileged status under the NHS, and they annexed a substantial slice of the first-class hospital accommodation in their regions'.<sup>10</sup> The administrative autonomy of BoGs,

the hubs, was bought at the expense of the spokes: RHBs and HMCs actually providing health services to local people.

Accordingly, despite possessing the political nous to establish the NHS where his predecessors had failed by nationalising hospital services, the compromise Bevan brokered built the organisation of hospital services on hierarchical regionalism which cemented inequalities of organisation, provision, and integration from before the NHS.

## THE HOSPITAL DOMESDAY SURVEY

Whilst securing political agreement for hierarchical regionalism provided a convenient template, putting it in place proved more difficult. Medical schools were disproportionately concentrated in London which required a separate solution. By 1948 in the provinces of England there were only nine university medical schools in contrast to four in Scotland and one in Wales. The location of these meant creating regional units was fraught with contention. Bevan was far more detached from this process, entrusting it to senior civil servants in the Ministry of Health. Here, the devil was very much in the detail in giving substance to what – and where – the NHS would be.

Fortunately, the Ministry of Health had such information on hand. The depth of detail needed to underpin these crucial decisions was provided by a series of major surveys undertaken in partnership with the Nuffield Provincial Hospitals Trust (NPHT) during the Second World War. Services had already undergone some tacit nationalisation and regionalisation under the auspices of the Emergency Medical Services (EMS) put in place to manage casualties with the bombing of cities, but this was more by accident than design.<sup>10</sup> The demands for money the EMS generated also placed more information about hospitals in the hands of the Ministry. However, the Hospital Surveys enumerated every single hospital in the country. Historian Harry Eckstein notes that 'not a bed escaped the researchers' attention'.<sup>12</sup> Such was the sense of foreboding among the health sector that the surveys became known as the 'Domesday Book' which NPHT kept for the subtitle of the collated report.<sup>13</sup>

From 1942 to 1944 when the Hospital Surveys were being conducted it was clear that change was imminent, although the compromise forged by Bevan to secure the NHS in 1946 had not yet been reached. This was in the minds of the surveyors. When it came to the North West, the preliminary report of an informal tour of the Hospital Survey in 1942 noted that their role was not just detailed enumeration of beds and hospitals, but 'boundaries and spheres of influence'. Given the implicit notion of hierarchical regionalism which prevailed, it was clear that partition was about balancing the interests of Manchester and Liverpool. This was evident to contemporaries. The Vice Chancellor of the University of Manchester and the Clerk of Manchester City Council were aggrieved to discover that all the other hospital leaders of Lancashire met without them prior to the informal Hospital Survey tour to agree a common policy. Health service leaders in Lancashire held the secret meeting 'due to the feeling ... that Manchester and Liverpool were trying to run



this show and divide the Region between them'.<sup>14</sup> For the surveyors, however, there remained but two problems in how the spoils should be shared: North Wales and crucially, 'the Preston case'.<sup>15</sup>

The surveyors assessed 'the Preston case' closely. Manchester was clearly favourable with close social, economic, and communication ties to Preston – which, for the surveyors, encompassed all the towns and hinterland of North Lancashire and Westmorland including Barrow, Kendal, Lancaster, Blackpool, Blackburn, Burnley and Preston. Liverpool was more ambivalent. Although specialist cases were referred to the city's hospitals – a point made clear in subsequent efforts to include Preston within the Liverpool region<sup>16,17</sup> – they were sent to Manchester and Leeds in equal numbers. Neither was favoured. None of the hospitals from the towns of 'the Preston case' in question had close medical connections to either Manchester or Liverpool. The bulk of the honorary consultants were from Scottish Medical Schools, and they were wary of the prospect of a tacit takeover by consultants who would regard their hospitals as their territory. Efforts to foster support for a local teaching hospital – the only means of securing regional independence – during this period stalled owing mainly to historic hospital rivalries. North Wales was less vexing. Nationalism dominated despite the close medical connections with Liverpool.<sup>15</sup>

## THE RACE FOR PLACE

It is not unsurprising, therefore, that when the Ministry were looking to delineate regions from 1946–48 that they leaned heavily on the Hospital Surveys for direction: both as documents but also the views of the surveyors. Their final report contained extensive short- and long-term recommendations for each of the enumerated hospital districts but averred from the weighty issue of spheres of influence. It was only on the question of including Cumberland with Newcastle that there was clear direction.<sup>18</sup> Even the Ministry of Health showed an unwillingness to commit. The first NHS White Paper in 1944 suggested having between 16 and 20 regional councils. This was reduced to 14 in discussions between John Pater, a senior Ministry civil servant and the *eminence grise* of the creation of the NHS, and senior medical figures across the country. By late 1946 when the Ministry engaged in consultation the situation was far from resolved.<sup>19</sup>

Senior health sector leaders within Lancashire and Westmorland acted quickly and decisively, laying aside factionalism which had undermined previous efforts. At a meeting of all the local authority hospital figures in December 1946 there was 'unanimous' backing that districts one to six – that is, the areas comprising 'the Preston case' – from the Hospital Survey should constitute an autonomous region given the size of the population and number of hospitals.<sup>20</sup> A parallel, but separate, meeting of voluntary hospitals came to an identical conclusion.<sup>21</sup> The most vocal proponent was, however, the Vice Chancellor of the University of Liverpool. He was dissatisfied at being given such a small territory; particularly the loss of North Wales for which Liverpool, in medical terms, had always been its capital.<sup>22</sup> Welsh domestic politics rather than Bevan was the determinant.<sup>23</sup> With the loss of territory also went the status of the University of Liverpool Medical School and the consultant sphere of influence.<sup>24</sup> Liverpool's loss was

also Manchester's gain, being given a population of 4.399m compared with their own 1.822m.<sup>19</sup> As they originally feared, 'the Preston case' was not being considered in its own right, but as the solution to the Liverpool question.

Despite this, the very first circular from the Ministry to RHBs on 27 June 1947, which outlined the powers and authorities of each NHS organisation, made it clear that there remained five areas which because of their status or remoteness from their university centre required special attention and separate governance arrangements outside RHBs: Cumberland and North Westmorland; Hampshire, Dorset, and the Isle of Wight; Devon and Cornwall; North Wales; and North Lancashire and South Westmorland.<sup>25</sup> Soon, each in turn obtained a special Advisory Committee with varying degrees of representation from competing interests and associated powers. Indeed, Hampshire would go on to provide the nucleus of Wessex RHB created from South West Metropolitan RHB in 1959 and later the establishment of the University of Southampton Medical School in 1971.<sup>26</sup> North Lancashire and South Westmorland remained a notable exception compared with other areas, each of which acquired a form of special status.

Having failed to obtain independence, regional leaders pressed for an Advisory Committee to provide some autonomy from the interests of Manchester. In early 1948 the voluntary hospital leaders for North Lancashire and South Westmorland submitted a lengthy memorandum to the Ministry denouncing Manchester's failure to consult or consider the matter. The memorandum was supplied with abundant evidence on the strength of the region's hospitals with detail derived from the Hospital Survey, not to mention a unanimous letter of support signed by all the region's hospital consultants that a region the size of Manchester was unwieldy in terms of hierarchical regionalism.<sup>22</sup> The Ministry equivocated. With the NHS due to begin on 5 July 1948 they did not want to fundamentally alter regional boundaries and instead insisted it was a matter for Manchester RHB to decide. This did not bode well. Lord Stopford, the Chairman of Manchester RHB was also the Chairman of its BoG, the Vice Chancellor of the University, having also sat as Vice Chair on the influential 1944 Goodenough Report and secured an appointment to the influential Medical Subcommittee of the University Grants Committee.<sup>27</sup> Despite the promise of the 1947 circular for other governance arrangements which had been established elsewhere, Manchester refused.

John Pater, the Ministry's *eminence grise*, felt that the Vice Chancellor was being 'rather naughty on this point' as his refusal also upset the delicate arrangements across the North West in relation to Liverpool and North Wales. Internal Ministry papers show that as late as March 1948, had North Lancashire and South Westmorland continued to press their case, significant action would reluctantly have been taken.<sup>22</sup> However, the interests of the City and University of Manchester prevailed. The Vice Chancellor even obtained a new personalised Rolls Royce and chauffeur on account of the extent of his NHS responsibilities; a 'harmless brag' according to the official history of the University.<sup>28</sup> Crucially, the primacy of Manchester's medical education interests continued to shape the character of hierarchical regionalism for hospitals until a series of reforms in 1974, 1991, and 2003, subsuming peripheral services in the interests of the centre of excellence.

## CONCLUSION

The NHP is hoping to achieve by 2030 what previous leaders failed to accomplish in 1948: a hub-and-spoke hierarchical regionalism which serves the people of what is now Lancashire and South Cumbria. Their failure in 1948 was not due to the inherent weakness of the model itself but how this translated into the architecture of the NHS; divided between teaching (BoG) and service (RHB) hospitals, contingent upon university medical schools as centres of excellence, and situated within a divided North West.

In the final analysis, leaders planning the NHP would do well to embrace three lessons from this case study. Firstly, that history is inescapable and should be embraced rather than neglected. The legacy of 1948 looms still in shaping the horizons for the future of the NHS, particularly for Lancashire and South Cumbria. Secondly, that the NHS cannot be changed in isolation. It is interconnected with a whole range of public and private stakeholders which are firmly rooted in place and its population. These connections remain as the experience of hospital nationalisation shows. Thirdly, and finally, that planning health services concerns more than providing medical treatment. Modernising medical technologies, careers, and capabilities are shaped through centres of excellence. These create winners and losers in terms of people and places. Recognising these inequalities and the impacts they bring remains a fundamental challenge to organising the NHS.

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