Community and the Voluntary Hospitals in Derbyshire and Nottinghamshire, 1900-1946: Economy, Society, Culture.

Edward Cheetham

A thesis submitted in partial fulfilment of the requirements of Nottingham Trent University for the degree of Doctor of Philosophy

In collaboration with the Midlands 4 Cities Doctoral Training Partnership

September 2020

Copyright Statement

Acknowledgements

Firstly, I would like to thank my supervisor, Nick Hayes, for the constant support and hard work he has put into this thesis with me. Over these last few years, he has become a true friend and confidant.

My wife, Alice, and daughter, Edith, whose love, patience, and fortitude have made this long piece of work possible.

My parents, who have supported me every step of the way, in this, and throughout my life.

My friends and family, too numerous to mention, who have made this difficult undertaking so much more tolerable with their humour and love.

Further to these thanks, I would like to add my sincere gratitude to the workers and archivists of the Derbyshire Record Office, who welcomed me and my research, and aided me in countless ways.

Abstract

This thesis spans the first half of the 20th Century, charting the progress and challenges of the voluntary hospital system in Derbyshire and Nottinghamshire. The voluntary hospitals were the key sites of acute medical care for the working-classes from their foundations in the late 18th Century to their demise after the Second World War. Funded by a mixture of charitable donations, mutualist mass-contribution schemes, and occasional state aid in times of crisis, the voluntary hospitals were otherwise independent from any overarching authority, subject only to the demands of their community. This thesis looks at how the voluntary hospitals operated in the mixed socioeconomic background of two Midland counties with drastic regional variation: geographically, socially, and economically. Home to many voluntary hospitals, ranging from the larger Derbyshire Infirmary and Nottingham General in the county capitals, down to tiny cottage hospitals ensconced in the industrial towns and rolling dales. Fundamentally, the thesis asks the question: to what extent are voluntary hospitals reflections of their community? To answer this, myriad sources from over a dozen different hospitals are drawn upon, addressing matters of finance, civil society, recreation and leisure, charity and philanthropy, leadership, mutualism and self-help, war and crisis. It looks at the large-scale fundraising events organised in the towns, the carnivals and parades, as well as the financial schemes masterminded by the hospitals to cultivate a sense of medical security for the populace, as well as financial security for the hospitals. It looks at each 'era' within its own context, using context at both a national and - more importantly - local level.

Contents

Introduction

Hospital Voluntarism

For two-hundred years, a vast portion of the population looked to the voluntary hospitals as their sites of acute medical care. But now, few know what they were. Their memory has become the discussion of scholars and historians, and while some old voluntary hospital institutions still exist as bricks and mortar, any administrative or infrastructural trace that they were anything other than property of the National Health Service has long since vanished. All that remains is perhaps a few commemorative plaques, maybe a number of dated keystones over the entrances of Victorian premises, or grainy photographs of staff faculties long since passed away. Until 1948, when Aneurin Bevan as Minister of Health founded the NHS, the voluntary hospitals were the forefront of medical care, providing vital services to the sick and injured of the United Kingdom. The voluntary hospitals have slipped beyond living memory, and those still living who may have attended the institutions in their younger days have no knowledge of how differently this system was administered, funded, or organised to the current state-funded system. This thesis focusses on the voluntary hospitals of Derbyshire and Nottinghamshire, from the turn of the century up to the end of the Second World War. It charts the course of a number of local voluntary hospitals, and explores how a provincial network of health provision operated in different environs. Prior to the foundation of the NHS, medical provision was a patchwork of different services. It consisted of three sectors: private, public, and voluntary. The private sector consisted of private nursing homes and practices, run for profit. This was the reserve of those who could afford to pay out of pocket. For the most part, these were small institutions, essentially the reserve of the middle-, upper-middle-, and upper-classes, though sometimes charitably-minded private institutions would offer spaces for poor patients too.[1] As Gorsky, Mohan, & Willis note, the middle classes would not expect to find themselves in a hospital, instead in a private practice nursing home, or treated in their own homes by an attending physician or nurse.[2] The private sector also consisted of GP practices, which were private practices geared towards all members of the general public, the practitioners charging a range of fees for services, and often providing pharmaceutical and minor or emergency surgical services when needed.[3] The 1911 National Health Insurance Act, ushered in under David Lloyd George's Chancellorship, reorganised the GP services in the nation, placing doctors on 'Panels' to treat those working-class patients who paid national insurance, and gave capitation grants to the doctors for the treatment they provided to patients on the panel scheme.[4] In this respect, the private sector was not necessarily the reserve of the rich, but simply where private enterprise met medical demand.

[1] Jonathan Reinarz, *Healthcare in Birmingham. The Birmingham Teaching Hospitals 1779-1939* (The Boydell Press: Woodbridge, 2009) p.16., p.20.
[2] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.19.
[3] S Leff, The Health of the People, (Victor Gollancz Ltd: London, 1950) p.210.
[4] Anne Digby and Nick Bosanquet, 'Doctors and patients in an Era of National Health Insurance and Private Practice, 1913-1938' *The Economic History Review*, 41:1 (1988) p.75., pp.79-82.

The voluntary medical sector is the focus of this thesis. Of the three broad sectors, its definition is a little more nuanced. Up until the turn of the 20th Century, the voluntary sector was solely run, funded, and administered along charitable lines.[5] The traditions of the voluntary hospitals were steeped in charity and philanthropy, stretching back to the monastic tenets of refuge and care for the sick poor.[6] Doctors and surgeons would consult at hospitals on a voluntary basis, and the hospitals themselves were governed by teams of volunteers. Their typical structure by the 20th Century was a Board of Governors, who were benefactors and trustees of the institution, and then a Committee or Board of Management, who were elected to their position and who had month-to-month decision making powers. However, the vast majority of people who worked at the institutions were not 'volunteers'. As well as the salaried junior house doctors and surgeons, and the salaried nurses, there was a cohort of plumbers, stokers, porters, cleaners, cooks, laundresses, mechanics, caretakers, clerks, secretaries, almoners, and many more occupations that helped run the hospitals. In addition, there were also the district nursing associations, run by a small committee of volunteers and a volunteer 'lady superintendent' who supervised the district nurses working in the association. Nursing associations were non-profit, often offering at-home services for elderly people for free, but paid their nurses by charging fees to ordinary sick citizens.[7] At the turn of the century, the voluntary hospitals were funded by a mixture of philanthropic donations, annual subscriptions, as well as legacies and bequests. As we shall see, this was to change significantly as we move into the interwar period.

The public sector, in many ways, dealt with the brunt of what was left over from the voluntary and private sector. If the private and voluntary sector dealt with individual healthcare, the public sector dealt with public health and welfare. Contagious or infectious disease, sanitation, old-age care, mental-health care, as well as long-term convalescence and the chronic sick. By 1900, it was largely defined by two key pieces of legislation in the 19th Century: the 1834 Poor Law Amendment Act, and the 1875 Public Health Act. Encased within these two acts, as well as various other pieces of legislation throughout the decades, were the provision for local governments to provide measures to the public for the treatment and containment of diseases or conditions that posed a risk to public health and were not able to be dealt with in the normal household setting.[8] The sorts of institutions that were run by the various local authorities were tuberculosis sanitoria, smallpox hospitals, isolation/infectious disease hospitals, mental hospitals and homes, homes for the blind, and later, maternity homes.[9] Further, each county, county borough, borough and district council had to appoint a 'legally qualified medical practitioner' as Medical Officers of Health, whose responsibilities ranged from confirming cases of smallpox to ensuring correct sewage piping and inspection of abattoirs.[10] The voluntary hospitals,

[5] F K Prochaska, *Philanthropy and the Hospitals of London* (Clarendon Press: Oxford, 1992). pp.2-5., pp.7-10.
[6] Guy Williams, *The Age of Agony* (Constable: London, 1975) p.89.
[7] Enid Fox, 'District Nursing in England and Wales Before the National Health Service: The Neglected Evidence', Medical History, 38:3 (1994) pp.303-8.; 'Proposed Federation of Notts Nursing Associations', The Nottinghamshire Guardian, 11 April 1896.
[8] Derek Fraser, The Evolution of the British Welfare State (MacMillan Education Ltd: Basingstoke, 1984) pp.48-54., pp.125-6.
[9] Levene, Alysa; Powell, Martin; Stewart, John, 'Patterns of Municipal Health Expenditure in Interwar England and Wales', *Bulletin of the History of Medicine,* 78:3 (2004) p.2., pp.8-11, p.15.
[10] R Ewart Williams, *Practical Information for All* (Odhams Press Limited: London, 1937) p.113.

more concerned with operations and short-term therapeutic treatment, would not admit any kind of infectious disease cases, nor long-term sick, unless they were performing a restorative operation upon that individual.

Also included within this category were the myriad 'services' available under the workhouse Poor Law system, which under the 1929 Local Government Act was changed into the Public Assistance network.[11] The workhouses, though originally intended to provide minimal refuge and care for only the most destitute of the populace, ended up expanding their remit according to local need.[12] Even by the 20th Century, the workhouses were run on an ancient parish system dating back to the original Poor Law enacted by Elizabeth I, amalgamated into 'unions' with the 1834 Poor Law Amendment Act, that were administered by elected volunteers called the Boards of Guardians.[13] It was largely down to the parishes in the union to provide the funds necessary to run the institutions, as such laying the 'burden' of the workhouses right on the doorsteps of local people. However, as time progressed, and the demands of the public and the destitute increased, the workhouses ended up as de-facto old-age care homes, public infirmaries, and convalescent nursing homes. In this capacity they managed the vast majority of 'hospital' beds in Great Britain; if, however, we look only at the provision of general beds, the balance was significantly closer: a ratio of 4:3 before 1914, and roughly equal after 1918 and into the interwar years.[14] Only in a few rare cases did the public sector provide acute medical care.[15] That is to say, provide medical procedures such as surgery, accident and emergency, or physical therapy. However, this became more common after 1929, as with the abolition of the Poor Law meant that the remit of healthcare (that the workhouses were previously providing ad hoc)was transferred to the local authorities officially.

The average citizen of the early 20th Century, finding themselves or their dependents in ill health, had decisions to make. For a non-emergency, they would likely go to their GP, who might offer treatment or refer them to a voluntary hospital, or other specialised institution if the case required it.[16] Prior to 1911 patients visiting their GP might expect to pay roughly 6d. for a consultation and prescription, but after 1911 (if they were paying national insurance) they paid no fees to visit the doctor, the doctor receiving a capitation fee from the state.[17] If the citizen found themselves with something seriously infectious like diphtheria, scarlet fever, or smallpox, they would be compelled to attend and convalesce in an isolation hospital under the administration of the

[11] Levene, Alysa; Powell, Martin; Stewart, John, 'Patterns of Municipal Health Expenditure in Interwar England and Wales', *Bulletin of the History of Medicine*, 78:3 (2004) pp.2-4.
[12] Alysa Levene, Martin Powell, John Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', 50 (2006) p.10., p.14.
[13] Derek Fraser, The Evolution of the British Welfare State (MacMillan Education Ltd: Basingstoke, 1984) pp.32-33.
[14] John V Pickstone, Medicine and Industrial Society (Manchester University Press: Manchester, 1985) pp.210-215.
[15] Becky Taylor, John Stewart, and Martin Powell, 'Central and Local Government and the Provision of Municipal Medicine, 1919-1939', English Historical Review, 122:496 (2007) pp.400-404., pp.407-401., p.426.
[16] R Ewart Williams, *Practical Information for All,* (Oldhams Press Ltd: London, 1939). p.177.
[17] Anne Digby and Nick Bosanquet, 'Doctors and patients in an Era of National Health Insurance and Private Practice, 1913-1938' *The Economic History Review*, 41:1 (1988) pp.74-80.

borough or county council. If they needed at-home care for themselves or a relative, they would apply to the local district nursing association, to whom they would ordinarily pay fees for the care given.[18] If the citizen found themselves in need of an operation or a procedure unable to be done by their local doctor, then they would have to acquire an admission ticket to a voluntary hospital from an annual subscriber, or otherwise hope to be admitted on the fact that they were deemed too poor to pay. They may also find themselves referred to the local workhouse infirmary, depending upon what services that particular Poor Law union offered (some offered little, some offered more) or for a more long-term recovery from their surgical procedure.[19] However, most citizens had a preference to go to their voluntary institution, rather than have the stigma that was attached to using the services of the workhouse. [20] This is why, for respectable working families, increasingly they chose to belong to hospital Saturday funds, and later contributory schemes, where for a small weekly payment access to hospitals could be attained through a recommendation. The differences between these two forms of hospital payment were nuanced. While the Saturday funds were a significant break from the ticketing system of the subscription, there was not a similar level of detachment between the Saturday fund and contributory scheme; both gave similar levels of 'entitlement' to the patient involved. However, Saturday funds were predominantly workplace-organised, meaning that the payments were channelled via occupation. Contributory schemes, conversely, were on an individual basis; a relationship directly between the hospital and the payee, rather than having the intermediary of a workplace (even though many contributory schemes were collected in the same way and in the same place as their predecessor Saturday funds). The barriers to care were whittled down, so that there was, under the contributory scheme, individual entitlement to care, rather than a collective entitlement. However, the hospitals, and their doctors, still had ultimate rights of admission, and just because someone was a member of the scheme did not mean they were entitled to be admitted. Prolonged stays, or admissions by patients who were not via recommendation/fund/scheme, would sometimes find themselves in front of a hospital almoner, who would grill them on their financial situation, and request that they pay what they could afford for the services they received. If the citizen found themselves injured in a serious way, they would be conveyed to their nearest voluntary hospital for treatment (either by ambulance if available, more often by horse and cart, or private car) where they would be admitted immediately for free – no matter their financial situation. As can be gleaned from these brief examples, the medical services of the pre-NHS world could potentially be complicated, disjointed, and inconsistent.

One key question, therefore, is the degree to which this changed through the first half of the twentieth century. It examines, too, the degree to which the voluntary general hospitals of the counties of Derbyshire and Nottinghamshire were reflections of their communities, and to identify the social, economic, and cultural

[18] Pamela Horn, *Victorian Countrywomen* (Basil Blackwell Ltd: Oxford, 1991). p.47.; Enid Fox, 'District Nursing in England and Wales Before the National Health Service: The Neglected Evidence', *Medical History*, 38:3 (1994) p.305.
[19] Bella Aronovitch, *Give it Time: An Experience of Hospital 1928-1932* (Andre Deutsch Ltd: London, 1974) p.95.
[20] Roy Porter, *The Greatest Benefit to Mankind A Medical History of Humanity from Antiquity to the Present* (Fontana Press: London, 1999). p.644.; Guy Williams, *The Age of Agony* (Academy Chicago Publishers: Chicago, 1986). pp.91-97.

character of these voluntary hospitals in these two counties. It has been suggested that voluntary hospitals became, essentially, the 'people's' hospitals, increasingly catering for the whole community and were particularly well regarded by local people.[21] Others suggest this not to be the case, arguing that the NHS was formed because of a widespread discontent with existing provision and a clamour for change.[22] Yet, either way, the connectivity between local hospitals, hospital communities (volunteers, fund-raisers, working-class medical associations) and the broader public provides a vital test of the effective functioning of the voluntary hospitals. If community is an elusive construct, it does and did, as Raymond Williams famously notes, also always carry wholly positive connotations.[23] This, it will be argued, was particularly the case for hospital communities. Those closely associated and invested in the hospital had a shared solidarity as a political and socioeconomic entity: it was foremost a rational community of interests. These were a community of believers: with their own rules, routines, customs, ceremonies and calendars. [24] Such hospital communities were spaces where people from different backgrounds came together. Effective functioning can be measured through a number of filters, which would include community financing, social engagement, and responsiveness. This can be tested at points of crisis and of prosperity. To fit the voluntary hospitals into the dichotomy of 'charity' or 'mutualism' misses out a lot of evidence that suggests there was a balance between the two, and many events that did not neatly fit into a category. For example, the large-scale fundraisers shall be looked at as displays of community spirit, one which had the object of charity but the ethos of mutualism.

Derbyshire and Nottinghamshire provide an excellent location for a case study of voluntary hospitals and their communities. Unlike the major urban conurbations of Manchester, London, or Birmingham which have been the focus of other studies, the two counties together offer so many different types of community, from rurally situated villages in the Derbyshire Dales to smoky industrial towns in the Erewash and Amber Valleys, to the cosmopolitan county capitals. Chesterfield, Mansfield, and Worksop to the north were surrounded by coalmining and ironworks, holding small middle-class nuclei in the towns themselves, surrounded by mining settlements teeming with workers. Down the border between the two counties, in Ripley, Heanor, Ilkeston, and other smaller towns and villages, was a hive of industrial activity existed that connected Derby and Nottingham by a near-unbroken belt of settlements.[25] Derby and Nottingham themselves had large middle-class populations, sizeable suburbs, and very diverse employment, from tobacco factories to locomotive production. To the extreme west of Derbyshire in the High Peak and the Derbyshire Dales, towns such as Buxton, Ashbourne, and Wirksworth sat nestled in the rolling and remote hills of the countryside. In the east of

[21] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', *Midland History*, 37:1 (2012). p.85.
[22] Rudolf Klein, *New Politics of the NHS: From Creation to Reinvention* (Radcliffe Publishing: London, 2010)., Charles Webster, The National Health Service, A Political History (Oxford University Press: Oxford, 2002). p.17.
[23] Raymond Williams, *Keywords: A Vocabulary of Culture and Society* (Oxford University Press: New York, 1983). p.76.
[24] Anton Zijderveld, *The Theory of Urbanity: The Economic and civic Culture of Cities* (Transaction Publishers: New Brunswick), 1998), pp.29-31; Daniel Monti, *The American City: A Social and Cultural History* (Blackwell: Massachusetts, 1999), p.1-5.
[25] Fredrick C Mutton, *Derbyshire and the Peak District* (Penguin Books Ltd: Harmondsworth, 1949) p.47.

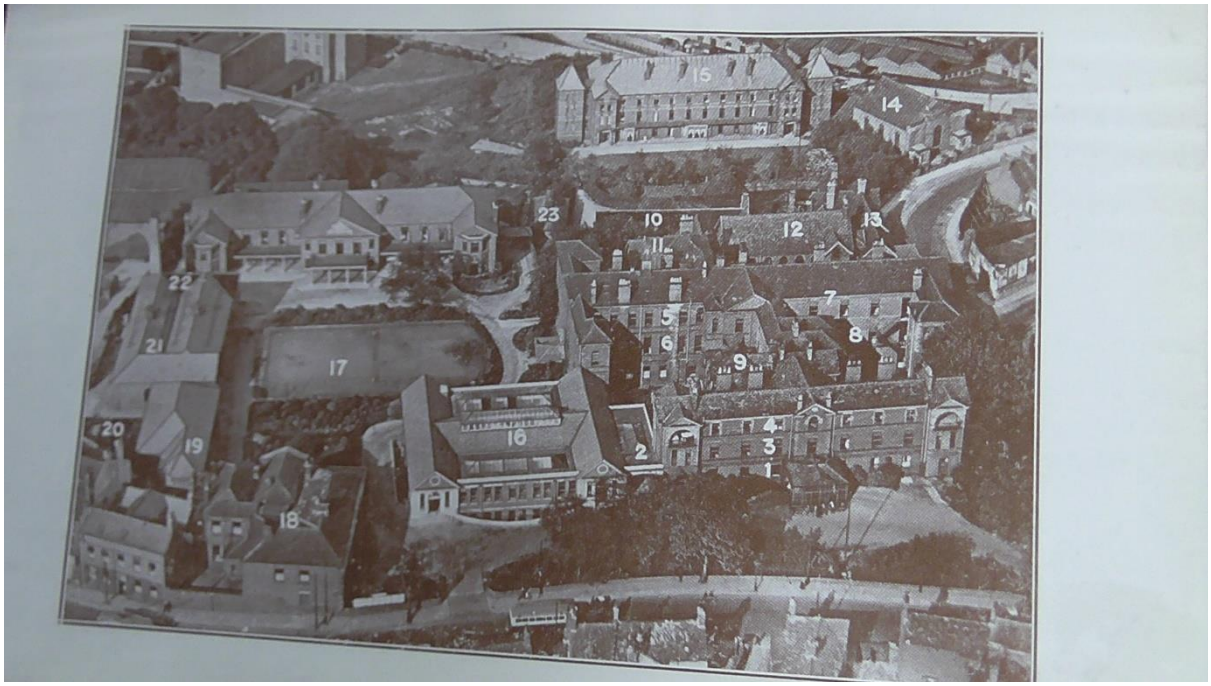
Nottinghamshire was Newark, with its considerable agricultural hinterlands that stretched on into Lincolnshire.[26] The three largest general institutions in the two counties were the Derbyshire Royal Infirmary, the Nottingham General Hospital, and the Chesterfield and North Derbyshire (Royal) Hospital. While these hospitals provide the key focus of this study, regard is also paid to smaller hospitals: the Ilkeston General Hospital, the Heanor Memorial Cottage Hospital, the Newark Town and District Hospital, the Mansfield and District Hospital, the Worksop Victoria Memorial Hospital, Wirksworth Cottage Hospital, Ashbourne Victoria Memorial Hospital, the Whitworth Cottage Hospital (Darley Dale), and the Buxton Devonshire Hospital.

Figure 0.1: Derbyshire Royal Infirmary, c.1900.

[27]

[26] Mutton, *Derbyshire and the Peak District*, p.71., p.157.
[27] Derbyshire Royal Infirmary Annual Report 1910-11.

Figure 0.2: Chesterfield and North Derbyshire Royal Hospital, 1931.



[28]

Structure

This thesis is split chronologically into six chapters. Each one deals with a distinct era in the history of the voluntary hospitals in Derbyshire and Nottinghamshire. The first chapter deals with the years 1900-1914, a time before world war when the values and traditions of the Victorian era merged into those of the twentieth century. Charity and philanthropy were key parts of the voluntary hospitals at this time, when the voluntary hospitals themselves did not have the wider remit that their ambitions and medical advances later allowed. Consequently, it examines leadership and civil society, as well as how carnivals and individual fundraising events defined the personality of the hospitals in their communities during this time. Cottage hospitals were founded and reformed in this era, finding a place in communities removed from the larger towns and cities. Financially, the hospitals were operating with the same incomes they had done for fifty or more years, with only minor examples of mutualist self-provision. Chapter Two looks at the voluntary hospitals in the Great War, and particularly how such a monumental crisis thrust upon the nation affected hospital regimes of what remained independent institutions. For the first time in voluntary hospital history, the government made direct demands on the doctors, nurses, and administrators of the voluntary hospitals in order to accommodate wounded and ill soldiers. The War Office paid hospitals across the nation many thousands of pounds for services rendered to the army as casualties flowed into the wards of the voluntary hospitals. But hospitals also had to deal with the fact that their doctors, nurses, and domestic staff either joined the forces or moved on to more lucrative war work. This chapter looks at the relationship between the hospital, the patients it treated, and the War Office (and other official bodies). It examines, too, the regular operations of the hospital;

[28] Chesterfield and North Derbyshire Royal Hospital Annual Report 1931.

subscriptions, Saturday funds, donations, and fundraising events. It was a uniquely tumultuous time for the voluntary hospitals, which would launch them into further turmoil after the war.

Chapter Three is split into two parts and looks at the social and economic aftermath of the Great War, and the economic conditions the hospitals had to deal with around the General Strike. The period after the war is seen as one of financial crisis for voluntary hospitals. One consequence of which was the launching of a national inquiry under Viscount Cave into the nation's voluntary hospitals, their viability and longevity. The Voluntary Hospitals Inquiry that was established looked chiefly at the London hospitals, because it was they that carried the largest debt, but, as we shall see, it also impacted on the provincial hospitals. The second part of the chapter focusses in on one year: 1926. Derbyshire and Nottinghamshire were affected by both unemployment and underemployment. Many of the industries in the hospital communities were heavily unionised. Hospitals were vitally dependent by this time on the wider donations and contributions of their working-class communities, so when the series of strikes in the mining, railways, and iron industries came, the hospitals faced potential drops in income. This decade, the 1920s, also saw most of the hospitals' Saturday funds (that coordinated large-scale donations from working-class hospital users) expand quickly. The fourth chapter deals with the years around the great economic 'Slump' of the late 1920s. This was a time of dour struggle for many people across Britain, but not necessarily so for the voluntary hospitals. After the difficulties of the 'hospitals crisis' and the extreme circumstances of 1926, hospitals were starting to grow once again. Carnivals and fundraising efforts were expanding year on year, the Saturday funds were finding new success as the hospitals started to re-concentrate their efforts on more effective methods of garnering income.

The fifth chapter deals with the rise of the contributory schemes, which expanded the Saturday fund remit into a semi-contractual and non-workplace-based system of rudimentary healthcare insurance. It was the final shift towards a mutualist hospital system. Contributory schemes were very illustrative of how the hospitals - and their patients – were moving towards a totally different approach to healthcare provision. It became equally important, even as mutualist schemes were growing significantly in importance, also to retain and sustain the traditional forms of income that had been present in the hospitals for generations. Further, this was when an era in which hospital carnivals reached a pinnacle, and examples here include the Long Eaton Carnival, and the Derby and Ripley Hospital Days, and the social and cultural impact these events and their accompanying magazines (the 'Ram-Page' and 'The Rip') had on the hospital communities. Attention will be paid, too, to the potentially negative impact that successful mass schemes had on traditional forms of income, such as subscriptions and donations. Did these suffer as various forms of patient pre-payment took hold? The sixth and final chapter examines how hospitals coped during the Second World War. It mirrors certain difficulties that the hospitals experienced in the Great War, and reviews how the relationship between the hospitals and the government had changed. It will not deal with the subsequent nationalisation itself, as that falls outside of the remit of this thesis, but linkages have been drawn between the two events that warrant investigation. One major problem was rapidly escalating costs. But the war also saw the state intervene in health provision at a previously unprecedented level. The Emergency Medical Service (EMS) was set up by the Ministry of Health to

rationalise medical services across the country at a time of potential crisis. Initially established to care for the expected high numbers of bombing casualties, as the war progressed, its remit changed. For the voluntary hospitals it became an overarching body that decided policy, and provided grants for the war work provided by the hospitals.

Literature Review/Debate

The origins of contemporary debates on the performance and viability of voluntary hospitals were laid down by Richard Titmuss and Brian Abel-Smith, two sociologists writing in the 1950s and 1960s. Titmuss' *Problems of Social Policy,* written in 1950, levelled a number of accusations against the voluntary hospitals, asserting that they were 'rigid' and 'conservative', bankrupt, understaffed and uncoordinated.[29] He argued that the often poor repair of facilities in the voluntary hospitals, and lack of modern purpose-built accommodation, made the voluntary system unsuitable providers of good medical and surgical care.[30] He argued, too, that their continuing reliance on charity and contribution placed them in a state of constant 'financial crisis', which impacted significantly on the treatment and accommodation of patients.[31] He was, but for different reasons, equally dismissive of the hospitals run by the public authorities. Thus, he judged the pre-NHS system to be financially - and morally - bankrupt. It was in many respects a prior justification of the NHS.[32] Indeed, Titmuss admitted that he never conducted real detailed research into the financial and material condition of the voluntary hospitals, basing his assertions more on ideological standpoints and outside observation of the system as a user.[33] Brian Abel-Smith, supporter of the Labour plans for the welfare state and specifically the NHS, took a very similar line. Abel-Smith largely and uncritically accepted all of Titmuss's conclusions.[34] Abel-Smith further asserted that 'only the rich could afford proper health services', arguing that the confusion and distress caused by the First World War in the hospital system opened up the severe failings of the voluntary hospitals.[35] He cited the resultant 'hospitals crisis' after the First World War as reason enough to condemn the whole system.[36] Their conclusions were borne out of the desire to legitimise the vision of the NHS and a welfare state – something that did undoubtedly improve the lot of the British working classes. But in doing so, they established certain myths about the pre-NHS system that still remain today.

Other contemporaries also had concerns. Constance Braithewaite, writing in the 1930s, argued that the paucity of public provision and the patchiness of voluntary provision meant the ordinary citizen was not well provided for: 'our provision is made by variety of systems with little co-ordination between them and with

[29] Richard M Titmuss, *Problems of Social Policy* (His Majesty's Stationery Office: London, 1950) pp.68-72.
[30] Titmuss, *Problems of Social Policy,* p.70.
[31] Titmuss, *Problems of Social Policy,* p.72.
[32] Brian Abel-Smith, *The Hospitals 1800-1948* (Heinemann: London, 1964) 'Chapter 26 The Second World War', pp.424-439.
[33] Titmuss, *Problems of Social Policy,* p.70.
[34] Abel-Smith, *The Hospitals,* pp.424-439.
[35] Abel-Smith, *The Hospitals,* p.286., p.294.
[36] Abel-Smith, *The Hospitals,* pp.294-297.

insufficient provision for many types of case'.[37] Even strong supporters of voluntary provision, such as Wells and Beveridge, largely agreed that the hospital system lacked rationality and required greater involvement from the state.[38] The left-leaning Political and Economic Planning (PEP), writing in the late 1930s stated that the voluntary hospitals 'are institutions responsible only to themselves', that medical staffs used the patients as a form of professional prestige, and 'waste time and energy on appeals for funds which make them resentful of criticism' and for their 'inability to co-operate, which so often lead to overlapping and waste'.[39] Indeed, many commentators on the left continued to view the voluntary system with scathing dissatisfaction. Leff, in 1950, argued that one of the main aims of the voluntary hospitals was to 'prevent loss of time in the factories', implying that the voluntary system was not much more than a functionary wing of the capitalist economy, and further accused voluntary hospitals of taking efforts to swell their payments by encouraging attendances to out-patient departments.[40] This sentiment was mirrored by Aleck Bourne in 1942, who implied that unless there was unprecedented social and economic reform, the ameliorative nature of the current health services were nowhere near up to the task of tackling the nation's ill-health.[41] Even defenders, who nonetheless favoured reform, noted that the voluntary hospitals were 'better in quality [than poor law institutions] but too small, badly distributed and restricted in their scope'.[42] Finlayson's study of the voluntary system found that it was unable to 'cope' with the financial and practical burden of delivering a comprehensive healthcare and welfare system. [43] But he also noted that voluntary hospitals were willing to coordinate under non-governmental organisations, and that voluntary organisations continued to play an important role throughout the wars.[44] He found that the hospitals were not quite so 'rigid' as Titmuss argued.

Later financial studies have critically reviewed Titmuss' blanket statements about the finances and organisation of the voluntary hospitals. Martin Gorsky, John Mohan, and Martin Powell found that, while some hospitals were in financial trouble (especially the larger London hospitals and teaching hospitals), patterns of deficit were nowhere near as endemic as Titmuss had claimed, and there was in fact drastic variation depending on locality and actual type of hospital.[45] But if they were not the moral and financial pits that Titmuss described them as, then what were they? If some were successful, how did they do it? Chief among the interests of more recent accounts were the Saturday and contributory schemes. As already noted, they

[37] Constance Braithewaite, *The Voluntary Citizen An Enquiry into the place of Philanthropy in the Community* (Methuen & Co. Ltd.: 1938, London) p.17., p.19.
[38] Lord William Henry Beveridge, *Voluntary Action A Report on Methods of Social Advance* (The MacMillan Company: New York, 1948) p.116., p.209., p.292.
[39] S Mervyn Herbert ('on the basis of the Report on The British Health Services by Political and Economic Planning'), *Britain's Health* (Penguin Books Ltd: Harmondsworth, 1939) p.111., p.115., p.122.
[40] S Leff, *Health of the People* (Victor Gollancz Ltd: London, 1950) pp.99-101.
[41] Aleck Bourne, *Health of the Future* (Penguin Books Ltd: Harmondsworth, 1942) pp.183-192.
[42] John E Pater, *The Making of the National Health Service*, (King Edward's Hospital Fund for London: London, 1981) p.3.
[43] Geoffrey Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History*, 1:2, (1990), p.188., p.190.
[44] Finlayson, 'A Moving Frontier', p.198., p.204.
[45] Martin Gorksy, John Mohan, Martin Powell, 'The Financial Health of Voluntary Hospitals in Interwar Britain', *The Economic History Review*, 55:3 (2002) p.554.

provided low-cost, quasi-insurance for hospital treatment, where workers would donate or prepay a weekly sum to cover treatment costs. These schemes, as well as a rise in pay-beds at voluntary hospitals, provided greater access to hospitals across the social spectrum, and added significantly to hospital income.[46] Voluntarism itself has been argued to be a flexible and robust a system, more than able to cope with the complex social mandate with which it was saddled. Elizabeth Macadam, writing in the 1930s, described a 'new philanthropy of state and voluntary interaction', and more recently Finlayson has charted the 'moving frontier' of voluntarism which rejects any simplistic notion of a linear state expansion post-1900 and focusses instead on interaction between sectors, with Hinton arguing that the participation-in and benefits-of voluntarism had an 'emancipatory' aspect, far more so than local authority or central government initiatives did.[47] This study of hospital voluntarism seeks to explore how the ensconcing of the voluntary hospitals into their community expanded their appeal as necessary services, as well as being a driving force behind mutualist and self-help innovations. The voluntary hospitals were more than just providers of a service, but a focal point for communities and a complex mechanism of financial and medical exchange.

Many of the studies, primarily conducted at a national level, examine broad spending and income patterns. Steve Cherry focussed particularly on the effectiveness of contributory schemes in restoring voluntary hospital finances that increased income from these sources and other forms of patient payment, but which nonetheless was insufficient to provide a comprehensive network of provision. Thus, it was left to the state to provide extra income to meet wartime emergencies.[48] Thus, Cherry was inclined to agree with Titmuss that hospital finances and rising costs meant provision was inadequate.[49] Gorsky and Mohan concluded that there was broad geographical differences in the quality of hospital provision across the country, that 'funding trends broadly confirmed earlier pessimistic accounts of the difficulties faced by interwar hospitals as expenditure demands rose and traditional charity stagnated'.[50] They noted also that despite the innovations in funding, hospital finances, in real terms, remained insecure during the 1930s, and whilst for many hospitals there was no looming crisis, for others – particularly in London – this was not the case.[51] Others have been less pessimistic, pointing to voluntarism's resilience, and the continuing vibrancy of voluntary forms of income streams to the financial health of hospitals.[52]

---

[46] Gorsky, Mohan & Powell, 'Financial Health', pp.553-4

[47] James Hinton, 'Voluntarism and the Welfare/Warfare State. Women's Voluntary Services in the 1940s', *Twentieth Century British History*, 9:2, (1998) p.285., p.289.

[48] Steven Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *The Economic History Review*, 50:2 (1997) p.322.

[49] Cherry, 'Before the National Health Service', p.306.

[50] Martin Gorsky, John Mohan, 'Uses of Yearbooks: The Voluntary Hospitals Database', *Social History of Medicine,* 24:2 (2011) pp.481.; John Mohan, *Planning, markets and hospitals* (Routledge: London, 2002). pp.24-38.

[51] Gorsky, Mohan & Powell, 'Financial Health', p.554.

[52] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) pp.720-724.; F K Prochaska, *Philanthropy and the Hospitals of London The King's Fund 1897-1900* (Clarendon Press: Oxford, 1992). pp.127-130.

The rise of contributory schemes marked not just a shift to a newer, more efficient, method of income collection, but a major 'shift in entitlement'. This meant that ordinary people no longer related to hospitals as distant charitable institutions, but instead built a relationship between themselves and their institutions based on an expectation of treatment. Collection funds – essentially forms of direct donation to the hospitals in return for a non-contractual notion of healthcare cover – dated back in that form to the 1860s.[53] By the 1930s, however, in some locales, worker 'contributions were practically the sole source of hospital income; the absence of a philanthropic middle-class left industrial communities with no realistic alternatives'.[54] This shift towards contributory schemes was a result of necessity as much as a drive for healthcare coverage by hospital communities. But it increasingly became a form of quasi-insurance, where payment brought entitlement. Barry Doyle's studies of Yorkshire towns found that the absence of a large middle class meant a much more mutualist style of hospital funding for the hospitals.[55] It emerges among hospital historiography that there is a sort of blanket attachment of the traditional income to the upper and middle classes, and of mutualist income to the working classes. In this thesis, there shall be a review of the incomes that the Derbyshire and Nottinghamshire voluntary hospitals had, and exactly how they accumulated them, as well as how they fit into this dichotomy of 'mutualist' versus 'traditional'.

A number of studies have been conducted of specific hospitals, or hospitals in specific cities. Doyle looked at Middlesbrough, as well as comparisons between Middlesbrough, Leeds, and Sheffield hospitals. He found that class, as well as party political structure, informed (though not necessarily defined) the route that hospital voluntarism took in those urban centres.[56] Where there was a strong labour movement, the hospital payment structure was very much based around Saturday and contributory funding, whereas anywhere where there was also a considerable middle-class, there was greater charitable funding (though the two were not mutually exclusive). Doyle's studies are important because they illustrate the marked differences between institutions in the same vicinity, a characteristic to be explored in this thesis. Gorsky, in examining the relationship between hospitals in Northeast Scotland, found a 'hierarchical regionalism' operating, where the junior institutions would defer to central teaching hospitals.[57] He noted, too, that hospitals were fully aware of problems of regional and local fragmentation, even if there was some measure of communication between

[53] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.23.
[54] Gorsky, Mohan, and Willis, *Mutualism and Healthcare*, p.52.
[55] Barry Doyle, 'Power and Accountability in the voluntary hospitals of Middlesbrough 1900-1948', in Anne Borsay and Peter Shapely (eds.), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550-1950*, (Ashgate Publishing Limited: Aldershot, 2007) pp.217-9.
[56] Barry M Doyle, 'Competition and Cooperation in Hospital Provision in Middlesbrough, 1918-1948', *Medical History*, 5:3 (2007) p.343., p.344., p.352.; Barry Doyle, 'Power and Accountability in the voluntary hospitals of Middlesbrough 1900-1948', in Anne Borsay and Peter Shapely (eds.), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550-1950*, (Ashgate Publishing Limited: Aldershot, 2007) p.209., p.218., p.219.; Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010) p.377., p.380.
[57] Martin Gorsky, '"Threshold of a New Era": The Development of an Integrated Hospital System in Northeast Scotland, 1900-39', *Social History of Medicine*, 17:2, (2004) p.248.

them on a hierarchical basis.[58] John Pickstone's regional study of the Greater Manchester health services similarly explored questions of integration and responsiveness, though his conclusions on pre-war provision and organisation make pessimistic reading.[59] He notes, too, the financial outlook of hospitals, in terms of expansion and day-to-day provision, was strongly tied to local economic circumstance. A decline in trade – in this case cotton – severely impacted on the ability to meet the growing demand for health care.[60] That voluntary hospitals were all so varied and different remains hidden in aggregated national studies. Hayes's and Doyle's study of large provincial hospitals in the Midlands and North, for example, illustrates the rich variety of pathways taken by voluntary hospitals and the consequences this had, in terms of finance and community connectivity.[61] The root rationale of this study is to illuminate how hospitals in a region like Derbyshire and Nottinghamshire might operate in the contexts of the counties themselves, rather than part of a larger national narrative.

The two counties are intrinsically linked, with communities that spread across county lines. In terms of population, they were at very similar levels, with a large portion of the population situated down the central border between the counties, with many towns equidistant between Derby and Nottingham.

The three key county hospitals of Derbyshire and Nottinghamshire (Chesterfield and North Derbyshire Hospital, Derbyshire Royal Infirmary, and Nottingham General Hospital) did not have solid geographical 'boundaries', and thus, for instance, Nottingham General would often take Derbyshire patients from the likes of Ilkeston and Ripley, while Chesterfield Hospital often had the duty of not just dealing with north Derbyshire patients, but north Nottinghamshire too. Geographically, and in terms of hospital makeup, the two counties are quite distinct from their surrounding counties and other urban networks. Manchester, and the rest of Lancashire, as Pickstone's study showed, was of its own unit, linked already by 1900 by a network of hospital relationships, and in many ways cut off from Derbyshire by the geographical impediment of the High Peak.[62] Similarly for Yorkshire, as shown by Doyle, hospital networks were largely operating within county boundaries, the populations and hospital districts rarely straying into other counties (with the exception of Sheffield, whose relationship with Chesterfield and north Derbyshire shall be discussed). Lincolnshire to the east was (and still is) predominantly agricultural, with a very sparse population. As such, and although there were links between Lincolnshire and Nottinghamshire, it was distinctly different from Derbyshire and Nottinghamshire, and preliminary searches through the Lincolnshire County Archives found that the hospital relationship and networks established in Lincolnshire, as well as its social, economic, and cultural makeup, were so different to Derbyshire and Nottinghamshire that inclusion in the study would be inappropriate.

Derbyshire and Nottinghamshire were well-provided-for in terms of hospitals services, and indeed the population sorely needed it. The industrial makeup of the counties was such that health issues, from lung

[58] Gorsky, 'Hospital System in Northeast Scotland', p.248.
[59] John V Pickstone, *Medicine and Industrial Society: A history of hospital development in Manchester and its Region, 1752-1946*, (Manchester University Press: Manchester, 1985). pp.299-300.
[60] Pickstone, *Medicine and Industrial Society*, pp.253-4.
[61] Hayes and Doyle, 'Eggs, Rags, and Whist Drives', pp.738-740.
[62] Pickstone, *Medicine and Industrial Society*, pp.1-5., pp.251-256.

maladies to high likelihoods of serious injury, meant that one witness described the workers of the counties as 'old men before they were young ones'.[63] There were hospitals in most of the towns, and in quite a few in the villages stretching into the Derbyshire Dales. This meant that Derbyshire and Nottinghamshire had quite high ratios of beds-per-population, with roughly 1.1 beds per 1,000 people by 1931, as well as a high number of local institutions rather than just institutions in county capitals.[64] However, doctor-patient ratios were less attractive, with 0.52 per 1,000 population.[65] This was considerably lower than the national average of 0.73 doctors per 1,000 population, and indeed lower than most of the neighbouring counties – Leicestershire 0.55 per 1,000, Lancashire 0.61 per 1,000, Lincolnshire 0.55 per 1,000, and Yorkshire 0.57 per 1,000.[66] It is in the unusual situation of a large number of beds and hospitals per population, but a lower number of doctors, which begs the question as to how communities have cultivated their hospitals, and how they perhaps rely more on a higher number of situated institutions than a higher proportion of doctors. Using these two counties, that are so strongly linked in so many social, economic, and cultural ways means that there has been considerable scope for comparisons of institutions and hospital networks.

Very few studies have examined smaller institutions that include the medium-sized county town hospitals, as well as the small village and town cottage hospitals. R M S McConaghey found that cottage hospitals are often difficult to define because of the way that they form from their individual community, and were as much defined by the efforts of interested individuals as they were by the demand for healthcare.[67] However, this theory can be expanded, by looking at the interests of communities who develop demand for hospital services. Thompson's extensive study of the South Wales mining towns and villages shows how working-class people took their healthcare into their own hands. This region was remote, its peoples occupied in dangerous mining occupations, and as a result the general health of the male population in those communities was poor and mortality high.[68] Yet, the employer led schemes associated with the voluntary hospitals, so common elsewhere, were in the South Wales mining areas the exception.[69] The region under Thompson's study is actually similar in a number of ways to that of Derbyshire and Nottinghamshire. The populations roughly equal (approximately one million by 1921), coalmining was one of the chief employers, and many parts of Derbyshire (High Peak, The Dales) and eastern Nottinghamshire were isolated and had poor transport links to the urban

[63] J E Williams, *The Derbyshire Miners*, (George Allen & Unwin: London, 1962), p.64.
[64] B R Mitchell, Abstract of British Historical Statistics, (Cambridge University Press: London, 1962). p.22.
[65] *Marketing Survey of the United Kingdom & Census of Purchasing Power Distribution* (Business Publications Limited: London, 1938). p.347., p.381.
[66] *Marketing Survey,* p.368., p.372., p.374., p.400.
[67] R M S McConaghey, 'Evolution of the Cottage Hospital', *Medical History*, 11:2 (1967) p.128.
[68] Steve Thompson, *Unemployment, Poverty and Health in Interwar South Wales* (University of Wales Press: Cardiff, 2006) pp.1-6, pp.180-185.; Ben Curtis, Steven Thompson, '"This is the Country of Premature Old Men" Ageing and Aged Miners in the South Wales Coalfield, C. 1880-1947', Cultural and Social History, 12:4 (2015). p.529.
[69] Steve Thompson, 'The mixed economy of care in the South Wales Coalfield, c.1850-1950.' , Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014). p.146.

hubs where the key medical centres lay.[70] So, was there a similar 'paucity' of philanthropic activity in Derbyshire and Nottinghamshire, and did the mutualist schemes emerge directly from within working-class communities?

Marcel Mauss argued that many societies were built on an obligatory idea of gift exchange – the giving of something contains the implication of receiving something back, even if it is not the same as the original gift.[71] This can be seen in the structures of charity and deference in the English class system, which was also carried into the nature of the voluntary hospitals. Deference was a key element of the philanthropic relationship, wherein the receiver offered up their gratitude and deference to the individual or group offering them charity.[72] The voluntary hospitals subscriber ticket system is an exemplar of this, wherein working-class patients would have to ask a subscriber for a ticket to gain entry into the hospital for treatment. However, class distinction in the hospital systems was not necessarily a catalyst for conflict, as some Marxian class schema might suggest, considering the different, non-profit objective of the hospitals.[73] Although class was very much evident within the voluntary hospital system, and reinforced by the hierarchical structures inherent within its volunteer bodies, hospitals were sites of class coalescence, especially as the years progressed. Philanthropic activity remained important to charitable fundraising right into the twentieth century. The 'great and the good' continued to lead many such initiatives, and to enjoy the privileges of rank within the hospital administration.[74] The system was in-built to the vast majority of voluntary hospitals: for example, with the rank of 'Life Governor' afforded to anyone who donated or subscribed a certain amount of money. It is true, also, there was little antagonism within this system of philanthropic leaders, other than when there were disagreements between them and other board members or volunteers on how the hospitals should be run. Richard Trainor found that elite disengagement from civic society was less marked in charitable management when compared with the political sphere, because the object was less rancorous.[75] Garrard, however, saw the traditional 'elites' as almost withdrawing from society altogether, finding that the number of official (county and legislative) positions filled by elites, and by the twentieth century this had become par for the course.[76] However, the presence of elites in the voluntary hospital system as leaders and volunteers was significant, and suggests that there was not so much a decline, but a move sideways into different forms of leadership.

[70] Thompson, 'The mixed economy of care in the South Wales Coalfield', p.142.
[71] Marcel Mauss, *The Gift The form and reason for exchange in archaic societies* (Routledge: London, 2002) pp.3-5.
[72] E P Thompson, *The Making of the English Working Class* (Penguin Books Ltd: Harmondsworth, 1968). p.202., p.308., p.706., p.852
[73] Simon Gunn, 'From Hegemony to Governmentality: Changing Conceptions of Power in Social History', *Journal of Social History*, 39:3 (2006). p.706., pp.716-720.
[74] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', *Midland History*, 37:1 (2012) pp.90-95.
[75] Richard Trainor, 'The "decline" of British urban governance since 1850: a reassessment', in R J. Morris and R. Trainor (eds.), *Urban Governance: Britain and Beyond Since 1750* (Routledge: Aldershot, 2000). Pp.28-46
[76] John Garrard, 'Urban elites, 1850-1914: The Rule and Decline of a New Squirearchy?', Albion: A Quarterly Journal Concerned with British Studies, 27:4 (1995). p.603.

Rubenstein and Hayes disagree, asserting that in fact the elite expanded as more industrialists came to the fore, establishing themselves in civil society in equal measure to the aristocracy.[77]

There were a number of respective 'Gift' relationships within early hospital voluntarism. Waddington identifies a pessimism amongst historians, who have moved back to the Marxist-leaning interpretation of philanthropy as a mode of social control by the middle-classes upon the susceptible working-classes.[78] But the class involvement in the voluntary hospitals is a little more nuanced than the usual class dialectic. Local upper- and upper-middle-class people in the 19th and early 20th Century were keen on promoting their own public image, as well as offering public service.[79] There was also the deferential relationship between the prospective patient and the hospital: a complicated procedure of acquiring a ticket (either by subscribing themselves or having to acquire one from a charitably inclined subscriber or via an employer) and then submitting themselves to the hospital for decision on whether they need treatment. This was to change through time. As Gorsky, Mohan, and Willis found, in the 1920s and 1930s the relationship between the hospital and its community changed, with the shift in entitlement addressing more power to the individual patient and the volunteer bodies that organised the mass schemes.[80] Finally, as noted earlier, there was the relationship between the ordinary hospital volunteers and fundraisers, and the hospital itself. There was a distinction, as Pete Alcock has stated, in the difference between charity given philanthropically for 'altruistic purposes', and charity given in a voluntary way for 'collective self-protection'.[81] Indeed, the public's understanding of terms 'charity' and 'voluntarism' were markedly different: the latter was viewed benignly; the former much less so.[82] These distinctions certainly tie into the debates around the transformation of the voluntary hospitals system from one run along charitable lines going on to be taken over by mutualist efforts. The fundraisers and volunteers worked for the hospitals for a number of reasons, but not least of which was the sense that they were caring for themselves by caring for their local institution. Thompson has shown that the English working classes were far from passive, even some hundred years earlier, and were often keen through trade unionism and rejections of deference to try and improve their living and working conditions, symbolised through the 'Philanthropic Hercules' – the first General Union of all trades.[83] As Prochaska argued, 'Victorians saw few alternatives beyond benevolence and self-help'; a society based on the idea that the only social services should

[77] William D Rubinstein, 'Britain's Elites in the Inter-War Period, 1918-1939: Decline or Continued Ascendency?', *British Scholar*, 3:1 (2010). pp.19-21.; Nick Hayes, 'Things Ain't What They Used To Be! Elites and Constructs of Consensus and Conflict in Twentieth Century English Municipal Politics', Barry M Doyle (ed.) *Urban Politics and Space in the Nineteenth and Twentieth Centuries: Regional Perspectives* (Cambridge Scholars Publishing: Newcastle Upon Tyne, 2007). P.48., pp.52-54.
[78] Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Boydell Press: Woodbridge, 2000) pp.23-25.
[79] Garrard, 'Urban Elites, 1850-1914', p.587.
[80] Gorsky, Mohan, Willis, *Mutualism in healthcare,* p.30.
[81] Pete Alcock, *Social Policy in Britain Themes and Issues* (MacMillian Press Ltd: Basingstoke, 1996) pp.80-81.
[82] Nick Hayes, 'Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948', *English Historical Review*, CXXVII:526 (2012) pp.625-661.
[83] E P Thompson, The Making of the English Working Class (Penguin Books Ltd: Harmondsworth, 1968) p.308., p.706., p.852.

really be as a result of charitable giving, and not state intervention.[84] He noted that London had especially acute social and economic problems, which were dealt with not through an encouragement of mutualism or self-help, but through philanthropic initiatives that reinforced a system of charity.[85] Waddington denies the idea that philanthropy was the only thing that defined voluntary hospitals in the late-Victorian era, displaying the popular working-class support for Saturday funds in the London hospitals.[86]

So, there seemed to be emerging a 'new philanthropy', defined not by the wealthy offering donations to the poor or needy causes, but instead the poor banding their resources together to fund a community service. It has been argued that the more financially successful hospitals in the interwar period blended together different evolving income streams, incorporating not just the popular new mass schemes, but carefully cultivating the old-fashioned network of subscription and donation, as well as retaining the vast armies of volunteers that were eager to evangelise the cause of the hospital. Looking at the contributory schemes and fundraising events of the Nottingham General and the Sheffield hospitals shows how there was considerable variation in how contributory schemes were constructed and conducted. Nottingham's scheme was focussed upon the General Hospital, whereas Sheffield's scheme had ambitions of encapsulating all the hospitals within the city bounds.[87] The volunteer army of Nottingham General Hospital was able to drum up tremendous support for the hospital in material and financial aid – most notably with 'gifts in kind' like the hundreds of thousands of eggs regularly collected by volunteers for use by the hospital.[88] Nottingham's volunteer community, as well as its general public, was found by Hayes to be one of the key elements of the hospital's success. Being able to tap into a network of dedicated people, who were able to communicate effectively with a sympathetic public, was something that not all voluntary hospitals had. 'Our Hospital', as the volunteers so fondly referred to the Nottingham General, was identified by Hayes as a prime example of civic pride and participation.[89] A world away, in the South Wales mining towns, Curtis and Thompson identify how, in the absence of a philanthropic class, the miners were compelled to organise and provide their own care.[90] They identify that the South Wales Miners' Federation – a trade union – was a key instigator and ideological thinktank in founding and sustaining the 'medical aid societies' in the remote towns and villages of South Wales.[91] In Derbyshire and Nottinghamshire, there was little involvement from the trade unions in healthcare;

[84] F K Prochaska, *Philanthropy and the Hospitals of London. The King's Fund 1897-1990* (Clarendon Press: Oxford, 1992) p.2.
[85] Prochaska, *Philanthropy and the Hospitals of London*, pp.5-6.
[86] Waddington, *Charity and the London Hospitals,* pp.38-9.
[87] Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010) pp.381-383.; Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) p.717.
[88] Hayes, Doyle, 'Eggs, rags and whist drive', p.735.
[89] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', *Midland History*, 37:1 (2012) pp.90-95.
[90] Ben Curtis and Steven Thompson, '"A Plentiful Crop of Cripples Made by All This Progress": Disability, Artificial Limbs and Working-Class Mutualism in the South Wales Coalfield, 1890-1948', *Social History of Medicine,* 27:4 (2014) p.716.
[91] Curtis and Thompson, 'A Plentiful Crop of Cripples', pp.712-3.

although many workers did organise to provide their own care, it was not as a result of trade union agitation or organisation. The trade unions largely confined themselves to matters of industrial dispute, rather than becoming involved in matters of community welfare.[92] Instead a lot of the change came from within the armies of volunteers of the voluntary hospitals themselves, who enfranchised the community by involving them in the work of the hospitals.[93] The nature of the voluntary hospitals was intrinsically variable dependent on locale. Gosling's study of Bristol hospital services found that contributory schemes were already in place there in the early 1920s, whereas other studies have mostly found contributory mutualist schemes to emerge much later, not emerging properly until the late 1930s.[94] Similarly, Hayes' and Doyles' study of Nottingham and Sheffield show how contributory schemes in two cities could be run very differently, and with very different results.[95] So clearly there are certain conditions under which different schemes and initiatives emerge, which needs to be tested across the landscape of Derbyshire and Nottinghamshire. Participation - that is, the involvement of different classes in the organising and funding of hospital schemes - was vital to the success of the schemes in Nottingham and Sheffield.[96] However, Hayes and Doyle point out that some of the activities organised by the volunteers, like the whist drives, were attractive for the recreation, rather than out of a sense of charitable duty.[97] But the fact that the hospitals were able to tap into contemporary culture and entertainment was clearly an important point in their fundraising, much in the same way that traditional events were continued because they were attractive to participants.[98] There emerges from the studies of hospital voluntarism a theme of innovation, a personality of progressiveness rather than of traditionalist conservatism.[99]

The vast majority of the archival material was from the Derbyshire Record Office and University of Nottingham Special Collections archive, and the British Newspapers Online Archive, as well as fewer pieces from the Nottinghamshire County Archives and National Archives in Kew. Extensive records were found for three chief hospitals: Derbyshire Infirmary, Nottingham General, and Chesterfield Hospital. They form the backbone of the archive material for this study and are used as central comparisons for the rest of the hospitals in the study. As

[92] Alan R Griffin, *The Miners of Nottinghamshire 1914-1944 A History of the Nottinghamshire Miners'* Unions (George Allen & Unwin: London, 1962). pp.17-22., pp.50-57.
[93] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Conscious ness in Nottingham Before the NHS', *Midland History,* 37:1 (2012), pp.94-95.
[94] George Campbell Gosling, '"Open the Other Eye": Payment, Civic Duty and Hospital Contributory Schemes in Bristol, c.1927-1948', *Medical History*, 54 (2010) p.477.; Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) pp.47-52.

[95] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) pp.720-724.
[96] Hayes, Doyle, 'Eggs, rags and whist drives', p.716., p.717., p.724.
[97] Hayes, Doyle, 'Eggs, rags and whist drives', p.725.
[98] Eric Hobsbawm, 'Mass Producing Traditions: Europe, 1870-1914', in Eric Hobsbawm and Terence Ranger (eds.) *The Invention of Tradition* (Cambridge Universtiy Press: Cambridge, 1983) p.271.
[99] George Campbell Gosling, '"Open the Other Eye": Payment, Civic Duty and Hospital Contributory Schemes in Bristol, c.1927-1948', *Medical History*, 54 (2010) p.493.

a rule, the study uses the hospitals as its structure, basing analysis around the similarities and differences between various different institutions, or taking thematic issues that have been found in one particular institution and seeing if they apply to others. The types of sources used are annual reports (which contain extensive financial records, as well as detailed information about the institutions including patient statistics, medical personnel, committee members, subscribers, and other information), minute books, newspaper articles from various local Derbyshire and Nottinghamshire newspapers, as well as flyers, magazines, letters, and others. Detailed financial analysis has been carried out of the various institutions, identifying not just how various incomes were of benefit to the institutions, but also what those different incomes signified. Raising questions such as whether they were charitable, mutualist, or something else. Further, an analysis of the voluntary 'culture' around the hospitals will be looked at, using the carnivals and the volunteers themselves as indicators of community involvement and participation. Local material is vital to observing the voluntary hospitals from their own perspective, rather than using a top-down approach using aggregated national data. As such, it makes it possible to set hospitals within their community, rather than as the broader body of voluntary hospitals in the country.

Chapter 1: 1900-1913 – Old world, new hospitals

The early part of the Twentieth Century was a formative age for the hospitals of Derbyshire and Nottinghamshire. Many of the larger hospitals had already been founded in the late 1800s and through the 1900s, and so the turn of the new century meant new and exciting possibilities for the institutions dotted around the two counties. In line with the quietly progressive and civic-minded ethos of the Edwardian era, the hospital volunteers were active, involved, and innovative. Many hospitals had not grown significantly from their foundation some hundred or more years ago. Nottingham General Hospital had 233 beds; and Derbyshire Royal Infirmary 185, and these made up the vast majority of general beds in the counties. Cottage hospital provision was starting to see a period of expansion and construction. Ashbourne Hospital was established as a memorial to Queen Victoria in 1902, Ripley Hospital was not opened until 1911, and Heanor Hospital not until after the Great War. The smaller hospitals already established, like Wirksworth, Newark, Worksop, Mansfield, and Ilkeston, found new meaning and saw increasing expansion. Specialist institutions, like Buxton Devonshire Hospital, and the various Children's and Women's hospitals, garnered less civic focus, but nonetheless saw transformation and growth. Nearly all of these institutions were led by a traditional elite of aristocrats and major industrialists and other wealthy businessmen, mirroring broader conceptions of joint authority and shared interests.[1] Yet they were jointly managed, too, by middle ranking men of commerce and from the professions. As yet, despite claims that voluntary organisations, and hospitals particularly, brought society together, there was little working-class representation.

The Edwardian era, which dominates this chapter, was ironically defined by both traditionalism and social progress. Old elites remained in charge, while many pushed for political and social change among the populace. The rigid class structure was not breaking down, but starting to change – where once the aristocracy retained their own company, they were starting to mix with the upper-middle-classes, as their offspring started to attend school, university, and enter into occupations together.[2] This meant a broadening of the classes of social leaders, which at the same time gave an impression of 'elite decline' – a much lauded theory that the 20th Century saw a retraction of the aristocracy into a private sphere.[3] This, however, was far from the truth. Instead, there was an enfranchising of the middle- and upper-middle-classes, meaning that what was once the sole reserve of the landed aristocracy was now equally in the possession of the 'unlanded' classes.[4] This change was relatively rapid, harried along by social changes right down the class structure, and as stresses

[1] Harold Perkin, *The rise of Professional Society: England Since* 1880 (Routledge, 1989), pp.62-101.; Martin Daunton, '"Gentlemanly Capitalism" and British Industry 1820-1914', *Past and* Present 122 (1989), pp.119-158.;

[2] William D Rubinstein, 'Britain's Elites in the Inter-War Period, 1918-1939: Decline or Continued Ascendency?', *British Scholar*, 3:1 (2010). pp.6-8.

[3] E. P. Hennock, *Fit and Proper Persons, Ideal and reality in nineteenth-century urban government*, (Edward Arnold: London, 1973) pp.308-313.; John Garrard, 'Urban Elites, 1850-1914: The Rule and Decline of the New Squirearchy?', in *Albion: A Quarterly Journal Concerned with British Studies*, 27:4 (1995) pp.603-604.

[4] Nick Hayes, 'Counting civil society: deconstructing elite participation in the provincial English city, 1900-1950', *Urban History*, (2013) p.2., p.6., pp.10-12.

on traditional social structure were starting to bend the status quo. It was seen by the hegemonic powers that social reform was needed if revolution, or at the very least the rise of radical new ideas like socialism, were to be avoided. France's 19th Century had been dogged by war and revolution, instability and crises, and even the new German Imperial State was instigating progressive, working-class-focussed reforms to its welfare system.[5] In Britain, the Old Age Pensions Act in 1908 and the radical National Health Insurance Act of 1911 saw great leaps forward for a British government that had largely had a hands-off approach to individual welfare, for decades focussing on public health and the broader social moralising behind the workhouse system.[6] The Liberal Government, under the leadership of Asquith and Lloyd George, were keen to break with tradition and deliver new policies and new attitudes, and ameliorate those in the growing union movements that called for more drastic change.[7] The rise of the Labour Party was fuelled by a growing zeitgeist of social awareness, and writers from H G Wells to Robert Tressell, as well as the combined efforts of the Fabian Society, were capturing the focus of the British people by exposing the difficulties (and vast inequalities) of the working- and 'under' classes.[8] The old world of Victorian solidity and rigidity was starting to be slowly eroded, though the Liberals themselves would not lose their position to Labour as the key opponent to the Tories until after the Great War.

Throughout the Edwardian era, the economy ostensibly grew. Net national income increased (£43 in 1900, to £51 in 1914), as did gross national product, consumer expenditure, and income from employment.[9] But income inequality was as stark in the Edwardian era as it was in the Victorian era, and there was increasing dissatisfaction. In 1900 the total number of trades unions in the UK was 1,323, with a total membership of 2,022,000.[10] By 1914 the number of different trades unions had reduced, to 1,260, but the total membership had more than doubled, to 4,145, 000.[11] Alongside this increase in membership was the increasing occurrence of industrial disputes – just 648 per year at the start of the era, but 1,459 by the end.[12] It indicates that the population of England and Wales was starting to become mobilised towards its own interests, no longer placated by whatever promises the ruling classes were able to offer, instead looking to their own leaders for guidance. Derbyshire and Nottinghamshire had large parts of their population occupied in heavy industry, chiefly coalmining and steel and ironworks, as well as large railway works in Derby, and also manufacture and engineering at firms such as Rolls Royce, Players, and Boots. Many of these firms were in industries that were heavily involved in the trades unions, which although was less of an issue before 1914, came to a head in the mid-twenties. Living standards were varied, and as Gourvish states, the Edwardian period was 'associated with

[5] Eric Hopkins, *Working Class Self-Help in nineteenth Century England* (UCL Press: London, 1995). p.63.
[6] Eric Hopkins, *Working Class Self-Help in nineteenth Century England* (UCL Press: London, 1995). pp.63-65.
[7] Dennis Dean, The Character of the Early Labour Party, 1900-1914', in Alan O'Day (ed.) *The Edwardian Age: Conflict and Stability, 1900-1914,* ((MacMillan Press Ltd: London, 1979).pp.98-99.
[8] S Leff, *The Health of the People* (Victor Gollancz: London, 1950). Pp.113-114.
[9] T R Gourvish, 'The Standard of Living, 1890-1914', in Alan O'Day (ed.) *The Edwardian Age: Conflict and Stability, 1900-1914,* ((MacMillan Press Ltd: London, 1979). pp.13-14.
[10] B R Mitchell, *Abstract of British Historical Statistics*, (Cambridge University Press: London, 1962).p.68.
[11] Mitchell, *British Historical Statistics*., p.68.
[12] Mitchell, *British Historical Statistics*., p.71.

the first serious interruption to the upward movement of real wages for at least a quarter century', and he further points out that the years of wage regression were far more numerous that of wage progression.[13] Unemployment in the era varied, rising to as much as 7.7% in 1909, drastically higher than the supposed 2-3% of the late Victorian period.[14] Nowhere near the peaks of the nineteen-twenties, the unrest this caused was not of particular note by either the press or parliament. But it does indicate that there were growing tensions among the working classes with their employers, and the conditions they presented to their workers. A side-effect of this realisation of mutual benefit through the trades unions was the desire to secure for themselves decent hospital coverage. Many people throughout the nation, especially in industrial counties Derbyshire and Nottinghamshire, were employed in heavy industry, and as such were victim to dangerous working conditions. In 1913, the East Midlands coalfield was the junior of the big four coalfields (the others being South Wales, the North East, and South Yorkshire), but still produced 33.7 million tons of coal (11.7% of national coal output) and employing over 100,000 men across Derbyshire, Nottinghamshire, and Leicestershire.[15] Of the East Midlands region in 1913, Derbyshire accounted for 50% of coal production, with Nottinghamshire at 37%, and the remainder taking place in Leicestershire.[16] Going on census estimates, the amount of men employed in coal mining grew significantly in the East Midlands, from 84,800 in 1901, to 110,900 by 1913.[17] Thankfully, the mortality rates in Derbyshire and Nottinghamshire for miners was relatively low compared to other regions, but what deaths and injuries there were had lasting effects on local attitudes towards healthcare provision.[18]

Hopkins identifies three key areas in which the working classes practiced 'self-help': the expansion of the friendly societies, the trades unions, and the co-operative movement.[19] While he cites the friendly society movement as a search for insurance against ill-health (sick pay), he does not address that the working classes were also moving towards securing medical care for themselves as well. Hayes' works focussing on Nottingham civil society and the working classes around the Nottingham General Hospital coincide with the intentions of this chapter, namely to identify involvement in the hospitals by different types of people in the counties. He shows that the working classes were increasingly: 1. realising that the hospitals were a vital part of healthy living, and 2. focussed on securing hospital provision for themselves and their families.[20] This trend started, in its nucleic phase, between 1900 and 1914. By the Great War, there were more smaller hospitals than ever before, providing very localised cover. Pickstone has identified that cottage hospitals, after 1900,

[13] Gourvish, 'The Standard of Living', p.14.
[14] Mitchell, *Historical Statistics*, p.65. This figure taken from percentage unemployed in trades union memberships.
[15] Barry Supple, *The History of the British Coal Industry, Volume 4, 1913-1946 The Political Economy of Decline*, (Clarendon Press: Oxford, 1987). P.21.
[16] Supple, *British Coal Industry Vol 4,* p.21.
[17] Roy Church, Alan Hall, John Kanefsky, *The History of the British Coal Industry, Volume 3*, 1830-1913 Victorian Pre-Eminence (Oxford University Press: Oxford, 1986) p.141.
[18] Church, Hall, Kanefsky, *British Coal Industry Vol 3*, p.588.
[19] Eric Hopkins, *Working Class Self-Help in nineteenth Century England* (UCL Press: London, 1995). p.3.
[20] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Conscious ness in Nottingham Before the NHS', *Midland History*, 37:1 (2012), p.85., p.94.; Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) p.713., p.714.

were a focus for small-town charity, a way for people outside of the larger urban centres to secure coverage without having to travel, and that they were 'pre-eminently, community institutions'.[21] A case study of Ripley Cottage Hospital will show that this was true, and that the working classes of a district some ten miles from the nearest large town or city were able to band together and focus their efforts on a site of medical care. The cottage hospitals have been all but ignored by many historians who look at the voluntary hospitals on a national level, much in the same way as they were by the contemporary voluntary hospital officials and magnates. They were often seen as an only-just-necessary evil by experts, and any institution with less than 50 beds was seen as quite inefficient and essentially glorified first-aid stations.[22] But work by Neville into south-west England's large concentration of cottage hospitals (far more so than Derbyshire and Nottinghamshire) indicates that they became a vital service among the elderly and the paying middle-classes, especially in counties like Devon that were very rural and transport and infrastructure was poor.[23] They saw a huge spike of road traffic accidents in the decades to come, and bore a large burden of casualties from this new type of emergency.[24] Similarly, South Wales had a large quantity of cottage hospitals, which Thompson showed workers had a large influence over, where the towns and villages were not just geographically remote, as in Devon, but also mostly occupied in dangerous heavy industry.[25] McConaghey identifies that cottage hospitals are difficult to define for the very reasons that Thompson and Neville identify: that they are so closely formed by their communities that they end up as products of that community, growing or shrinking to their particular needs.[26]

Despite outward appearances, there were forces within the Edwardian period that were pushing for change and mobilisation. This ethos was certainly present within the voluntary hospitals of Derbyshire and Nottinghamshire. Community involvement in the funding and running of the hospitals, from the participation of aristocrats and tycoons, to the organising of fetes and carnivals by local men and women, was on the rise; more and more ways to get involved were being developed. Working men, by securing coverage for themselves and their families, were beginning to develop a strong bedrock for the hospitals for which they would become reliant upon in just a couple of decades. The three main hospitals in this study – the Derbyshire Infirmary, Nottingham General, and Chesterfield Hospital, entered the 20th Century as traditional institutions that had already treated their communities' ailments for decades. The Derbyshire 'Royal' Infirmary was given

[21] John V Pickstone, *Medicine and Industrial Society* (Manchester University Press: Manchester, 1985) p.3.
[22] Major Du-Plat-Taylor, John Coleridge, Dr J J Abraham, *Cottage Hospitals*, (Ernest Benn Limited: London, 1930) p.11.
[23] Julia Neville, 'Cottage Hospitals and communities in rural East Devon, 1919-1939', Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014) pp.120-121., p.122.
[24] Neville, 'Cottage Hospitals', pp.123-124.
[25] Steven Thompson, 'The mixed economy of care in the South Wales Coalfield, c.1850-1950.', Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014) pp.150-151.
[26] R M S McConaghey, 'Evolution of the Cottage Hospital', *Medical History*, 11:2 (1967) pp.128.

its title on 7 July 1894, prior to which it was the Derbyshire General Infirmary, in a grand ceremony presided over by the Duke and Duchess of Devonshire. At this time, significant building works had taken place (paid for almost entirely by local philanthropist George Herbert Strutt - £12,000 out of the total £15,000) to renew and expand the campus of the hospital to meet demands of the Derby and Derbyshire populace.[27] This was a rapid expansion on the part of the hospital: in 1893 the average number of patients in-house at the Infirmary was 82, but by 1899-1900, this had almost doubled to 151.[28] The Nottingham General Hospitals already had a considerable Saturday fund, developed for some years by a dedicated cadre of volunteers and supported wholeheartedly by the Board of Management and Governors, rising from an income of just £144 in 1873, to £2724 in 1899.[29] The institution was the oldest and the largest of the three and was the only one to date back to the 18th Century. Chesterfield and North Derbyshire Hospital (who gained its own 'Royal' title after its services to the nation in the Great War) entered the 20th Century after a similarly rapid growth, rising from 246 in-patients treated in 1887 to 420 treated in 1899.[30] The hospital had been serving Chesterfield and the North Derbyshire region since 1853, such that it was an institution of the size to nearly rival its southern neighbour, the Derbyshire Infirmary. Chesterfield Hospital, had a strong working men's subscription scheme, that accounted for a large portion of total income. Other institutions throughout the county made a patchwork of coverage for the citizens of the two counties. The Devonshire Royal Hospital and Bath Charity in Buxton was a truly ancient institution, with roots back to the Elizabethan period.[31] It was a specialist hospital that dealt primarily with rheumatism and physical therapy, stemming from its historical bathing therapies. It is a unique institution in that it not only served Derbyshire, but the whole nation, and workers from across the country would attend the Devonshire Hospital to seek treatment for their ailments. As such, its community was not just its local area or even county, but instead the whole country, where its patients and funding came from. It shall be looked at within its own context, especially in the Great War where it was used for the treatment of many, many wounded and injured soldiers. Other specialist institutions included the Children's and Women's Hospitals of Derby and Nottingham. Nottingham had two women's hospitals – the Nottingham Hospital for Women, and the Samaritan Hospital for Women (the two later amalgamating in 1924). These key county institutions were the leading lights of hospital innovation going into the 20th Century in Derbyshire and Nottinghamshire. This period spelled out the foundations of what was to come for the voluntary system. It was an era less affected by social and economic upheaval, unlike the decades to come, and so exists as a microcosm of hospital voluntarism that was shattered once war came. Discussion shall revolve around participation, leadership, and fundraising.

[27] V M Leveaux, *The History of the Derbsyhire General Infirmary* (Scarthin Books: Cromford, 1999) p.117.
[28] Leveaux, *Derbyshire General Infirmary*, p.118.
[29] Alfred Teeboon, 'The Nottingham and Nottinghamshire Hospital Satruday Fund, 1873-1948', *Transactions of the Thoroton Society,* Vol LXXXIV, (1980) pp.68-72.
[30] Chesterfield and North Derbyshire Hospital Annual Report 1899.
[31] Mike Langham and Colin Wells, *A History of The Devonshire Royal Hospital at Buxton and the Buxton Bath Charity* (Churnet Valley Books: Leek, 2003) p.9.

Leadership in the hospitals

The hospital management boards and boards of governors were the leaders of the voluntary hospitals. They made the key decisions of the institution, decided what money would be spent, and when. They decided on staffing, investment, repair, delegated to sub-committees, liaised with other hospitals and regional committees, decided which parts of the hospital to fund, what to build, how to fundraise, and generally had the final word in disputes or conflicts. Local aristocrats or upper-middle class business magnates prevailed in the positions of prestige as 'figurehead' presidents and vice-presidents, invited to the position by the committees for their pre-eminence in the broader community, as well as their social or business connections. Key aristocratic participants in the two counties included the Dukes and Duchesses of Devonshire, Portland, and Rutland, who had associations with many, if not most, of the hospitals in Derbyshire and Nottinghamshire. They were much less involved in the day-to-day or even month-to-month running, but they did provide social access and often used their own money to pay for certain projects they felt passionate about within their institution. Their involvement and participation was not necessarily quite as tangible as that of business leaders such as Jesse Boot (Boot's Chemist), the Player brothers (Player's Cigarettes), or Charles Markham (local construction and mining tycoon), but they did provide a legitimate figurehead for the hospital that was rooted in tradition, in much the same way they did for their own business and family interests.[32] The sixth, seventh, eighth, and ninth Dukes of Devonshire remained the presidents of the Chesterfield and North Derbyshire Hospital from 1854 right into the Second World War.[33] Whatever their physical role on committees might have been, aristocrats and magnates made donations of money, assets, and equipment to the hospitals that in many ways defined their impact on the hospitals far more than whatever official position they held. Donations such as that of £5,000 to the Mansfield Hospital by the Duke of Portland were uncommonly large, but were at many times a necessary part of hospital finances, going towards wards expansions or refurbishments that would not otherwise have been .[34] The Duke of Portland, upon his death in 1943, was dubbed 'The County's Great Benefactor', a legacy held over from his family's extensive donations in the Edwardian period.[35] The Duke, for example, was president of the General Hospital, the Nottingham Eye Infirmary, Ellerslie House (a nursing home for wounded soldiers), the Chamber of Commerce, the Mechanic's Institute, the Association for the Prevention of Consumption, the Midland Orphanage, the Prisoner's Aid society, and was vice-president of the Nottingham Children's Hospital. The Duke and Duchess were prolific hosts for events in aid of Ellerslie House, and the disabled children at the Grindley-on-the-Hill nursing home.[36] However, their investment spending power was not anything like that of the business leaders, especially during the interwar period. But even at this early period in the Twentieth Century the business leaders were

[32] E. P. Hennock, *Fit and Proper Persons, Ideal and reality in nineteenth-century urban government*, (Edward Arnold: London, 1973) pp.307-309., p.313.
[33] Chesterfield and North Derbyshire Hospital Annual Report 1854; Chesterfield and North Derbyshire Royal Hospital Annual Report 1937.
[34] 'A Welcome Benefaction', *Nottingham Evening Post,* 16 December 1913. A donation to Mansfield District Hospital of between £4,000 and £5,000 to clear their deficit was an uncommonly large amount to come from the upper classes, especially so late in the period.
[35] 'Death of the Duke of Portland. The County's Great Benefactor', *Nottingham Evening Post*, 26 April 1943.
[36] *Retford Times*, 30th April 1943.

already making competitive donations and contributions towards the hospitals, the likes of which were often transformative for the institutions on receipt of their benefaction. For example, T J Birkin, at the turn of the century, offered the Nottingham Children's Hospital a house with ample grounds, that they might expand their facilities and their ability to treat the poorly children of the county.[37]

Hospitals relied on their different leaders in different ways and for different tasks. Aristocratic landowners on the estates surrounding the counties' urban centres were expected to attend events, present awards, and add gravitas to the hospitals rather than access to their pocketbooks. Aristocrats drew crowds of people, bolstering potential for donations and public sympathy, as is greatly evidenced by most of the events organised by the hospitals, as well as by other charitable organisers. The Nottingham Women's Bazaar at the Albert Hall presided over by the Duchess of Portland, as well as the organisation of the Primrose League and a Queen Victoria Memorial Fund all serve to show how the great and the good managed to draw large crowds and inspire great efforts[38] But their direct involvement in the day-to-day affairs of the hospital was not as important as the public image that they managed to project to the hospital's community. It is difficult to draw conclusions about the state of the hospital's personality simply from observing which individual was chosen as its figurehead. But they do indicate how the hospitals became sort of microcosm of gentrified civil society, with social hierarchies and leadership matching that of the wider middle and upper-middle class system. In the pre-war world, such leadership was male, although wives and daughters were frequently heavily involved in fund-raising activities. The Duchess of Devonshire served in the Devonshire Hospital through the First World War, and served as Chairwoman in 1918; Derbyshire Hospital for Sick Children Annual Report 1913, Lady Walker and the Duchess of Devonshire served as president and vice president respectively for the Derbyshire Hospital for Sick Children before the First World War; Lady Whitworth was co-founder and leader of the Whitworth hospital while she was alive, and so involved that the hospital had to close its doors for a few years to secure new funding and leadership before reopening.[39]

Alongside these major local aristocrats was an emerging cohort of personalities that started to wield power and prestige in far larger shares than their upper-class counterparts. Business owners, both big and small, clergymen, lawyers, doctors, politicians. People like Sir Henry Bemrose, owner of Bemrose and Sons printers in Derby, who was a long-time member of the Derbyshire Royal Infirmary board of management, and also an MP for Derby.[40] At the other end of the spectrum was Ms Eliza Ogden, a prolific volunteer in the Red Cross, local nursing associations, sick society, as well as an organiser in events like the local Stanley 'Baby Show' and the county Derbyshire Day.[41] This was the extensive network of middle-class civil society that ran the towns and

[37] 'Munificent Gift', *Reading Mercury*, 28 October 1899.
[38] 'Nottm. Women's Hospital. Bazaar at the Albert Hall. Opened by the Duchess of Portland', *Nottingham Evening Post*, 18 February 1904.; 'The Primrose League in Nottingham', *Nottingham Evening Post*, 18 February 1904.; 'Queen Victoria Memorial Fund. Meeting in Nottingham', *Nottingham Evening Post,* 13 June 1901.
[39] Devonshire Hospital and Buxton Bath Charity Annual Report 1918.; 'Death of Lady Whitworth', *Nottinghamshire Guardian,* 30 May 1896.
[40] 'Death of Sir Henry Bemrose', *Dundee Evening Telegraph,* 5 May 1911.
[41] Stanley District Nursing Association, Assorted Papers, DRO D331/5/30-40; Papers of Ms Eliza Ogden, DRO D331/5.

cities. The hospital and nursing association boards were populated by a mixture of staple, long-serving individuals, and a pool of more transient volunteers that remain on the board for only one or two years. These were also volunteers of other charitable and voluntary organisations. A general evaluation of Derbyshire Infirmary, Nottingham General, and Chesterfield Hospital reveals the social makeup of the hospital volunteers, and the hospitals themselves. The sample taken consists of all sitting members of the boards of management from 1900 into the late nineteen-thirties, with a total of 277 individuals and 2,645 years served collectively. Among those who served the longest were the wealthier members of civil society, as well as the long-serving doctors and consultants that volunteered at the institutions. The wealthiest individuals were the ones with the resources to be able to set aside time for the hospital, and further to serve the hospitals for sustained periods.[42] Many of the members on the board at the start of the century still held their position in the following decades.

Figure 1.1: Sir Henry H Bemrose, Derby, 1898.

 [43]

[42] J M Lee, *Social Leaders and Public Persons A Study of County Government in Cheshire since 1888* (Oxford University Press: Oxford, 1963). pp.72-73.; Harmut Berghoff, 'British Businessmen as Wealth-Holders, 1870-1914: A Closer Look', *Business History*, 33:2 (1991). p.226.

[43] 'Sir Henry Bemrose', https://www.npg.org.uk/collections/search/person/mp84453/sir-henry-howe-bemrose [accessed 29/11/2019].

Figure 1.2: Ms Eliza Ogden, c.1910.

 [44]

Working-class involvement in the hospital boards or general running of the hospital was, at this point, essentially limited, although this was to change as patterns of hospital fundraising changed. Chesterfield had a number of working men co-opted onto the Board of Management, through the working men's subscription scheme. Their presence on the board stretches back to the 1860s, and a new representative was elected every year, so that the opportunity for individuals from the working class to have a constant and stable influence upon the managing of the hospital is limited.[45] It meant that no individual member of the working-class was allowed sustained influence within the board. However, they were accorded twelve men for six hospital districts, meaning that they almost equalled the number of regular board members.[46] They had votes, but it appears that according to the rules, there was only one vote per district (essentially one vote per two representatives) and the representatives had no mandate to raise topics or call their own votes. [47] Simply put, working class influence on the board of management was intentionally limited, essentially more of a show of good will rather than democratic enfranchisement of the working-class representatives. Mansfield Hospital, centred as it was in a coalmining district, also had representative workers from each major colliery within the

[44] Original Photograph, Papers of Ms Eliza Ogden, DRO D331/5.
[45] Chesterfield and North Derbyshire Hospital Annual Report 1868.
[46] Chesterfield and North Derbyshire Hospital Annual report 1900.
[47] Chesterfield and North Derbyshire Hospital Rules 1906.

catchment area of the hospital – twelve men for twelve collieries – a tradition that also stretched back into the 19th Century.[48] These were alongside the normal members of the board of management, as well as just two representatives of the colliery owners from two major collieries.[49] Nottingham General had only one working class member of its board of management before the Great War: John Taylor, a joiner who was co-opted onto the board as a member of the Nottinghamshire Saturday Fund. It had no guaranteed mechanism, like Mansfield or Chesterfield, to allow working class representatives of those paying into the hospitals. It was telling that working class members – those for whom the voluntary hospitals were explicitly geared towards providing healthcare for – were largely disenfranchised from the decision-making process of these older and larger institutions. Even where, in the case of Chesterfield, there were 'working men's representatives' allowed on the board, their position was more to relay the information enacted by the other members of the board, rather than participate in the decision-making. Traditional leadership held a tight grip on power, and although not necessarily antagonistic, it certainly wasn't shy about precluding certain members of society from becoming involved.

Traditional leadership within the hospitals often also meant involvement of the clergy, who could frequently be found on management boards.[50] Rev. Henry Charles Russell was chair of the board of management at the Nottingham Children's Hospital from the 1880s to 1922, as well as being the vice-president of the Cot Fund, and a governor of the Nottingham General.[51] At a time when Chandler argues that religion was still very much an inextricable part of national life and civil society, however, the hospitals were largely secularised and drew little influence from the churches themselves.[52] The Sunday Funds and Committees were small, and would remain small throughout the decades. The money they garnered only reached a maximum of a few hundred pounds, and were most effective in the larger hospitals with much larger areas of influence. [53] But nonetheless, the clergy had a role in the management of healthcare. Clergy had a lot of involvement in the local district nursing associations (often centred around small towns or a large district around a village), often comprising the majority or a large portion of the committee of management.[54] Their connections spread throughout the parishes of their respective counties, such that they represented a large number of people county-wide. The Derbyshire Infirmary's Sunday Committee, like others, began the century only representing either Church of England, or non-conformist chapels.[55] However, eventually the committee included representatives from the Church of England, Wesleyan, United, and Primitive Methodists, Presbyterians,

[48] Mansfield District General Hospital Annual Report 1921.
[49] Mansfield District General Hospital Annual Report 1921.
[50] Jonathan Reinarz, 'The funding of Birmingham voluntary hospitals in the nineteenth century', in Martin Gorsky, Sally Sheard (eds) *Financing Medicine: The British Experience Since 1750* (Routledge: Oxon, 2006) p.47.
[51] Nottingham Children's Hospital Annual Report 1922.; Nottingham General Hospital Annual Report 1914.
[52] Andrew Chandler, 'Faith in the nation? The Church of England in the 20th century', *History Today*, 47:5 (1997) pp.11-12.
[53] Nottingham General Annual Report 1900.
[54] The Royal Derby and Derbyshire Nursing and Sanitary Association Annual Report 1900-1901.; Ashbourne District Nursing Association Minutes, 4 March 1901.; Etwall District Nursing Association Minutes, 22 December 1924.
[55] Derbyshire Royal Infirmary Sunday Committee Minutes, 23 October 1901.

Congregationalists, Baptists, Church of New Jerusalem, Roman Catholics, Unitarians, Methodist New Connexion, and from the local Salvation Army.[56] Nominally, this was some thousands of people. The church parades that were conducted on religious days also expanded along with the expansion of the constituent membership of the Sunday Fund. Clergymen were able to impress upon their congregations the necessity of the hospital's work, the demand for funds, and how people could volunteer.[57] Leaflets were produced, letters of appeal distributing to outlying parishes, and statistics accumulated on the patients admitted from the respective parishes.[58] So while the Sunday Funds were small, the influence that the clergy had as ambassadors for the hospital in their community had significant potential. They were a vehicle through which the hospital might be able to find a sympathetic audience.

The churches and the voluntary hospitals were linked historically, and continued this unified countenance, the spirit of caring for the needy being of mutual interest to both church and hospital .[59] Within the hospitals, however, the role of the clergy was less uniform. As members of the hospital boards they either served in a secular capacity as any other board member, or like in the case of Derby they served simply as delegates of the Infirmary's Sunday Committee reporting on their activities.[60] At the Derbyshire Infirmary the clergy had historical influence on the board of management and as governors, and could wield significant influence. In 1852, an anonymous 'clerical governor' (later outed as the Rector of Breadsall) circulated a letter to his fellow governors on the abuses he witnessed and the remedies he demanded, which oddly enough included the abolition of the weekly board, the Master and Mistress, and the hospital chaplain.[61] In this he suggested that the clergymen of Derby should take up the responsibilities. The latter point was rejected vehemently by Reverend Wilkinson of St Werburgh's parish in Derby, on the grounds that the clergy were already overrun by the duties they held, and that the hospital should have a dedicated chaplain to administer to its spiritual needs.[62] Clearly from an earlier time in the hospital's history there was a high level of involvement from the clergy, as well as some disagreement upon their roles as actual functionaries of the hospital. However, what this incident laid out quite clearly is that as much as the goals of the voluntary hospitals and the clergy may be the same, there was little interest in necessarily creating a hand-in-glove relationship between the two. By the turn of the century, clergymen became a minority on the boards of both management and governance, remaining a 'helping hand' for the hospitals, willing volunteers and organisers, but not providing anywhere near the influence or input that other groups, such as the Ladies Committees or other fundraising sub-committees. Analysis of board membership finds that although the membership of clergymen was ubiquitous

[56] Derbyshire Royal Infirmary Sunday Committee Minutes, 17 October 1921.
[57] Derbyshire Royal Infirmary Sunday Committee Minutes, 26 October 1900;
[58] Derbyshire Royal Infirmary Sunday Committee Minutes 23 October 1901; Derbyshire Royal Infirmary Sunday Committee Minutes 24 March 1902; Derbyshire Royal Infirmary Sunday Committee Minutes 17 October 1918.
[59] Andrew Chandler, 'Faith in the nation? The Church of England in the 20th century', *History Today*, 47:5 (1997) p.11.
[60] Derbyshire Royal Infirmary Annual Report 1905.
[61] 'Our Hospital: Its abuses exposed and remedies suggested in a letter to the Governors of the Derbyshire General Infirmary by a Clerical Governor', (W Bemrose and Son: Derby 1852) pp.10-11.; Rev. William Francis
[62] Wilkinson, M.A., 'Remarks on the letter of a Clerical Governor to the Governors of the Derbyshire General Infirmary', (W. and W. Pike: Derby, 1852) p.3., p.6.

(there was always usually at least one clergyman sitting on the board of management, and even more on the governors), the length which each clergyman served was quite short[63] The prevalence of clergy serving fewer years is likely attributed to the transitory nature of the profession, such that it would be rare for clergymen to stay within the same areas for more than 12 or so years. Most of the other board members were local people, situated permanently in the area due to familial ties or business interests. However, the clergy were more at the mercy of their diocese, ordered to go wherever they were needed.[64] The Derbyshire Infirmary had only two clergymen throughout the period, who served on the board ex officio as nominees of the Sunday Committee, but no other members of the clergy served on the hospital board in a 'lay' capacity.[65] As indicated, the role of the clergy waxed and waned through the years, but ultimately their influence as board members, or as leaders in general, was limited. Far more influential were those with spending power, like the aristocrats, and increasingly like the industrialists that were quite ready to offer up money, land, buildings, or resources to the voluntary hospitals. These were the key figures. These were the ones to have wings and wards named after them, and these were the ones to wield sustained leadership power in the years to come.

Incomes

The income patterns of the hospitals were set to change in the five decades from 1900. The Victorian hospitals had formed a landscape of funding based on subscriptions and donations, essentially dominated by a charitable ethos that set the hospitals as the benevolent givers of charity and the patients as the humble receivers of that charity, with democratic participation reserved for the hospital management committees and boards of governors. Waddington points out that there was some measure of 'subscriber democracy' inherent within the subscriber system: 'the idea of an urban democracy where membership was limited to those who contributed', but it was tied up with the ability to pay a subscription, which at (usually) a guinea a year, it precluded most of the local populace.[66] The subscription was a traditional form of income that stretched back to eighteenth and nineteenth centuries.[67] It was a system that gave no guarantee of admittance to the hospitals, and enforced a 'supplicant' relationship between institution and patient, albeit a relatively amicable one.[68] As such, it remained a staple of hospital income throughout the nineteenth century and into the twentieth century, remaining useful while ever there were individuals and firms that were willing to set up a regular donation to the hospitals. However, as historians have shown, the innovations in other incomes meant that hospitals shifted their focus in the twentieth century away from employer-led and individual schemes like

[63] Derbyshire Royal Infirmary Annual Reports 1900-1914; Nottingham General Hospital Annual Reports 1900-1914; Chesterfield and North Derbyshire Hospital Annual Reports 1900-1914.
[64] Frances Knight, *The Nineteenth-Century Church and English Society* (Cambridge University Press: Cambridge, 1995) pp.15-16. Alan Haig, *The Victorian Clergy* (Croom Helm: London, 1984) p.307.
[65] Derbyshire Royal Infirmary Annual Report 1917-1918.
[66] Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Boydell Press: Woodbridge, 2000) pp.135-140.
[67] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.19.
[68] Guy Williams, *The Age of Agony* (Academy Chicago Publishers: Chicago, 1975) p.91.

subscription, and onto employee-led and en-masse schemes like work-based contribution.[69] But in this Edwardian period, these mass-schemes were limited and nucleic at best, and few hospitals were making significant moves away from the strong tradition of subscription, that had sustained the voluntary hospitals – and the voluntary ethic – for generations. In this respect, subscription was more than just a financial tool. It was an ingrained part of the voluntary system that required an extended class relationship between hospital, individual, employer, and employee. Subscriptions on the whole were a method of tying people to the hospital using social and cultural mechanisms alongside the obvious financial donation. As such, subscriptions are symptomatic of the wider hospital culture and of society at the time. The handling of subscriptions – both financially and socially – illuminates a hospital's attitude towards its patients and its wider community. The vast majority of subscriptions still came from individual citizens and small businesses, at between one and three guineas – this was the case for all the hospitals. It was a tradition stretching back into the Victorian era and beyond, when the hospitals were first starting to expand their charitable community away from singular philanthropists to the wider middle-class community.[70] Subscription was an innovation used by many Victorian charities, not just the voluntary hospitals.[71] But it was the voluntary hospitals that theoretically provided something in return, rather than just the satisfaction of helping a good cause. Subscriptions themselves were not a contractual obligation of the hospital to provide treatment, but they did provide tickets to subscribers for them to hand to people who needed hospital treatment.[72] Whether the hospital would treat them after receiving a ticketed individual was down to the actual medical need of the individual. Subscriber numbers reached into the thousands, and their numbers increased throughout the period; it was the established 'norm'. However, as Reinarz has pointed out, a large annual subscription scheme even in this earlier period was no guarantee of being free from deficits; the General Hospital in Birmingham treated one-half of the patients in Birmingham, but was in £10,000 debt at the turn of the century in spite of a very large list of subscribers.[73] The lists of annual subscribers in the annual reports of the hospitals grew from just a few pages at the start of the century to dozens of pages by 1914 – to the extent that they stopped printing them in the Great War.[74] But this increase in the number of subscribers, as well as the increase in larger subscriptions, was only enough to keep the subscriptions stable (in real terms). More people were subscribing, and more organisations were subscribing larger sums, but the subscriptions only decreased as a percentage of the whole income. A good measure of vitality within the subscription system is to look at the number of larger (£10 and over) subscriptions that the hospitals garnered in the period. Each annual report was printed with a form (that the reader could either fill in themselves or pass on to acquaintances) for signing up to the annual subscription

[69] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) pp.48-50., p.52., p.61.
[70] Jonathan Reinarz, *Health Care in Birmingham The Birmingham Teaching Hospitals 1779-1939* (Boydell Press: Woodbridge, 2009) p.14.
[71] John Woodward, *To Do The Sick No Harm: A Study of the British Voluntary Hospital System to 1875* (Routledge & Kegan Paul: London, 1974), pp.18-22.
[72] Woodward, *To Do The Sick No Harm,* pp.38-9.
[73] Reinarz, *Health Care in Birmingham,* pp.153-155.
[74] Derbyshire Royal Infirmary Annual Report 1901-2.; Derbyshire Royal Infirmary Annual Report 1914-15

scheme of the hospital.[75] This form outlined the loose 'contract' that the annual subscription constituted between the hospital and the individual subscriber.

The language used was important, as well as the degrees of separation implicit within the annual subscription mechanism. In actual fact, there was no binding 'contract' between the hospital and the subscriber. An annual subscription was purely in legal terms a donation, and not a payment for service.[76] Instead, if a subscriber wished to have themselves or another person admitted to the hospital, they would use up one of their 'recommends' to recommend a potential patient to a hospital.[77] The hospital (the medical staff chiefly) had the final say as to whom would be admitted as a patient, who not, on purely medical grounds. The only thing a subscriber was entitled to was the 'recommendation' itself, not the right to have a patient admitted.[78] This was to ensure two things: 1. that the hospital was able to have final say who was a patient, and not have the wards cluttered with people who were not ill enough to be admitted, and 2. it meant that the power to recommend remained in the as few hands as possible, preventing the abuse and/or overwhelming of the ticketing system. In a typical circumstance, a group of employees in a workplace would have money stopped from their pay to pay for a group subscription via their firm. For example, in a workplace, the subscriber was essentially the employer, not the employees who were most likely to be the patients of the hospital. As a result, the power to 'recommend' was in the hands of the employer, not the employee/patient.[79] It meant there was a further separation in that unless it was a private family that was subscribing, the subscriber was often not the patient. These distinctions became more important to the hospital community as time progressed, and demand for hospital treatment increased, as shall be illustrated in later chapters.

Subscriptions in Derbyshire and Nottinghamshire were generally stable and without the terrible deficits seen up in Sheffield and down in London, but they were open to fluctuations.[80] The Nottingham General's annual subscriptions remained almost the same from 1900-1914, hovering just above £3,000 until the Great War broke out, upon which it declined.[81] Conversely, the Derbyshire Infirmary showed a more positive and growing trend. From 1901 to 1908, it raised £3,900, yearly, but had a swift increase to £4,537 in 1910, reducing to roughly £4,300 from 1911-1914.[82]

[75] Derbyshire Royal Infirmary Annual Report 1905.; Nottingham General Hospital Annual Report 1904; Chesterfield and North Derbyshire Hospital Annual Report 1904.
[76] 'Extract from the Rules', Derbyshire Royal Infirmary Annual Report 1911.; Rules of the Derbyshire Royal Infirmary 1904.
[77] Woodward, *To Do The Sick No Harm,* p.38.
[78] Rules of the Derbyshire Royal Infirmary 1904.
[79] 'Extract from the Rules', Derbyshire Royal Infirmary Annual Report 1911.
[80] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) p.720.; A E Clark Kennedy, *London Pride The Story of a Voluntary Hospital*, (Hutchinson Benham: London, 1979) p.192.
[81] See Appendix, Nottingham General Finances, annual subscription column.
[82] See Appendix, Derbyshire Infirmary Finances, annual subscription column.

Table 1.1: Nottingham General and Derbyshire Infirmary Subscriptions, 1900-1914.

Year	Nottingham General	Derbyshire Infirmary
1900	2967	3231
1901	3130	3651
1902	3163	3700
1903	3208	3744
1904	3137	3701
1905	3197	3744
1906	3103	3701
1907	3105	3776
1908	3173	3751
1909	3159	4062
1910	3212	4419
1911	3168	4361
1912	3076	4347
1913	2944	4278
1914	2858	4329

Derby Infirmary and Nottingham General, as shall be illustrated in the next section, had obverse progressions in their finances. Derbyshire Infirmary's subscriptions grew, while its Saturday Fund remained stationary. The exact opposite was true for Nottingham General, whose Saturday Fund grew well while its annual subscriptions remained at more or less the same level. Saturday Funds in this time were small. They would not reach any level of momentum until after the Great War (see 1919-1927 chapter). Their original intention was as a small social fund run by hospital volunteers for associated patients. These committees often created events and fundraising opportunities that were extended out to the wider membership of the fund. Saturday Funds were garnering a couple of thousand pounds for the hospitals. Chesterfield was an exception – its Saturday Fund was only founded in 1902, bringing in £69 to the hospital, dropping to only £39 in 1913. However, the other hospitals were far more robust. Derbyshire Infirmary saw a rise from 1900 to 1913 of £1002 to £1108, with a peak in 1905 of £1,504. This was a steady progression, with fluctuations, but it indicates a solid state of affairs.

Nottingham General interchangeably used the terms 'Saturday Fund' and 'Workmen's Collection' for what was essentially its own version of a mass-scheme. It had delegates on the Saturday fund executive committee from the various workplaces that were part of the fund scheme, but those workers did not appear on the board of management of the hospital itself.[83] In 1900 the income from the Saturday Fund was £3144, booming to £9469, but then lulling to £6952 by 1914, and sloping still into the war years.[84] Chesterfield's Saturday Committee was miniscule, instead placing efforts in its innovative working men's subscription scheme. But the

[83] Gorsky, Mohan, Willis, *Mutualism and health care*, p.23.
[84] Nottingham General Hospital Annual Report 1900; Nottingham General Hospital Annual Report 1911; Nottingham General Hospital Annual Report 1914.

Derbyshire Infirmary and Nottingham General Saturday Committees were already extensive by the 1910s. The Committees espoused an ethos of camaraderie that wasn't not seen in other aspects of fundraising or income raising in hospitals, something more easily captured by the methods and ethics of the Saturday funds than the regular annual subscriptions. The Saturday Committees organised entertainments and recreational days out for their members and members of the public.[85] By the end of 1914, Nottingham Saturday Fund had 71,992 employees donating, with as many as 679 individual firms.[86] The Nottingham Saturday Committee split its proceeds among multiple institutions – eye hospital, children's hospital, women's hospital – but the lion's share (70-80%) always went to the Nottingham General.[87]

The Nottingham General Hospital's Saturday Executive Committee made a special effort in 1902 to mobilize the delegates from the wider Saturday fund membership to drum up more subscriptions for the Hospital.[88] The scope of the Saturday Committee was not just within its own parameters; it looked beyond and strove to aid the hospital in gaining forms of income with which the committee itself was not directly concerned. In this capacity the Saturday fund was an all-round organising body for local hospital volunteering; a pool of dedicated volunteers who were open to any and all work that the hospital might require. Mr. Oakland, member of the Saturday Executive, remarked that:

> 'It may appear at first sight that this was outside the province of the committee, but they thought that it was not so. There were members of the Hospital Saturday Committee who from time to time had been the means of inducing new subscribers to the institution, and this had not in any way retarded their efforts in connection with the Hospital Saturday movement; in fact, he was disposed to think it had been otherwise. There were on the committee between 600 and 700 delegates, practically covering the whole of the district; and the committee thought it was not too much to say that at least one-third must know and be in touch with some ladies or gentlemen who were probably willing to become subscribers, and the most likely persons to succeed with them were members of the Saturday Committee, who knew the work and could explain matters'.[89]

His comments show the size and ambition of the body of delegates in the committee, and further illustrates the extent to which these delegates were ensconced throughout the community. Additionally, it serves to show how the sense of responsibility to the institution was larger than their duty to just their own committee and its own specific goals. The Saturday Committee was making efforts to advertise the 'inclusivity' of subscriptions, stating that in fact it was not necessary to subscribe the standard one or two guineas, but that any amount was welcome.[90] The committee, in its nature as a mutualist endeavour, was trying to target those

[85] Nottingham Saturday Fund Executive Committee Minutes, 4 November 1914.; 'Derbyshire Royal Infirmary Saturday Fund', *Derbyshire Daily Telegraph*, 24 March 1913.
[86] Nottingham Saturday Fund Executive Committee Minutes, 1 December 1914.
[87] Nottingham Hospital Saturday Committee, *Nottingham Evening Post*, 24 March 1902
[88] NGH Saturday Committee Minutes, 1902, 'Report of the Executive to the Hospital Saturday Committee'
[89] Nottingham General Hospital Saturday Committee Minutes 1902, Anonymous Newspaper Cutting 'Hospital Saturday Committee Presentation to Mr Joseph Radford'.
[90] 'Nottm. Hospital Saturday Committee', *Nottingham Evening Post*, 24 November 1902.

people on less extravagant incomes for the subscriptions, much the same as they did for the Saturday Fund itself. The hospital and the Saturday fund seemed to recognise that income needed to be varied and not solely focus on one method. It was a recognition that the Saturday fund itself was not suited to all people who would desire hospital coverage, and so helped to advertise the more traditional alternatives.

There were many people involved in the Nottingham Saturday fund, from workers to company directors and professionals. In 1914 the Executive Committee reported it was having difficulties in maintaining the fund to a 'high standard', primarily blaming a reduction in workplace collections on the advent of the National Insurance Act.[91] The National Insurance Act theoretically provided for sick pay and subsidised GP cover via the compulsory contribution to Approved Societies, meaning that ordinary people were having to pay to another fund that ostensibly was already providing for their medical welfare. It was heralded at the time with both applause and condemnation, some stating it to be the 'death-knell of the voluntary hospitals', with less money coming from philanthropists but an increased workload of poorer patients.[92] The fund committee stated that attempts to get employers to organise new funds, as well as simply meeting with employers to discuss arrangements at all, was proving exceedingly difficult.[93] It also blamed industrial unrest, and the 'slackness in trade', that other hospitals also readily blamed.[94] In the same year, J D Player, key donor and philanthropist, stepped down as Vice President of the Saturday Committee, and his brother William was swiftly invited to take his place. Despite a successful Annual Ball that year, it bemoaned the 'meagre' support that it had received in previous years, also stating that there was often not sufficient collectors volunteering for these type of events.[95] This could either be attributed to a lack of enthusiasm, or that they only saw the hospital collections as a form of social insurance, rather than a social activity to engage in. There was a general sense from 1914 that the Saturday Committee is on very unsure ground, and that the Executive is pessimistic about its future. By 1915 they report a 'considerable falling off' of collections, though the amount of events and general efforts made in the year seemingly increased on the previous year, with football matches and other communal events. This was a very gloomy picture projected by the fund, compared to the optimism of 1902, where there was a lot of praise both for the results of collection as well as the number of volunteers.

To the north in Chesterfield, democratic organisation was key to the proliferation of their aforementioned mass scheme. It was not borne of the Saturday movement, but rather evolved from the traditional subscriptions instead. The hospital was founded in 1854. In 1871, there appears in the annual report

[91] 'Report of the Executive To the Hospital Saturday Committee', 14th of March, 1914, Nottingham General Hospital.
[92] Steven Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *The Society for the Social History of Medicine*, 5:3 (1992) p.464.
[93] 'Report of the Executive To the Hospital Saturday Committee', 14th of March, 1914, Nottingham General Hospital.
[94] 'Report of the Executive To the Hospital Saturday Committee', 14th of March, 1914, Nottingham General Hospital.
[95] Report of the Executive To the Hospital Saturday Committee, 14th of March, 1914, Nottingham General Hospital.

'Workmen's Representatives', with the hospital's catchment area split down into districts.[96] These have already been discussed briefly, but here they shall be studied in the context of the financial benefit of the system. These 'representatives' were delegates from the various districts that fed into the hospital, and their presence on the Board was stipulated by the hospital's constitution:

> '26. The district around Chesterfield from which the subscriptions of the various bodies of Working Men are received shall be separated into six divisions, according to a map placed in the hands of the secretary, which divisions shall be called respectively, the Chesterfield district, the Sheepbridge district, the Eckington district, the Staveley district, the Grassmoor district, the Pilsey and Tibshelf district.'[97]

In all, there were 12 representatives, two from each district. They did not make up the majority of the members of the board. They were still outnumbered by the regulars of the Board of Management, numbering 16, including the Chairman and Vice-Chairman. Furthermore, there was the President of the Board, as well as 7 Vice-Presidents. So while the presence of the Workmen's Representatives on the Board could have possibly suggested that power was meted out to the 'community' of people that supported the hospital, power still lay with the traditional 'hospital elite'. Even so, it is very significant that working men's representatives were given some access to the management of the hospital so early. By all accounts, it was a unique mechanism. Gorsky, Mohan, and Willis describe how the early mutualist subscriptions usually came via friendly societies or guilds, but these subscriptions around Chesterfield seemed to be coming straight from the workplaces dotted around the town and its hinterlands.[98] Gorsky, Mohan, and Willis illustrate the small sums garnered from direct workplace subscriptions from Sunderland Royal Infirmary, but they were nowhere near the same scale as Chesterfield, nor did they engage the workmen subscribers in such a way.[99] It was put down clearly in 1888 that the workmen's representatives should indeed be: '"Working Men" in the Rules should be construed in their popularly accepted sense'.[100] Essentially that the representatives should not be the managers or the owners, but elected from the larger workforce of waged workers. In this respect, it was a mutualist effort encased within the subscription model, with the mechanisms inherent in annual subscription. Class was a conscious element in the construction of the subscription network around the hospital. This scheme, though basic in its early years, grew to be incredibly successful in later years. It also indicated how, even early on, Chesterfield Hospital was innovative and also receptive to the desires of its working populace – perhaps far more so that its neighbouring institutions.

The hospital also turned to its working men subscribers on a number of occasions for extra funds, on top of what was already being subscribed. In 1906 Chesterfield Royal Hospital appealed to the working men's fund for an increase on their subscription to pay for the increased number of beds

[96] Chesterfield and North Derbyshire Royal Hospital Annual Report 1871
[97] Chesterfield and North Derbyshire Royal Hospital Annual Report 1905
[98] Gorsky, Mohan, Willis, *Mutualism and health care*, p.20.
[99] Gorsky, Mohan, Willis, *Mutualism and health care*, p.22.
[100] Chesterfield and North Derbyshire Hospital Annual Report 1888

within the institution. The hospital argued that there was no other alternative than to appeal to the fund membership to try and raise the £15,000 capital sum needed for the extensions.[101] By 1908 the estimated cost had increased to £16,000, of which the subscribers had raised £11,036.[102] In 1909 they have to make a fresh appeal for the subscribing workmen to all contribute a uniform amount of 2s 6d per capita – many subscribing firms remain underneath this threshold.[103] This opened up questions of what exactly was the remit of the delegates and scheme members – were they simple latent contributors or did they have a greater responsibility towards their hospital in the form of organising and fundraising?[104] This was answered ultimately by the growth of the scheme and the subsequent use of its financial and physical clout to advance future endeavours within the hospital. This was the beginning of a more reactive relationship between the hospital and its smaller donors, where the hospitals increasingly looked to the broader community, rather than a smaller number of philanthropists, for larger projects. But it meant galvanising the community behind the hospital, engaging them in the idea that the hospital's viability was tied to their own wellbeing.

Active Fundraising: Pageantry and Participation in the Hospitals

The subscriptions schemes, be they smaller annual subscriptions or the later mass schemes, were in essence passive. They did not necessarily require the active participation of the men and women paying into them, and only demanded either an annual renewal, or weekly payment (in the case of workplace subscriptions).[105] The fact that many of the Saturday fund committees were active participants in other forms of hospital voluntarism, the schemes themselves required little actual engagement by the public. However, aside from subscriptions and Saturday funds, there was a growing tradition of active fundraising. Committees inside and outside of hospitals had a legacy of utilising local community events for the benefit of their institutions. Gorsky discusses the impact of locality on a hospital's finances and operations, pointing to the vitality of the aforementioned mutualist schemes as an indicator of community involvement in the hospitals.[106] While true, the strength of a mutualist scheme did not necessitate an active 'social calendar' of hospital-oriented events, such as carnivals, parades, or other singular organised events that garnered income and publicity. Although locality is a guiding concept, organising them by location is not necessarily the most useful or constructive way. Instead, an attempt to categorise the different types of events has been made. The first part of this section will deal with the broad idea of 'Carnival' in hospital fundraising. These events were attended by all shades of society, and in huge numbers. They often lasted multiple days, and were not always confined to one location,

[101] Chesterfield and North Derbyshire Hospital Annual Report 1906.
[102] Chesterfield and North Derbyshire Hospital Annual Report 1908.
[103] Chesterfield and North Derbyshire Hospital Annual Report 1909.
[104] Report of the Executive To the Hospital Saturday Committee, 14th of November, 1915.
[105] Martin Gorsky, 'Community Involvement in Hospital Governance in Britain: Evidence from Before the National Health Service', *International Journal of Health Services*, 38:4 (2008) p.759.
[106] Gorsky, 'Community Involvement', p.763.; Martin Gorsky, John Mohan, 'London's Voluntary Hospitals in the Interwar Period: Growth, Transformation or Crisis?', *Nonprofit and Voluntary Sector Quarterly*, 30:2 (2001) pp.255-260.

sometimes conducted across the different districts of a city. They required huge and prolonged effort to organise. There were also the smaller but far more numerous town and village carnivals that were organised by far smaller committees, but which nonetheless put great effort into diverse attractions and spectacles.

The concept of the 'Carnival' is something rooted in European history, with a strong tradition stretching back to the early-modern era and beyond.[107] More typically they were based around festivals of religious significance such as the 'Wakes', but as the 19th Century progressed, the religious meaning was side-lined for the sake of general celebration and merry-making.[108] The southern European countries had a much more overt tradition of carnivals; they were celebrations of excess, of 'Misrule' and 'Unreason'. [109] Burke and Reid assert that the Northern European and Scandinavian traditions of carnival were more conservative, more orderly, and more focussed towards certain goals than just organised for their own sake. [110] The hospital carnivals were not the debauched affairs of the Mediterranean carnivals but were very 'British' affairs with careful structure, clear purpose, and orderly entertainment. However, traditional carnival elements were still present by 1900. In the absence of the Lord of Misrule and the Abbot of Unreason, as in the old days, they retained the more stable institution of a carnival monarchy, which nonetheless offered a subversion of usual class structure, elevating a commoner to become king. Carnival Kings and Carnival Queens were a staple of most carnivals, where a member of the procession would be elected to the 'prestigious' position, indeed being crowned and given mock ceremonial robes. Folk heroes also continued to be an important part of some carnivals. Robin Hood, the robber-of-the-rich and giver-to-the-poor, was an ideal character both for the subversive flavour of the carnival, but also for charitable giving.[111] At heart, the hospital carnivals were grounded in British and European tradition, and were not just spontaneous tools implemented by hospital fundraisers to garner cash. They were long held as forms of community entertainment, recognised as such by their community audience. Holidays from the normality of life, where fancy dress and pageantry allowed participants the opportunity to party and pretend and engage in 'role-reversal'.[112]

Out in the smaller villages and towns, with disparate populations in mixed rural hinterlands, it was more difficult to set up the security of the subscription schemes that the larger hospitals enjoyed, and so community fundraising was far more vital for survival. Even so, often the funds raised were not uniform from year to year, but in Ashbourne hospital fundraisers were able to raise an average of roughly £100 a year from all its many events.[113] These hospitals were often small, with low patient turnover and relatively low incomes. Total incomes for cottage hospitals the size that served Matlock and Ashbourne were roughly between £200-£300

---

[107] Peter Burke, *Popular Culture in Early Modern Europe*, (Ashgate Publishing Limited: Aldershot, 1994). p.180.
[108] Douglas A Reid, 'Interpreting the Festival Calendar: Wakes and Fairs as Carnivals', in Robert D Storch, *Popular Culture and Custom in Nineteenth Century England* (Croom Helm: London, 1982) p.127.
[109] Ronald Hutton, *The Stations of the Sun A History of the Ritual Year in Britain* (Oxford University Press: Oxford, 1996) p.95., pp.105-108.
[110] Douglas A Reid, 'Interpreting the Festival Calendar: Wakes and Fairs as Carnivals', in Robert D Storch, *Popular Culture and Custom in Nineteenth Century England* (Croom Helm: London, 1982) p.125.; Peter Burke, *Popular Culture in Early Modern Europe*, (Ashgate Publishing Limited: Aldershot, 1994) p.191.
[111] Burke, *Popular Culture*, p.180.
[112] Hutton, *Stations of the Sun*, p.105.
[113] Ashbourne Victoria Hospital Ladies Committee Minutes, 1920-1929

between 1900 and 1905 whereas, for comparison, Chesterfield Hospital's total income was £4,952 in 1903.[114] The events themselves were of mixed succss, and of course, depending on the recipient, were met with mixed gratitude. The Whitworth Hospital in Darley Dale (consisting of roughly a dozen beds, at most) received £13 8s 2d from the carnival in 1903, over which the hospital was jubilant, and in the same year the Bolsover Hospital Demonstration raised an estimated £30 for the Chesterfield and North Derbyshire Royal Hospital, which went largely ignored.[115] What was a poultry sum for the likes of Chesterfield was a vital lifeline for a hospital the size of the Whitworth. But aside from the obvious financial gain, these events hold other significance. They indicate that the hospitals were receiving support from all over the counties. While the people of Bolsover or Matlock were not able to garner the money that the larger and more prosperous population of Chesterfield proper could, they still made appreciable efforts, that could make a difference in the right place.[116] The Bolsover carnival in 1903, despite 'showery weather', was a success; the local school played host to the band recital, and 'several of the tradespeople kindly [gave] the provisions for tea'.[117] Local people were able to ease the burden of organising the carnival by lending their time and resources, and by 1910, the repertoire of events at the carnival had grown to a fancy-dress parade, a mock football game, a clown performance, and a procession of the local fire brigade and ambulance corps.[118] The carnival organisers were determined to ensure success by being flexible, and relying on local people to aid in the organisation. In spite of the Chesterfield Hospital's indifference towards these events, the people of Bolsover were determined to continue their new tradition, because they saw a certain importance in raising money for their hospital.

Voluntary organisations would rely on event-fundraising to supplement the incomes that came from subscription schemes and larger (though often sporadic) philanthropic donations.[119] These smaller incomes were vital for supplementing a hospital's expansion and maintenance, as well as acting as publicity for the institution. New equipment was always needed, more staff required, and upkeep of the hospital (new boilers, repainting, new roof, etc.) were all costs that lay outside of what 'regular' income covered – 1905 was a particularly costly year for Ashbourne Hospital, with various structural repairs, repainting of wards and waiting room, and a new boiler and pipework installed.[120] Therefore, the fundraising committees had to remain

---

[114] 'Whitworth Hospital. Darley Dale', *Derbyshire Times and Chesterfield Herald*, 2 May 1903.; The Whitworth Hospital Annual Report 1912.; The Whitworth Hospital Annual Report 1914.; Ashbourne Victoria Hospital Annual Report 1917 (see 'General Summary for the last Sixteen Years', p.7.).; Wirksworth Cottage Hospital Annual Reports, 1900-1905; 'Chesterfield Hospital', *Derbyshire Courier*, 3 March 1903,.

[115] No title, *Derbyshire Telegraph and Chesterfield Herald,* 18 April 1903; No title, *Derbyshire Telegraph and Chesterfield Herald*, 15 August 1903.

[116] No title, *Derbyshire Times and Chesterfield Herald*, 15 August 1903.

[117] No title, *Derbyshire Times and Chesterfield Herald*, 15 August 1903.

[118] 'Bolsover Revelry', *Derbyshire Courier*, 4 June 1910.

[119] John Garrard, 'Urban elites, 1850-1914: The Rule and Decline of a New Squirearchy?', *Albion: A Quarterly Journal Concerned with British Studies*, 27:4 (1995) p.596.; Martin Gorsky, 'Community Involvement in Hospital Governance in Britain: Evidence from Before the National Health Service', *International Journal of Health Services*, 38:4 (2008) p.755.; Steven Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *The Society for the Social History of Medicine*, 5:3, (1992) p.456., p.464.

[120] Ashbourne Ladies Committee Minutes May 1905.

flexible and forward-thinking if they were to satisfy the (potentially unforeseen) needs of the hospital. From the large county hospitals, down to cottage hospitals and local district nursing associations, funds needed to roll in. This spurred many concerned individuals to form dedicated fundraising committees both inside and outside of the institutions to attempts to alleviate the worrisome position that hospitals were often in.[121] On these committees, much like their larger counterparts concerned with the subscriptions or the Saturday funds, sat businessmen, labourers, landowners, women (single, married and widowed), and all other sorts of people, who very often were involved in a number of other committees within their community, and their county. There was almost always a narrative of 'need' within the hospital – financially successful years were underplayed, and bad financial years were exaggerated; Whitworth Cottage Hospital liked to state that it was working at 'full financial capacity' to give the impression of needing more funds, despite quite healthy finances going into the 1910s.[122] It shows the anxiety that the committees of management for the smaller voluntary hospitals had for their finances, fearing that one bad year might spell the end of the small institutions, or force ward closures in the large institutions. Even if incomes were traditionally stable, not one penny of their income was necessarily guaranteed, all of it coming in the form of 'donations'. The Whitworth especially had legitimate cause for anxiety, having closed briefly at the end of the 19th Century due to lack of funds after the death of Lady Whitworth (the hospital's founder). Whitworth Hospital management committee had seen how complacency and over-reliance on a single income stream (i.e. the benevolence of one philanthropist) could spell disaster once that stream dried up.

This 'pluralism' among volunteers was certainly reflected in the type of fundraising events they decided to hold. In the villages of Derbyshire, cycling clubs were very often at the heart of fundraising efforts for hospitals and local charities in the early century, and would host yearly events using their own funds to supplement the payment for the services rendered at their 'carnivals'. In Matlock, a yearly procession was organised, which would snake throughout the town. Led by the cyclists, who would have decorated their bicycles in all manner of amusing or interesting ways, they would be followed by a procession of people in fancy dress, including 'Old Lady, 'Blackpool Wheel', 'Hussar', 'Baker', 'Parrot', and dozens more.[123] After the procession, a series of prizes were awarded to the best dressed individuals or the best decorated bicycles.[124] This procession around the town is very significant in that it was intended to encompass the area which the hospital served. Instead of remaining static in a field, or in a town square, as others did, it took the Carnival to the townspeople, moving among them, not letting them forget what they were proceeding in aid of. Similar processions were commonplace for hospital carnivals. Fancy-dress was a staple, and characters from history and current events

[121] Jonathan Reinarz, 'Investigating the 'deserving' poor: charity and the voluntary hospitals in the nineteenth-century Birmingham', Anne Borsay and Peter Shapely (eds.), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550-1950*, (Ashgate Publishing Limited: Aldershot, 2007) p.126.; Martin Gorsky, John Mohan and Martin Powell, 'The Financial Health of Voluntary Hospitals in Interwar Britain', *The Economic History Review*, 55:3 (2002) pp.539-543.
[122] The Whitworth Hospital Annual Report 1911
[123] 'Cycle Carnival at Matlock', *Derbyshire Times and Chesterfield Herald,* 21 September 1901.
[124] 'Matlock's Cycle Carnival – Attractive Charity Parade', *Derbyshire Times and Chesterfield Herald*, 15 September 1906,

were mimicked or mocked. Lord Nelson was in Bolsover, heralded as a very noble entry, while a group of women in Whittington Moor (near Chesterfield) mocked the suffragettes by dressing up as them and acting out a comic tableaux.[125] As well as illustrating the political views of the local populace, this sort of pageantry showed that there was a satirical interest in both historical and current affairs that lent humour-driven flavour to the carnivals. The following photograph shows a good example of hospital publicity; bringing home to the local public how the hospitals cared for their patients. A tongue-in-cheek microcosm of a hospital ward, with nurse, heavily-bandaged patient, and doctor all crammed onto a dray.

Figure 1.3. First prize-winning cart decorated with nurse, doctor and patient. C.1914. [126]

In a rare opportunity for working-class people to engage in amateur dramatics, folk theatre and make-believe became key parts of hospital carnivals as shown by a 'mock' game of football held at Whittington Moor Carnival. It was one large play, acted out by both teams and a harassed referee. Players made pratfalls, to which the St John's ambulance team would respond by bandaging the player from head-to-foot, and stretchered him off to cheers from the crowd. Although humorous and fun, this brought the seemingly unrelated farce back to the subject of health. At about half-way through the match, the referee made a poor decision, which caused a theatrical display from the team at fault, who carried the referee off the pitch, whilst the other team scored goals behind their backs, with local Boy Scouts attempting to protect the referee.[127] At another event at Whittington Moor, a 'comic' cricket match was put on, which '[as] nobody knew which side was the victor, the game was ended somewhat abruptly'.[128] At the same event, a tug-of-war was held by the fancy dress contestants and event organisers, which ended in farce when the rope snapped (whether

[125] 'Bolsover Revelry. Big Crowd at Hospital Carnival', *Derbyshire Courier*, 4 June 1910.; 'In Aid of Hospital – Cycle Carnival at Whittington Moor', *Derbyshire Courier*, 20 April 1909.
[126] DRO 1678z/z2
[127] 'Bolsover Revelry. Big Crowd at Hospital Carnival.', *Derbyshire Courier*, 4 June 1910,.
[128] 'Carnival for Charity. A Commendable Effort At Whittington Moor', *Derbyshire Courier*, 21 May 1910.

deliberately or not) and all the participants fell over, which the journalist eloquently called a 'Picturesque Debris'.[129] These examples of humour and theatrics certainly indicate that these events were fun, and not taken too seriously despite their serious charitable raison d'être. They enforce the idea that fundraising for a hospital meant that there was a mutual benefit for both the hospital and its community, which all the more reinforced a community's desire to fundraise for its local institution: the local people were able to have fun in the name of the hospital, which made fundraising all the more appealing.

It was rare that an event was poorly attended. The weather certainly put paid to a few events, as events were often held in a farmer's field donated for the carnival's use. If weather was inclement, events had to be called off or downsized, and generally at-gate payment would be reported as lacking.[130] For smaller hospitals that relied on these yearly events for a welcome injection of cash into their budgets, they would resultantly suffer considerably from one day's summer rain. In Ashbourne, they tried to prevent putting all their eggs in one basket, and held a series of small events throughout the year, including Christmas concerts, plays, collections, afternoon tea-parties, and others.[131] Pound Days ran all the way from the hospital's foundation to the Second World War. These and other events proved very successful, with a steady stream of money coming into the hospital all year, ready to pay for maintenance and improvements around the institution.[132] Throughout the years, the Ladies' Committee at Ashbourne Cottage Hospital was quite innovative in coming up with new forms of community fundraising, both in a participatory and passive sense. Envelopes were sent out to residents of the village, to be returned with cash on entry to the Christmas party.[133] They would always organise their street collection on the same day as the Shire Horse Show, so that they were tapping into an established traditional event when more than just the population of Ashbourne was out in force.[134] These small, nucleic organising committees in the towns and villages were vital to the sustenance of the smaller hospitals, and tapped into the existing and easily recognised traditions of society to try and create an appropriate hybrid; one that provided welcome entertainment, while also garnering much-needed funds for the hospitals.

What is seen in the presence of the carnivals, parades, and other organised events throughout the two counties was a different course between charity and philanthropy, and mutualist self-help. It muddies the waters of the typical dichotomy developed by historians, who have generally asserted that the voluntary hospitals started the century defined by their charitable attitudes and charitable methods of fundraising and doling out care, to an eventual transition to mutualism, wherein contributory schemes meant that individuals

[129] 'Carnival for Charity. A Commendable Effort At Whittington Moor', *Derbyshire Courier*, 21 May 1910.
[130] 'Carnival for Charity. A Commendable Effort At Whittington Moor', *Derbyshire Courier*, 21 May 1910.; 'Clowne, Cresswell, Whitwell, Barlborough and District', *Derbyshire Times and Chesterfield Herald*, 30 May 1914.; 'For the Hospital. Brampton Carnival in the Rain', *Derbyshire Courier*, 14 August 1915
[131] Ashbourne Victoria Hospital Ladies Committee Minutes 1905.; Ashbourne Victoria Hospital Ladies Committee Minutes 1924.; Ashbourne Victoria Hospital Ladies Committee Minutes 1939.
[132] Taking 1913 as an example, there were seven recorded events through the year, including a Dance and Whist drive that brought in £51, a Pound Day, a Street Collection, a second Dance and Whist Drive, and a Rummage Sale, which brought in £20.
[133] Ashbourne Victoria Hospital Ladies Committee Minutes, 12 May 1924 - 15 December 1924.
[134] Ashbourne Victoria Hospital Ladies Committee Minutes, August 1911.

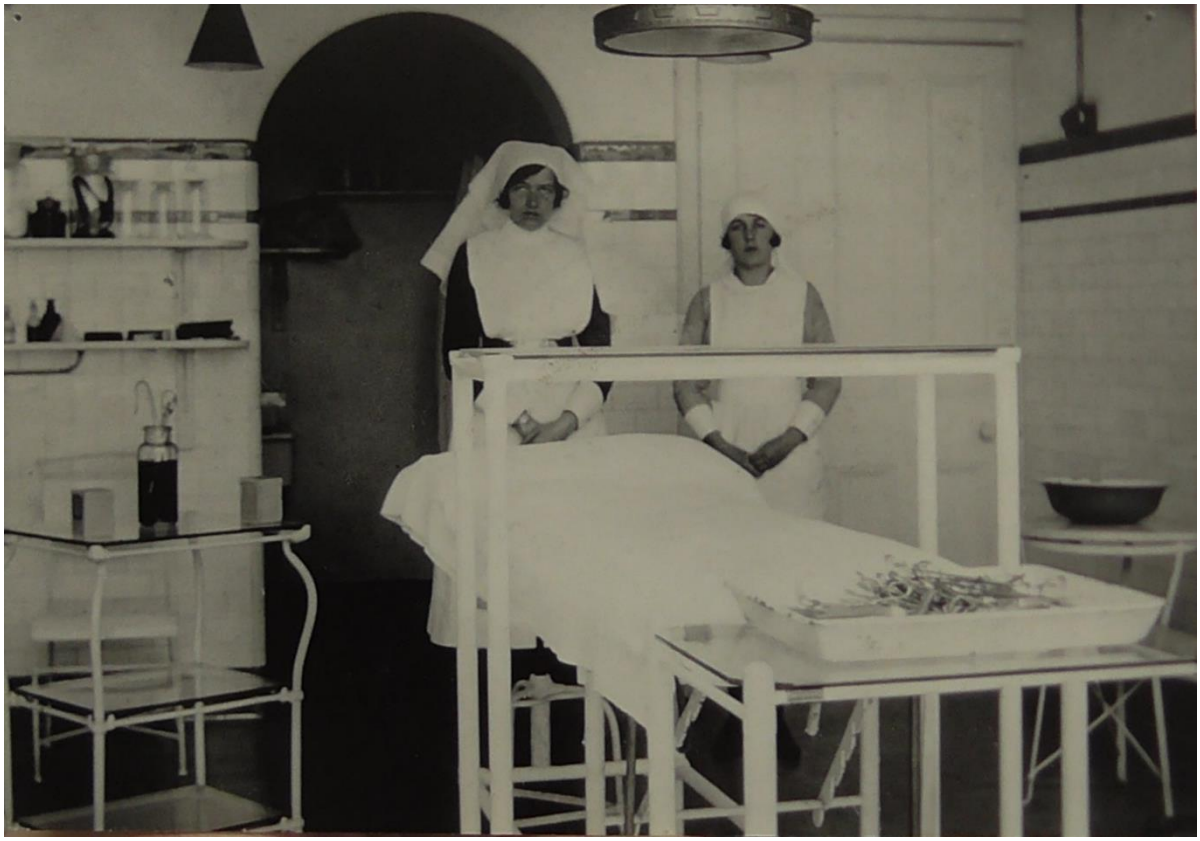
were able to essentially 'pay' for their care. What the organised fundraising displayed was a mix of the two. Its object was charity, and often involved were the usual suspects of philanthropy – the middle-classes and the upper-classes. But at the same time, it involved volunteers from all walks of life who participated both in the organisation and in the events, as well as ordinary citizens who attended these events and gave donations. They melded the appeal of charity (sympathy for a good cause, self-satisfaction at having given) and the appeal of self-help (giving to a hospital that an individual and their family may indeed need to use). In this era, the events were many, and small. They were often in towns that were detached from their hospitals, sending their funds from places like Sheepbridge or Matlock to Chesterfield, and so the latter 'self-help' idea of event fundraising was not quite so established. But when larger events started to be hosted in towns with hospitals, like Derby and Ripley (after its hospital was established), the connection between the community and the hospital was consolidated by these events.

Smaller Hospitals in Urban and Rural Industrial Environments

The two counties had different patterns of hospital coverage. Derbyshire had a greater number of smaller institutions, both in the industrial towns and in the rural towns up in the Derbyshire Dales. As a whole, there were ten smaller hospitals by 1910 in Derbyshire and Nottinghamshire – five of which were situated in the remote regions in the Peak District and Derbyshire Dales.[135] These added to the three large general hospitals in Chesterfield, Derby, and Nottingham. Thompson found a similar situation in the South Wales coalfields at the same time, where twenty new small general, accident, and cottage hospitals were founded between 1893 and 1917, in a flurry of activity that was heralded in by the boom in the coal output and massive increase in population.[136] He also found that it was often the trades unions that sparked the initiative for founding (or taking democratic control over) the hospitals that sprang up throughout the South Wales coalfield. It was different for Derbyshire, where the unions were more interested in tackling the coalowners and getting involved in local party politics than procuring direct healthcare for their membership.[137] Examples which illustrate this are Ripley Cottage Hospital and Ilkeston General Hospital, both sitting on the industrialised belt that stretches up the Nottinghamshire-Derbyshire border. These two hospitals were in relatively close proximity to each other.[138]

[135] There were small voluntary hospitals in Ashbourne, Bakewell, Buxton, Darley Dale (near Matlock), Ilkeston, Mansfield, Newark, Wirksworth, and Worksop.
[136] Steven Thompson, 'To Relieve the Sufferings of Humanity, Irrespective of Party, Politics or Creed?: Conflict, Consensus and Voluntary Hospital Provision in Edwardian South Wales', *The Journal of the Society for the Social History of Medicine*, 16:2 (2003) p.250.
[137] J E Williams, *The Derbyshire Miners* (George Allen & Unwin: London, 1962) pp.500-505.,
[138] The third chapter shall also look at neighbouring Heanor hospital, established after the Great War.

Figure 1.4: Nurses at Ilkeston General Hospital c.1920., Display Collection, Ilkeston Community Hospital.



[139]

At the beginning of the 20th Century, Ripley was a medium-sized town settled on the industrial eastern belt of Derbyshire. It was sustained by heavy industry, such as steel and coal mining, as well railways and brickworks.[140] The largest company employer, aside from perhaps the Ripley Co-operative Society, was the Butterley Company, which not only owned the large steelworks and rail tracks, but also numerous coal mines in and around Ripley.[141] The town had roughly 12,000 inhabitants, sitting 10 miles from the Derbyshire Royal Infirmary, and further again from the Chesterfield Royal Hospital, it lacked a convenient hospital service. [142] Ilkeston General Hospital (upgraded from a cottage hospital in 1894) was closer to Ripley than Nottingham or Derby, but was too small to accommodate patients from outside of the town, having only 25 beds to serve a population of 21,000 (only peaking at 60 beds in 1928.[143] Ilkeston nurtured a close association with the local Co-operative Society, who fully furnished the operating theatre in 1909, and indicates the close links that the hospital had not just to local philanthropic individuals, but to local mutualist organisations in the community as

[139] Nurses at Ilkeston General Hospital c.1920., Display Collection, Ilkeston Community Hospital.
[140] Roy Christian, *Butterley Brick 200 years in the Making*, (Henry Melland: London, 1990) pp.20-23.
[141] Christian, *Butterley Brick 200 years in the Making*, p.164.
[142] *Souvenir of the Ripley Cottage Hospital, Being a Record of Incidents leading up to the Establishment of the Institution with a few notes on the Town of Ripley,* 1911
[143] 'General's Centenary – Dawn of a new era for the 'old lady', *Ilkeston Advertiser*, 2 November 1984.; Ilkeston General Hospital Annual Report 1914.; Voluntary Hospitals Database, Ilkeston General Hospital Bed Numbers.

well. Ilkeston relied on miners for the bulk of its subscriptions, and through the years even relied on the Shipley, Ilkeston, Cossall, and Mapperley Colliery Companies to furnish the hospital with fuel.[144] Indeed, the pride which they have in their community was self-evident, stating that:

> 'May the day never dawn when, through lack of interest or selfishness, such a work as this is hindered by the paucity of subscribers to the Hospital, the establishment and carrying on of which redounds to the credit of Englishmen and England – a country where such institutions are pre-eminently a national characteristic – and by which not only her sons but the whole civilised world are justly and rightly ennobled'.[145]

Ilkeston Hospital, already established some two decades, was determined to continue its work, and provide for its town the best hospital care it could, without the burden of debt. However, in Ripley, there were fresh calls for the founding of a cottage hospital, so as to provide local emergency care for workers in Ripley and district. The story, still commonly held today, is that a young collier Tom M Neal suffered a terrible crushing accident down one of the pits, resulting in a severely fractured thigh.[146] He was patched up at the coalface, seen to at the local surgery, and then loaded onto a horse-drawn cart to head for the Derby Infirmary, as was the available process. Unfortunately, on the way he suffered a serious bleed, and perished.[147] It was a story retold at the hospital's first meeting of the board of management, and still today the hospital's League of Friends use this story to illustrate the necessity of having a local hospital for the town, so that others might not befall Neal's fate. The narrative of Ripley Cottage Hospital is important for realising the needs that a local populace had for accident and emergency services close-at-hand, especially in a era where such industries as mining were fraught with danger. It was not just Neal's death that caused the subsequent landslide of local support for a hospital, but it certainly served as a rallying cry. Curtis and Thompson's work on the disabled services provided for the miners in South Wales shows how it was almost always down to the miners themselves to organise and provide care or orthopaedic and convalescent support for their comrades injured or disabled down the pits. Their study finds that the capacity of local people to found medical societies based in towns and villages that were clustered around the coalmines was remarkable, and a prime example of self-preservation in the absence of a sympathetic state or capable philanthropists.[148] Their study draws out a lot of similarities in the methods and attitudes utilised by the miners around Ripley.

In early 1911, the men at the collieries and works of Ripley and district were balloted to see if they would be amenable to a hospital being erected at their expense. They were asked whether they would be willing to contribute a penny a week towards the maintenance of a hospital, but initially to donate a shilling per man

---

[144] Ilkeston General Hospital Annual Report, 1935.
[145] 'Ilkeston General Hospital', *Ilkeston Advertiser,* 20th Sept 1912.
[146] *Souvenir of the Ripley Cottage Hospital, Being a Record of Incidents leading up to the Establishment of the Institution with a few notes on the Town of Ripley,* 1911, pp.3-10.
[147] *Souvenir of the Ripley Cottage Hospital, Being a Record of Incidents leading up to the Establishment of the Institution with a few notes on the Town of Ripley,* 1911, p.15.
[148] Ben Curtis and Steven Thompson, '"A Plentiful Crop of Cripples Made by All This Progress": Disability, Artificial Limbs and Working-Class Mutualism in the South Wales Coalfield, 1890-1948', *Social History of Medicine,* 27:4 (2014) pp.711-713., p.716.

towards its erection.[149] There was initial hesitation, with the representatives of Swanwick colliery and the Butterley Company questioning whether the scheme was feasible, and whether it was worth diverting the money they sent to the Derbyshire Royal Infirmary for the sake of a smaller hospital (which would inevitably have fewer services to offer than a large general hospital like the Infirmary).[150] Similarly, the men from Loscoe were already contributing to both Derbyshire Infirmary and the Nottingham General.[151] There was an air of general scepticism surrounding it, mostly coming from the representatives of the works, who feared that the one shilling initial donation (albeit only around 2.5% of the average coalface worker's weekly wage) would put many off, and also that it would cost so much money that the net would have to be cast unmanageably wide.[152] Initial balloting showed just a slim majority in favour of a new hospital.[153] The hospital committee was unable to clarify whether workers would have to switch their subscriptions wholly to the proposed hospital. Clearly the works representatives felt put in an awkward situation between what was clearly a positive idea and on the other hand upsetting the relationships they already had with the larger hospitals. Furthermore, politics was evidently an issue. The Butterley Company's managing director, Mr A Leslie Wright, was also on the Board of Trustees at the Derbyshire Royal Infirmary, and another director from the same family, Fitzherbert Wright, was on the Board of Management.[154] Unsurprisingly, their subscription was with that hospital. If only, they argued, cases could be 'more speedily transferred' to the hospital, then that would suffice – essentially, just use the money for an ambulance.[155] The company employed thousands of men around Ripley and its district, in its pits, factories and railways. There clearly could not be a Ripley Cottage Hospital without the support of the workmen from this particular company.

However, fate would provide a further galvanising influence that swayed the miners' opinions. On the day of the second ballot, a young collier, Herbert Clarke, was severely injured, this time by the pit cage, and 'in such a precarious condition that it was deemed impracticable to remove him to a hospital and he was accordingly taken to his lodgings'.[156] The next day, the results of the ballot were solid – of the nearly 3,000 votes cast, 2,396 were in favour, and 594 against.[157] Clearly the impact of another serious pit accident not long after Neale's must have struck a chord in the close-knit communities around Ripley. As the local GP, Dr Doyle, later noted: 'It's not far to Derby…It's only ten miles, but if any of you have been the journey after an accident you would think it was fifty'.[158] The same day that the ballot was reported, Clarke died. It was further remarked

[149] 'Ripley Cottage Hospital Project', Nottingham Evening Post, 24 February 1911.
[150] 'Ripley Cottage Hospital Project', Nottingham Evening Post, 24 February 1911.
[151] 'Ripley Hospital Scheme. Balloting the Miners.', *Nottingham Evening Post*, 2 March 1911.
[152] 'Ripley Hospital Scheme. Balloting the Miners.', *Nottingham Evening Post*, 2 March 1911.
[153] 'Ripley Hospital Scheme. Workmen's Ballot Incomplete.', *Nottingham Evening Post*, 10 March 1911.
[154] Derbyshire Royal Infirmary Annual Report, 1910.
[155] *Souvenir of the Ripley Cottage Hospital, Being a Record of Incidents leading up to the Establishment of the Institution with a few notes on the Town of Ripley,* 1911, p.18.
[156] 'Serious Colliery Accident Near Ripley. Young Miner Severely Crushed.', *Nottingham Evening Post*, 23 March 1911.
[157] 'Cottage Hospital for Ripley. Scheme decided upon.', *Nottingham Evening Post*, 24 March 1911.
[158] 'Cottage Hospital for Ripley. Scheme decided upon.', *Nottingham Evening Post*, 24 March 1911.

that there were a great number of men not balloted, but who would be willing to subscribe. There was apparently some doubt still in the meeting of representatives. Again, Dr Doyle intervened:

> '[he] did not think a cottage hospital scheme has ever been launched in the country under more auspicious circumstances. If they had not sufficient enterprise and confidence in the people of the district to carry on a cottage hospital in Ripley with the nucleus they had, he was sorry for Ripley'.[159]

If medical men and workmen were united, opinion amongst the owners remained divided. The Wrights of Butterley Company still had to be persuaded, and further intrigue unravelled in April, as the Nottingham Evening Post reported:

> 'A meeting of the ladies' committee in connection with the Ripley Cottage Hospital scheme was called for last night for the purpose of discussing with the Nursing Association Committee the proposal to amalgamate the two funds. Only those, however, of the Nursing Committee who are members of both the committees put in an appearance, and it transpired during the evening that the president of the Nursing Association (Mrs A Leslie Wright) was opposed to the hospital scheme, favouring a motor ambulance instead'.[160]

Mr Crossley (local factory owner) of the Hospital Committee, and his wife of the associated Ladies Committee, and Mr A Leslie Wright of the Butterley Company and Derbyshire Infirmary, and his wife of the established Nursing Association. Nevertheless, public opinion overcame individual influence, and within 18 months of the original meetings, the hospital was opened.[161] Despite early concerns about the costs of opening the hospital, it managed to do it free of debt – the final outstanding sum of £116 being covered by Mr Charles Ford, 'a local colliery proprietor', with the rest of the sum raised totally via donations and subscriptions from Ripley workers and townspeople.[162] Popular opinion, ratified by the support of medical professionals had meant that the hospital was built, despite resistance from some of Ripley's – even Derbyshire's – most powerful businesspeople. By the Great War, two towns in this area had their own small hospital, soon to be joined in the 1920s by another in Heanor. But at that, it offers comment on the potential narrow-focus of the voluntary system – whether intentional or unintentional. Three towns, next to each other, with short and direct road links to each other, were not able to rationalise their efforts and have a united hospital service over the small geographical region. They did not have the scope or ambitions of the South Wales miners, who Thompson shows were adept at self-organising to make town and region-wide schemes in efforts to provide what the government and charity would not provide.[163] However, what they did have in common with the South Wales

[159] 'Cottage Hospital for Ripley. Scheme decided upon.', *Nottingham Evening Post*, 24 March 1911.
[160] 'Ripley Hospital Scheme. Attitude of the Nursing Association', *Nottingham Evening Post*, 6 April 1911.
[161] 'A Good Start', *Nottingham Evening Post*, 9 September 1912.
[162] 'A Good Start', *Nottingham Evening Post*, 9 September 1912.
[163] Steven Thompson, 'The mixed economy of care in the South Wales Coalfield, c.1850-1950.', Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014) pp.146-147.

miners, to a certain extent, was the 'consensual' foundation of the hospital, wherein different classes and social groups coalesced to fund a hospital, with only a small contingent of opposition from some of the local elites.[164]

Turning west to the Derbyshire Dales, there was a different situation altogether. Ashbourne and Wirksworth were comparatively as remote as some of the Welsh mining towns, but were not of the same industrial makeup. Chief employers were quarrying, farming, and small-scale factory work, meaning that although there was little coal mining in the Derbyshire Dales, there was still demand for convenient healthcare. However, there was not over-riding medical logic or rationale for the establishments of cottage hospitals. For example, Wirksworth Cottage Hospital was founded in the middle of the Victorian era, being the only source of medical care for a dozen miles or more. Ashbourne, conversely, was established in the early 1900s. Both were of a similar size and operated in very similar ways, however, Ashbourne was much closer to an established general hospital (Derby) whereas Wirksworth's closest neighbour was only the Whitworth Hospital near Matlock until Ripley was established in 1911. Establishment, therefore, depended not just on need, but local organising and enthusiasm, as well as how concentrated the interested population was. Ashbourne and Wirksworth had a rich tapestry of community activity between them. Ashbourne Hospital had an especially active Ladies Committee.[165] As well as the usual hospital visiting duties and day-to-day running of the hospital, the Ladies Committee was incredibly active in drumming up financial and physical support from the people in and around Ashbourne. Indeed, it would seem that a large portion of the village's calendar consisted of events in aid of the hospital. It was much easier, in a tightly-knit village setting, to raise money from the local populace, when the collectors were known to the people being collected from. The Hospital 'Pound' Day, where donations of money or goods (£'s or lb's) were asked for and collected on a single day, were organised regularly, and sometimes more than once a year, and met with great success.[166] For this, the Ladies Committee requested that the clergymen of the Ashbourne and neighbouring areas be given notice and get involved in the organising and advertising of the event.[167] So, the committee was able to tap into established networks, and presumably the clergy themselves were amenable to promoting a good cause within their parishes.

In December 1910, there were concerns arising out of the Ashbourne hospital management committee about a deficit that was developing in the hospital's finances. The Ladies Committee took it upon themselves to organise some events to alleviate this. They decided upon a 'Town and village collection', as well as a street collection at the local market, and had a hand in organising a children's play at the local chapel, in aid of the hospital and the District Nursing Association.[168] Indeed, the Town and Village Collection was refined into not simply collecting cash on the day, but signing up individuals for subscriptions to the hospital – a method also prioritised by the women involved in the House Canvass for Derby Royal Infirmary.[169] Similarly organised, the

[164] Thompson, 'To Relieve the Sufferings of Humanity', pp.253-255.
[165] Ashbourne Victoria Cottage Hospital, *Rules, Preliminary Statement, List of Officers, Subscribers, &c*., 1898.
[166] Ashbourne Victoria Hospital Ladies Committee Minutes, March 1909.
[167] Ashbourne Victoria Hospital Ladies Committee Minutes, March 1909.
[168] Ashbourne Victoria Hospital Ladies Committee Minutes, December 1910.
[169] Ashbourne Victoria Hospital Ladies Committee Minutes, 31 March 1911.

town was split into districts and women officers assigned. The Ashbourne Shire Horse Show was chosen year after year as the site of the street collection in the end.[170] This indicates another example of hospital volunteers adopting the traditions and functions of their immediate area for not only ease but also maximum benefit. Other events organised by the Ladies Committee included a rummage sale, operettas at the Congregational Chapel, and amateur dramatics.[171] While these events were not themselves of a necessarily local 'flavour', they do indicate that events were inspired by contemporary culture, one operetta being 'Princess Butterfly'.[172] Events were incredibly well organised, with adverts tendered to the paper, invites sent out to houses in the countryside, as well as door-to-door sales conducted throughout the town, with tickets priced at two and three shillings.[173] This seems to conflict with Finlayson's suggestions that pre-First World War charitable works were far more unorganised than their post-war equivalents.[174] In fact, time and again in the Derbyshire voluntary hospitals, we see high levels of organisation within the smaller cottage hospitals and small fundraising events, as well as a growing trend of organisation amongst the larger hospital volunteers. Du-Plat-Taylor, Coleridge, & Abraham argued that cottage hospital committees had to organise, had to effectively fundraise, and had to fully utilise their townsfolk as volunteers if they were to make their hospital a good service to the public, because they were not able to rely on the usual income mechanisms that larger hospitals did. [175] They outlined how women volunteers were vital for the running of hospitals, organising linen leagues, street collections, as well as acting as hospital visitors (lay-inspectors of the wards and facilities) but should remain in an auxiliary or support role, rather than as chief protagonists of the institutions.[176]

Ashbourne and Wirksworth Hospitals offer insight into the fluctuating fortunes of women volunteers in the early Twentieth Century. As already alluded to, Ashbourne Hospital forcibly changed the makeup of its management committee in its early years. In 1900-1904 Ashbourne had ten women on the committee of management out of a total of 19 members, but in 1905 all of the female members are removed from the management committee and the total management Committee numbers are reduced to the ten men.[177] The women on the committee were transferred, it appears, to be members of the newly-founded Ladies Committee, subordinate to the commands of the management committee. Conversely, Wirksworth at the turn of the century had a very small management committee populated by men, but a very large Ladies Committee

[170] Ashbourne Victoria Hospital Ladies Committee Minutes, August 1911. This was the first instance of the show being used for the street collection, but the practice continues for many subsequent years.
[171] Ashbourne Victoria Hospital Ladies Committee Minutes, July 1913.; Ashbourne Victoria Hospital Ladies Committee Minutes, December 1912 and March 1914.; Ashbourne Victoria Hospital Ladies Committee Minutes 27 March 1916.
[172] Ashbourne Victoria Hospital Ladies Committee Minutes, March 1914.
[173] Ashbourne Victoria Hospital Ladies Committee Minutes, 15 August 1917. Tickets were sold at 3/- for reserved seats, and otherwise at 2/-.
[174] Geoffrey Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History*, 1:2 (1990) p.202.
[175] Major Du-Plat-Taylor, John Coleridge, Dr J J Abraham, *Cottage Hospitals,* (Ernest Benn Limited: London, 1930) p.15
[176] Du-Plat-Taylor, Coleridge, Abraham, *Cottage Hospitals*, pp.14-17.
[177] Ashbourne Victoria Cottage Hospital Annual Report 1905.

that had a broad range of responsibilities.[178] However, in 1906, this changed, when the two committees were merged, and women served on the committee of management for the first time, albeit in a minority, right through to 1914.[179] Two similar sized institutions, in similar areas, but with different attitudes towards women on their hospital boards. A pattern can't necessarily be extrapolated from just analysing the presence of women on boards. Ashbourne Hospital had a relatively complicated beginning, and an equally complicated relationship with its women volunteers. The Ashbourne hospital Ladies Committee consisted of nearly three-times the amount of members on the Management Committee, and consisted of a range of women, some of whom were titled.[180] Original rules from 1898-9 state that the Management Committee should be filled by 12 members 'elected from annual subscribers of 10/- and upwards'.[181] It is stated that a Management Sub-Committee shall be elected, and that '[Rule] 8. One or more lady visitors may be appointed by the sub-Committee to assist in the domestic arrangements of the Hospital…' and so it may be presumed that those ladies listed under 'Committee of Management' were perhaps women from the sub-Committee, although this does not explain their absence from the list of names of 'Ladies Visitors appointed under Rule 8.'

The hospital was rebuilt in 1903, with more appropriate premises.[182] Women were on the Management Committee in 1903, 1904 and 1905, but the rules were changed in 1906, so that rather than the previous general term 'members', the Committee of Management was stated to consist of 'Twelve Gentlemen' (elected from Annual Subscribers).[183] Furthermore, the subordination of the ladies Committee is consolidated under Rule 7, where it states that the 'twelve Ladies…shall be annually appointed by the Committee of Management at its first Annual Meeting'.[184] So while women were heavily involved in the support and running of the hospital (The Ladies Committee sustained its 20+ members right from 1904 to 1947), they were denied any decision-making by the rules of the institution. Indeed, it is recorded in the minutes for the 13th July 1905 that the Secretary had prevented the Ladies Committee from arranging something so minor as the Matron's holiday, stating that the Ladies Committee had 'acted ultra vires'. [185] This was not undisputed, and the President of the Ladies Committee, The Hon. Mrs Okeover, managed to argue the point that there was provision for such action within the hospital rules, and it was resolved that the Ladies Committee would thenceforward have the authority to arrange staff holidays.[186] So, as evidenced by this managerial scuffle, there was some dispute about the boundaries of authority between the men and the women of the hospital's management. Certainly, the Ladies Committee was not a passive organisation, but still they were unable to broach the more important decisions of the hospital. By the Second World War, women were once again on

[178] Wirksworth Cottage Hospital Annual Report 1900, 1903.
[179] Wirksworth Cottage Hospital Annual Report 1906, 1907, 1913.
[180] Ashbourne Victoria Cottage Hospital Annual Report 1904.; Ashbourne Victoria Cottage Hospital Annual Report 1906.
[181] Ashbourne Victoria Hospital Annual Report 1898. Original text asserts just twelve members, but hand-written amendments stated 'not less than 12', but 'no more than 18'.
[182] Ashbourne Victoria Memorial Hospital Annual Report 1902.
[183] Ashbourne Victoria Memorial Hospital Annual Report 1908.
[184] Ashbourne Victoria Memorial Hospital Annual Report 1908.
[185] Ashbourne Victoria Hospital Minutes of Management Committee, 13 July 1905.
[186] Ashbourne Victoria Hospital Minutes of Management Committee, 13 July 1905.

the Management Committee.[187] However, they were in a severe minority (2 out of 19 overall members) and were nowhere near their pre-1904 number, and the first re-entry of a woman onto the committee remained a singular anomaly from 1927.[188] It begs the question as to what the personality of hospital voluntarism was with regards to women. Certainly, in these localised contexts, they made up the brunt of the volunteer workforce, but were denied honorary or actual leadership until later in the interwar period.

There was a certain dearth of women in positions of 'executive' power within most of the hospitals. Although women like the Duchess of Devonshire became patron and then president of the Devonshire Hospital by the Great War, non-symbolic positions of power in the hospitals were almost all held by men. At the Derbyshire Infirmary only one woman, Mrs Innes, found her way onto the board in 1913, and Nottingham appears to have none.[189] Chesterfield, Buxton Devonshire, and Newark are no better, with only one woman in Chesterfield (Mrs C P Markham, wife of industrialist Charles Markham, was a long-serving member of the board) and none at all in Buxton or Newark.[190] Using Du-Plat-Taylor et al's model for women's roles in hospitals, one would infer that they were not an essential part of a hospital's operations. They relegate women to what could be boiled down to as domestic work.[191] Digby's research into women in medicine and hospital voluntarism finds the attitude of Du-Plat-Taylor, Coleridge, & Abraham to be commonplace; women were limited to certain proscribed roles within the medical and volunteer role.[192] It was an extension of 'political domesticity', insofar as women were expected to be in the linen league, to volunteer on the wards, to be the nurse, rather than be on the management committee, or performing surgery.[193] However, as dominated by men (like any field at the time) as voluntarism was, it was a vehicle for women to enter into a professional sphere under their own agency. Ladies Committees were much more of a driving force in the community than Du-Plat-Taylor seems to recognise. By membership, they were usually one of the largest if not the largest single committees in a hospital or nursing association, they attracted many local women to the cause of fundraising and aiding the hospital physically. Wirksworth Ladies Committee in 1902 had more than two dozen women on it – matching the Derbyshire Infirmary at the time.[194] It would appear that the size of the institution really influenced the roles that the Ladies Committee would take on, and as shall be suggested, the larger an institution was, the more its Ladies Committee was physically detached from the hospital and concentrated on fundraising.

In Ashbourne the Ladies Committee was active all-year-around and was present in efforts for fundraising and physically supporting the work of the hospital. Ashbourne Ladies Committee was especially depended upon by the hospital Management Committee to take regular visits into the wards, and relay to them any concerns or

[187] Ashbourne Victoria Hospital Annual Reports 1938-47.
[188] Ashbourne Victoria Hospital Annual Report 1927
[189] Derbyshire Royal Infirmary Annual Report 1913; Nottingham General Hospital Annual Reports 1900-1913,
[190] Chesterfield and North Derbyshire Royal Hospital Annual Report 1900-1913.; Buxton Devonshire Hospital Annual Reports 1900-1913; Newark Hospital Annual Reports 1900-1913;
[191] Du Plat Taylor, Coleridge, Abraham, *Cottage Hospitals,* pp.15-16.
[192] Anne Digby, 'Medicine and the English State, 1901-1948', in S J D Green, R C Whiting (eds.) *The Boundaries of the State in Modern Britain*, (Cambridge University Press: Cambridge, 1996) p.220., p.223., p.226.
[193] Digby, 'Medicine and the English State, 1901-1948', p.221.
[194] Wirksworth Cottage Hospital Annual Report 1902; Derbyshire Royal Infirmary Annual Report 1903-4.

requests that the Matron and patients had.[195] On many occasions, they would relay spending requests to the Management Committee relating to boiler break-downs, damp, and inadequate staff, and in this capacity doubled not only as the Visiting Committee, but also the House Committee, in the hospital's early days. The House and Visiting Committee largely drew their membership from the Ladies Committee.[196] In a small hospital in a small town, where volunteers were not so readily abundant as in Derby or Chesterfield, the responsibility of day-to-day communication with the hospital was given to the Ladies Committee. Similarly, in Wirksworth, the hospital management relied on Women volunteers to provide for the hospital not just raising money, but in raising supplies. Wirksworth had a series of successful 'Pound Days' which would call for '£1 in Money, or in Pounds of Tea, Coffee, Cotton Wool [etc.]' which would supplement funds as well as alleviating spending.[197] Wirksworth's Ladies Committee is less well documented than Ashbourne, and as mentioned was abolished early in the century, but at this point a 'Ladies Visiting Committee' was established that consisted of 12 members, with two or three responsible for two months out of the year. This indicates that the hospital certainly saw it not only appropriate for women to take this role but would suggest that the requirement of visiting was a task that needed a sizeable and dedicated team.

A good example of a highly organised fundraising effort in the larger hospitals was the Mayoress of Derby's Ladies Committee at the Derbyshire Infirmary. The committee was founded under the auspices of the Mayor and Mayoress of Derby, who usually presided over meetings and lent their status to the event, but were not themselves active members.[198] Their highlight as an organisation was the 'House-to-House Canvass', a yearly event that required all members of the Ladies Committee to commit to going door-to-door asking for donations to the hospital, as well as signing up people to new subscriptions. Derby was divided into districts, in charge of which was one member of the Ladies Committee, who then herself organised her team of women to go around the district collecting.[199] The Nottingham General did not have a dedicated Ladies Committee in the Twentieth Century. The inspection duties were conducted by the Visitors Committee (a sub-division of the House Committee), which would enter the institution on a regular, usually weekly, basis to assess the cleanliness, efficiency, and care within the institution.[200] Similarly, Chesterfield Hospital possessed a small Ladies Committee, at this time only really occupied with hospital visiting and helping in the Alexandra Rose Day appeal.[201] Elements like the Rose Day remained minute in comparison to other fundraising efforts, and thus the collecting team assembled as well as the committee that organised it did not wield significant power in their own right.[202] There were as many as twenty five active members of the committee, the

[195] Ashbourne Victoria Hospital Ladies Committee Minutes May 1905; Ashbourne Victoria Hospital Ladies Committee Minutes July 1905; Ashbourne Victoria Hospital Ladies Committee Minutes January 1906
[196] Ashbourne Victoria Hospital Ladies Committee Minutes February 1906; Ashbourne Victoria Hospital Ladies Committee Minutes December 1909;
[197] 'Wirksworth Cottage Hospital Pound Day', Poster, 1925, Derbyshire Record Office.
[198] Mayoress of Derby Ladies Committee Minutes 23 May 1922.
[199] Derbyshire Royal Infirmary Annual Report 1900-1.
[200] J E Stone, *Hospital Organization and Management (Including Planning and Construction)*, (Faber & Gwyer: London, 1928). P.151.
[201] Alexandra Rose Day Committee Minutes 12 June 1913.
[202] Alexandra Rose Day Committee Minutes 12 June 1913.

majority of which were women volunteers that aided in the setting up of the collections and jumble sales. It indicates that there was less dependence on women volunteers in the larger hospitals to conduct organisational work, but instead they filtered down into minor fundraising roles very much on the periphery of the hospitals' financial networks.

The period before the Great War saw the voluntary hospitals start to thrive and innovate. Their numbers were growing, and their respective sizes swelling. There was the start of real professionalisation within the hospitals, with duties and responsibilities divided up along semi-official lines. The middle-classes had ensconced themselves among the upper-classes and had brought a new age of business-minded focus to the hospitals and nursing services. The armies of female volunteers had enabled a number of hospitals to reach their potential, as well as allow the hospitals to be the grounds for some level of social mobility. There was a lot of vibrancy in the hospital volunteering scene, where town and village folk were coming out of their homes and putting their hands in their pockets for their local hospitals. New hospitals had been founded in Ripley and Ashbourne through the support of their local communities. It is unfathomable in this age of nationalised healthcare that a hospital might be founded without the overarching umbrella of public or private funding. But in the dawn of the new century the necessity for localised healthcare meant that townspeople were determined to overcome difficulties and provide healthcare for themselves. The cottage hospitals illustrated the level of democratic control that hospital communities had, and also prove that hospitals did not spring up on the whim of philanthropists but emerged organically from the needs of the populace. The dour conservatism that pervades the image of the Edwardian era is totally smashed by the vibrant, silly, humorous, and celebratory carnivals organised by hospital volunteers. The sensible and serious medical institutions were supported by a community that was more than willing to have fun to raise support for their hospital. Overall, however, the pre-Great War era did not necessarily hint at the changes that were to come in the hospitals. Only Chesterfield Hospital's Working Men's Subscription Scheme showed the ethos (if not the numbers) of creating what would become a mass fundraising scheme. The hospitals were tied to their traditional incomes, and the stability of the economy and the slowness of social change meant that there was no compulsion or conviction to radically change how the hospitals garnered their funds. That was soon to change, as the drums of war heralded unprecedented turbulence not just for the nation, but for the very fibres of hospital voluntarism.

Chapter 2: 1914-1919 – The Impact of War

This study, overall, is defined by its localised focus. It examines the personality and culture of Derbyshire's and Nottinghamshire's voluntary hospitals within their own context, against the backdrop of a national narrative set out by other historians. At times of national crisis, however, the national elements become more important, imposing new conditions and presenting different sets of challenges. This and the following chapter survey the local impact of the First World War, the subsequent 'Hospitals Crisis', and finally the 1926 general strike. They investigate whether or not hospitals dealt with crises differently, and to what extent they were able to recover (or not) between the war and the general strike. It looks at how the war and the economic upheaval affected hospitals in different ways, and how hospitals addressed the unavoidable problems presented to them. While the rest of the study focuses on the agency of the hospitals themselves, this chapter examines how the hospitals reacted to events far beyond their control, and the extent to which it limited their own agency.

The general mechanisms for the voluntary hospital system and the debates surrounding them have already been largely outlined. By 1914 the majority of hospital income came from subscriptions and philanthropic donations. Saturday Funds not yet reached their maturity, only gaining momentum in a few isolated cases like Nottingham.[1] Fundraising was vibrant, but still dealing with relatively small amounts of money, and organised of a small scale. The outbreak of the Great War presented a set of new and difficult problems for medical care of the civilian and military population in the United Kingdom. The role of the War Office and its grants, as well as the voluntary services outside of the hospitals (Voluntary Aid Detachments, British Red Cross, St John's), and the schemes established for the utilisation of the hospitals for wounded servicemen will be assessed in terms of their impact upon the voluntary hospitals in Derbyshire and Nottinghamshire. The lessons of the Boer War and the Russo-Japanese War had been absorbed into the planning for the next great conflict by the Royal Army Medical Corp (RAMC) and the Army Medical Service. William MacPherson, a colonel-commandant of the RAMC and later historian of the conflict, argued that the provision for treating wounded soldiers and infectious diseases in the South African campaigns at the turn of the century were wholly inadequate, and informed much of the new steps taken in 1914.[2] Elements as simple as nomenclature had caused confusion and

[1] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006). pp.27-29.
[2] Major General Sir W G MacPherson, *History of the Great War Based on Official Documents Medical Services General History Vol I.*, (His Majesty's Stationery Office: London, 1921)., pp.1-2.

inefficiency, resources diverted to the wrong places.[3] Soldiers in the Boer War were refused inoculations, sanitation was terrible, and resultantly instances of disease were huge by retrospective comparison to the Great War.[4] Better organisation and sanctioned vaccination programs meant that between 1914-18, instances of typhus were drastically reduced.[5] These lessons and advances directly informed the way in which the War Office dealt with the civilian voluntary hospitals. Abel-Smith, sceptical of the ability of the voluntary hospitals to deal with crisis, calling the existing system 'haphazard' at the start of the war, lacking the necessary organisation and malleability to adjust to what was to follow.[6] However, he also pointed out how the War Office was also not quite so organised as MacPherson suggests; its planning arrangements turned out to be ad hoc.[7] No one was able to predict, or adequately plan, for the scale of casualties that the war presented. Yet, the voluntary hospitals were only a small part of the medical war effort on the home front. There were numerous organisations willing to donate their time, effort, and resources for the sake of helping wounded soldiers. Key support lent to the War Office was received from the British Red Cross Society and Order of St John's. Abel Smith illustrated that these two organisations, along with the Soldiers' and Sailors' Help Society, vied for overall power and prestige of administering care for wounded soldiers, eventually settling into a Joint War Committee following mediation by the government.[8] The Red Cross, in Britain and in other nations, had diverged from its original internationalist tenets by 1906, and become an 'integral' extension of Britain's military medical services.[9] Yet, as Meyer notes, the Red Cross and St John's Ambulance were equally ill-prepared for a large-scale European conflict as any other organisation, and their lack of coordination with the military medical services had palpable impacts for the early months of the war.[10] They were largely untested as instruments of the national war machine.

Meyer further argues that this 'Red Cross patriotism' was a type of 'medical voluntarism as a distinct form of wartime service'; both a viable alternative for conscientious objectors, and an outlet for women to participate in the war effort as they were excluded from military service.[11] What had emerged by the First World War, and crystallised through the years of conflict, was a

[3] Macpherson, *History of the Great War,* p.3.
[4] Roy Porter, *The Greatest Benefit to Mankind A Medical History of Humanity from Antiquity to the Present* (Fontana Press: London, 1999) p.443.; Macpherson, pp.13-16.
[5] Porter, *Greatest Benefit*, p.443.
[6] Brian Abel-Smith, *The Hospitals,* (Heinemann: London, 1960) p.252.
[7] Abel-Smith, *The Hospitals,* p.253.
[8] Abel Smith, *The Hospitals,* p.254.
[9] Jessica Meyer, 'Neutral Caregivers or Military Support? The British Red Cross, the Friends' Ambulance Unit, and the Problems of Voluntary Medical Aid in Wartime', *War & Society*, 34:2 (2015) p.110.
[10] Meyer, 'Neutral Caregivers or Military Support?', p.110.
[11] Meyer, 'Neutral Caregivers or Military Support?', p.120.

form of inherent patriotism embodied in providing care for the sick and wounded of the British Empire. Indeed, it was an extension of the 'war machine' which sought to rationalise chaos, where the unstoppable momentum of war was tackled by officialdom and attempts at increasing efficiency.[12] Jarboe argues that the hospitals of both the wounded British and Indian soldiers served not just the purpose of healing soldiers for active duty again, but as 'sites of propaganda and helping to sustain popular support for the war'.[13] The cultural impact of hospitals healing the wounded masses that were being shipped from the battlegrounds of Europe cannot be readily ignored, for it served as a re-forging of the hospital services through the challenges and strain of dealing with the war alongside dealing with their civilian sick. The voluntary hospitals of Derbyshire and Nottinghamshire were having to expand their remit not just to the sick in their own medical neighbourhoods, but to the wider community of Great Britain, and even the Empire and its allies. It condenses down to questions of voluntary pragmatism and national duty. This concept could have some bearing on later conversations about the place of voluntarism during crises, and to what extent voluntarism was resilient enough to absorb the losses and trials of national crises.

Beds, waiting lists, and War Office grants

Schemes were established prior to 1914 to prepare for the likely eventuality of large-scale war. Authorities strove to establish a delineation between services and responsibilities, as well as a rationalisation of the hospitals currently operating in the United Kingdom. Hospitals were categorised into: Military Hospitals, War Hospitals, and Auxiliary Hospitals.[14] The size and capacity of voluntary hospitals, in the two counties and nation-wide, had related directly to the ability of an institution to garner sufficient funds from their communities and benefactors, growing organically with demand and available provision. The war meant that hospitals were swollen in an 'artificial' way with more beds and more patients than they had ever had to deal with before. The demands and expectations placed on voluntary hospitals by the War Office were limited at the start of the war, but started to expand with the sheer numbers of casualties being sent from abroad.[15] Most voluntary hospitals of the United Kingdom were allocated as 'Auxiliary Hospitals' by the War Office and RAMC.[16] They, therefore, sat alongside the myriad small VAD hospitals set up in houses and

[12] Jeffrey S Reznick, *Healing the Nation Soldiers and the Culture of Caregiving in Britain Curing the Great War*, (Manchester University Press: Manchester, 2004) p.3.
[13] Andrew Tait Jarboe, 'Healing the Empire: Indian Hospitals in Britain and France during the First World War', Twentieth Century British History, 26:3, (2015) p.353.
[14] MacPherson, *History of the Great War,* pp.85-86.
[15] MacPherson, *History of the Great War,* p.97.; Porter, *Greatest Benefit*, p.642.
[16] MacPherson, *History of the Great War,* p.85.

private buildings donated temporarily for the sake of the war effort. Within this category, hospitals were split into two classes: the Class A institutions were sites that facilitated adequate medical and surgical treatment for wounded soldiers, whereas Class B were places that could not provide this, and mostly housed convalescent cases.[17] As such, they were entitled to different grades of War Office grants, with Class A hospitals receiving two shillings per patient per day at the start of the war, which was increased to three shillings sixpence, and two shillings sixpence for Class B.[18] As a point of comparison, the average in-patient cost to Nottingham General immediately prior to the war was 3/8d, which by the war's end (because of inflation) had risen to 5/7d.[19] In short, war payments failed to cover costs.

In practice, the large voluntary hospitals were categorised as Class A, with the cottage hospitals and VAD hospitals as Class B. There grew from this scale of payments a seeming dichotomy between 'hospital' and 'convalescent' services, and the resultant response from the larger institutions varied, with Class B institutions likely to have far fewer staff and facilities (thus lower running costs). Concentrating of four large hospitals, Nottingham General Hospital, Derbyshire Royal Infirmary, Devonshire (Buxton) Hospital, and Chesterfield and North Derbyshire Hospital, the following table shows the approximate total beds held by the hospitals in 1914, and then the number of total beds they offered for war service by the end of 1914[20]:

Table 2.1: Hospital Beds, Derbyshire Infirmary, Nottingham General, Chesterfield Hospital, Buxton Devonshire, 1914-1917.

Hospital	Total beds in 1914	Extra beds provided by War Office	% of original bed capacity	Total Beds in 1917
Nottingham General Hospital	254	102	40	554
Derbyshire Royal Infirmary	256	100	39	367
Devonshire Hospital, Buxton	300	150	50	316
Chesterfield and North Derbyshire Hospital	120	20	17	162

[21]

[17] MacPherson, *History of the Great War,* p.85.
[18] MacPherson, *History of the Great War,*, pp.85-86.
[19] Nottingham General Hospital Annual Report 1924.
[20] These figures are based on the closest known data which was 1911 returns to the Hospitals Yearbook.
[21] Voluntary Hospitals Database, http://www.hospitalsdatabase.lshtm.ac.uk/.

The war impacted differently on different hospitals. The Devonshire Hospital eclipsed others in its advanced preparation of extra beds. It was better able to facilitate this because it specialised in rheumatic and allied illnesses and fewer acute cases, and it was not required to treat accident and emergency cases.[22] It, therefore, had greater immediate capacity in its extensive and ancient campus, nestled in the hills of Buxton. The hospital was created utilising various different buildings already erected for the use of the ancient spa, even including some old stables. When these buildings were handed over to the institution by the Duke of Devonshire, they were said to be 'a very extensive range of buildings', of 'handsome proportions'.[23] Noticeably, it did not increase its total bed capacity across the war. The 150 beds that it gave over to the wounded soldiers were subtracted from total civilian bed capacity; they were not supernumerary.[24] The institution's capacity to treat its civilians even at this basic level was thus limited by the requirements of the War Office. Initially, too, bed numbers at the Nottingham General and Derbyshire Infirmary did create 'extra' beds, but evidently reduced the number of beds available for treatment of civilians.[25] Only later did numbers expand. Chesterfield Hospital, who handed only a small fraction of beds compared to Derby and Nottingham, increased its bed capacity from 120 to 140 to accommodate the wounded, investing its own money in new beds, and utilising spare beds from storage.[26] Chesterfield's hospital was smaller – roughly half the size of those counterparts in Derby and Nottingham. The use of hospitals for the war effort was on a voluntary basis, and although extra requests were made of the institutions, they were not necessarily compelled to comply. While the demands on the Devonshire Hospital remained essentially the same through the war, these initial war beds were just the tip of the iceberg for the general hospitals. Bed numbers at the Derbyshire Infirmary grew to 337 in 1916, and 367 in 1917. At Chesterfield Hospital numbers rose to 162 beds in 1917. Nottingham General had almost doubled its bed numbers by 1917, at 554 beds across the institution.

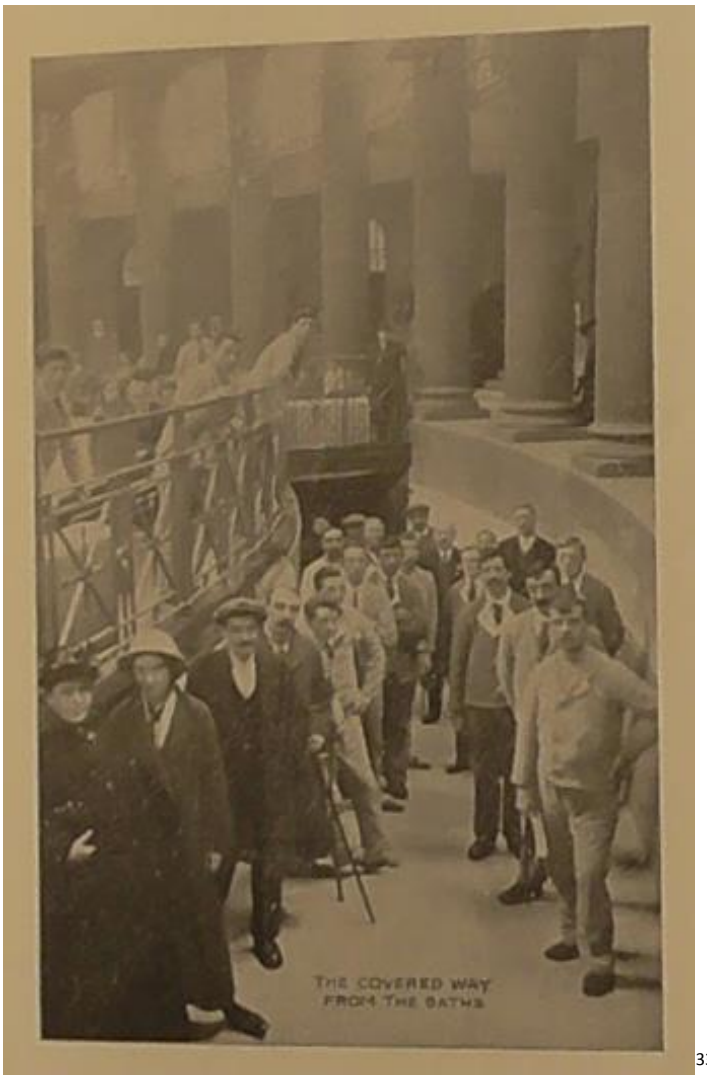
The smaller hospitals were similarly keen to offer up their services at the beginning of the war. Ilkeston General announced that the: 'Governors decided to fully equip one ward and offered free to the Government the use of 12 beds for wounded soldiers for one year, the whole of which has been borne during the current year and has helped to accentuate the large deficiency shown in the

[22] Devonshire Hospital Annual Report 1900; Devonshire Hospital Annual Report 1914.
[23] Devonshire Hospital Annual Report 1914.
[24] Voluntary Hospitals Database, Devonshire Hospital Bed Numbers, 1916 and 1917. Both these years indicate a total bed capacity of 316.
[25] Wartime bed levels rose in these two institutions. DRI: 337 in 1916, 367 in 1917. NGH: 254 in 1916, but rising to 554 in 1917. The Devonshire Hospital remained at 316 in 1916 and 1917.
[26] Chesterfield and North Derbyshire Hospital Annual Report 1914.; *Voluntary Hospitals Database*, Chesterfield and North Derbyshire Hospital Bed Numbers, 1916 and 1917. Both these years indicate a bed capacity of 140 and 162 respectively.

Balance Sheet'.[27] Despite the difficulty, there was a sense of duty inherent in even the smallest provincial hospitals. Fifty wounded soldiers were treated in the institution from 1914-1915.[28] The burden was considerable for a hospital which only had 20 beds. The waiting list for civilian patients grew, and the initial 'donation' of time, space, and resources that the hospital offered to the war effort had to be recouped from the War Office in the form of grants when it became clear that the hospital could not afford to treat so many extra patients.[29] In-patients numbers over the year jumped by 70, out-patients by 80, and one of the hospital's former nurses, joining the armed forces at the start of the war, had already died abroad.[30] This selfless response, which in many ways led to the obfuscation of normal hospital operations, was not confined to the earnest efforts of the voluntary hospitals, but was spread throughout the UK. From Lord Curzon housing horses of Belgian refugees on his estate, to the patriotic writings of H G Wells, the nation was making efforts for a war it did not yet fully understand.[31] The colliery companies around Ilkeston hospital started to donate 20 tons of coal per year – or more as needed – to the hospital at the start of the war to try and help out with their expenses.[32]

[27] Ilkeston General Hospital Annual Report 1915.
[28] Ilkeston General Hospital Annual Report 1915.
[29] Ilkeston General Hospital Annual Report 1915.
[30] Ilkeston General Hospital Annual Report 1915.
[31] A J P Taylor, *English History 1914-1945*, (Book Club Associates: London, 1965) pp.17-20.
[32] Ilkeston General Hospital Annual Report 1915.

Figure 2.1: Soldier and Civilian patients, Devonshire Hospital, Buxton, 1918.



[33]

The Derbyshire Royal Infirmary took wounded and sick soldiers from the very outbreak of war, and as early as August 1914, it had 30 beds ready for the reception of wounded troops.[34] It treated soldiers even as they were stationed in Derby as they were being mobilised and recruited, before they were sent to France:

> During Mobilization, while troops were stationed in Derby, 18 cases were admitted as In-patients and a large number of their casualty cases were treated, as also from among the recruits who have been sent up since that date. Twenty beds in a temporary ward have been placed at the disposal of the Territorial Forces, and in the event of the Military

[33] Devonshire Hospital Annual Report 1918. Note the wounded soldiers in 'hospital blues', the uniform issued to wounded and convalescent soldiers during their recovery.
[34] 'War Items', *Nottingham Evening Post*, 14 August 1914.

> Hospitals receiving larger numbers of wounded than they can conveniently treat, the Board are quite ready to receive men from the front.[35]

If the Derbyshire Royal Infirmary was the very first to treat soldiers during the war, its offer of 30 beds was indicative of the lack of awareness of what was to come as the war entered its most lethal phase when casualty levels were proportionately at their highest.[36] Yet, on the 22nd August the Nottingham Evening Post published a message from the War Office announcing that there was no further requirement for the offers of 'houses, &c., for the use of sick and wounded…for the present no more are required'.[37] There were not, as yet, enough casualties coming from the front to warrant the extension of available accommodation. It was a failing chiefly on the preparation of the War Office that they did not predict both the magnitude of the casualties, and they failed to realise they might need far more help from the voluntary hospitals than they initially thought. The hospitals themselves were privy only to the same information that the general public had. Therefore, blame cannot really wrest upon the voluntary hospitals themselves for their lack of organisation and preparation, but on the War Office for not viewing the situation with the seriousness it deserved, and not preparing the hospitals adequately.

The British suffered some 20,000 casualties on the Marne, and 50,000 during the first battle of Ypres. In the three and a half months of fighting since August, the BEF lost more than the total strength of the army at the outset of the war.[38] The limitation even on these high numbers of casualties was chiefly due to the smaller size of the British Army in comparison to others – the French and the German armies received much heavier losses.[39] It was a wakeup call for the nation, and for its hospitals. Kitchener's call for a new volunteer army saw 750,000 men had enlist by the end of September.[40] By the 19th of October, the Derbyshire Royal Infirmary had responded to a fresh call for aid from the regional military authorities in York to increase accommodation and await the receipt of wounded soldiers.[41] One hundred beds were prepared: forty each in wards 3 and 4, with the VADs and St John's tending the twenty remaining beds in ward 6.[42] Charity met patriotism at the 105th hospital anniversary meeting and church service that were held on the 25

---

[35] Derbyshire Royal Infirmary Annual Report 1913-1914.
[36] Jay Winter, 'Some paradoxes of the First World War', in Richard Wall & Jay Winter (eds) *The Upheaval of War Family Work and Welfare in Europe, 1914-1918* (Cambridge University Press: Cambridge, 1988) pp.13-15.
[37] 'Houses for Sick and Wounded. No More Required at Present', *Nottingham Evening Post*, 22 August 1914.
[38] John Bourne, *Britain and the Great War 1914-1918* (Edward Arnold, London, 1989). p.26.
[39] Martin Gilbert, *First World War*, (BCA: London, 1994) pp.57-61.
[40] Bonnie J White, 'Volunteerism and Early Recruitment Efforts in Devonshire, August 1914-December 1915', *The Historical Journal*, 52:3 (2009) p.641.; Taylor, *English History*, p.20.
[41] Derbyshire Royal Infirmary Annual Report 1914-1915
[42] 'The Annual Meeting', *Derby Daily Telegraph,* 25 November 1914.

November 1914, with an appeal to the conscience of the people of Derby by the Bishop of Manchester.[43] He linked the work of the institution with the work of God, and argued that by supporting the Infirmary, the people of Derby supported both the material struggle of the war and the ideological struggle of Christianity.[44] In this, he was asking that the citizenry donate what money and material they could to their local hospitals, especially the Derbyshire Infirmary. In the eyes of the Bishop of Manchester, the work of the war and the work of a hospital were no different – they both ultimately served the greater good. But in reality, the difficulties that the hospitals were to face in the war years equated to a division of labours between the war wounded and the civilian sick.

Early in the war, local Nottingham papers were reporting stories about German atrocities, which Taylor argues largely developed at this period from the arrival of 100,000 Belgian refugees.[45] Stories of cruelty to British prisoners of war, Germans killing wounded Russian dragoons in the eastern front, and of Belgian civilians having their feet crushed by rifle butts were all stories that gained local currency.[46] Nottingham's civil society was getting its injection of propaganda. Sympathy was being built for the allies that faced the Central Powers alongside Britain, and it was actually Belgian soldiers that were among the first wounded to be sent to the voluntary hospitals of Derbyshire and Nottinghamshire. One hundred wounded Belgians arrived at the Derbyshire Infirmary on 1 November 1914, putting considerable strain on the institution's facilities due to the lack of warning and the sheer number sent.[47] Twenty more wounded Belgians were admitted to Chesterfield Hospital, who were unable to receive any more because their beds were at capacity.[48] By this early point in the war, Chesterfield was being cautious with the facilities it offered to the War Office, and it had not lost as many staff members to war effort as other hospitals.[49] More wounded Belgian soldiers were received in the various VAD hospitals across the counties as well,

[43] 'Royal Infirmary Anniversary', *Derby Daily Telegraph,* 25 November 1914.
[44] 'Royal Infirmary Anniversary', *Derby Daily Telegraph,* 25 November 1914.
[45] A J P Taylor, *English History 1914-1945* (Book Club Associates: London, 1965) p.19.;
[46] 'Ill-Treatment of British Prisoners By German Bullies', *Nottingham Evening Post*, 8 September 1914. Contains an account of Germans having British troops conduct a forced march as a form of 'Roman triumph' – the worst crime being that they had stolen all their helmets on a hot sunny day. 'Wearied and hatless'; 'Austrian Centre Broken. Russians' Victorious Advance. 20,000 More Prisoners', *Nottingham Evening Post,* 10 September 1914. 'It is semi-officially stated that German soldiers have killed wounded Russian dragoons in the district of Valugne'; 'German Atrocities', *Nottingham Evening Post*, 14 September 1914. This reports on the lack of official confirmation on war atrocities by the Prime Minister Asquith.; 'Fiendish Cruelty. Feet Crushed with Rifle Butts. Wounded Belgian's Story', *Nottingham Evening Post*, 13 August 1914.
[47] Derbyshire Royal Infirmary Annual Report 1914-1915.; 'The Annual Meeting', *Derby Daily Telegraph,* 25 November 1914.
[48] Chesterfield and North Derbyshire Hospital Annual Report 1915.
[49] Chesterfield and North Derbyshire Hospital Annual Report 1914.; Chesterfield and North Derbyshire Hospital Annual Report 1915.; Chesterfield and North Derbyshire Hospital Annual Report 1916.

and at least one hospital, in Ockbrook, was established solely for Belgian troops.[50] By 1916, the Derbyshire Royal Infirmary had treated British, Belgian, Canadian, Australian, and New Zealand troops.[51] The Great War's closer proximity and astronomically-high casualty figures, in contrast to the Boer War, meant that the British public became far more aware, and far more politicised, than they previously had been during more distant Empire conflicts.[52] One consequence was that almost immediately, donations were starting to come into the hospitals specifically for the comforts of the wounded soldier patients, rather than the regular civilian patients, such as the £75 raised by the 'masters and men' of the lace trade for 'Christmas fare and comforts' for the wounded soldiers present in the hospital over the Christmas season.[53]

On 3rd September 1914 the *Nottingham Evening Post* reported on the first wounded soldiers arriving at Leicester Royal Infirmary; 'No wounded have yet been sent to Nottingham, where everything is ready…'.[54] In fact, there were no reports of wounded troops arriving in Nottingham until 6th and 7th October, when the first small contingent of British soldiers arrived at the city's General Hospital.[55] After that point, the work intensified. In that short period until the end of December, 255 wounded soldiers were treated in the total of 102 beds set aside for the task at the hospital.[56] The whole of the 'Jubilee Wing' was allocated for this purpose, which they reasoned would 'without in any way interfering with the proper care and treatment of the full number of ordinary patients'.[57] Military authorities, too, wanted to maintain a clear distinction between service personnel and civilians. Clearly there were concerns that this influx of soldiers – even smaller numbers at the very beginning of the war – would stunt the hospital's ability to treat its full host of patients. Nottingham General Hospital stated that:

> It is clearly understood between the Hospital Authorities and the War Office that the number of ordinary civilian patients is to continue as heretofore, and that their care and

[50] 'Ockbrook Hospital for Wounded Belgians', *Derby Daily Telegraph*, 14 November 1914.;
[51] Derbyshire Royal Infirmary Annual Report 1915-1916
[52] Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical power in the First World War*, (Oxford Univeristy Press: Oxford, 2014). p.3.
[53] Nottingham General Hospital Annual Report 1915. The 'masters and men' connected to the lace trade donated the sum of £75 for 'Christmas fare and comforts' for the sick and wounded soldiers within the hospital.
[54] 'Wounded Soldiers Arrive At Leicester', *Nottingham Evening Post*, 3 September 1914.
[55] 'Wounded British Soldiers At The General Hospital', *Nottingham Evening Post*, 6 October 1914.; 'Toll of the Battlefield. More Wounded Arrive in Nottingham', *Nottingham Evening Post*, 7 October 1914.
[56] Nottingham General Hospital Annual Report 1914.
[57] Nottingham General Hospital Annual Report 1914.

attention is in no way to be interfered with by reason of the accommodation given to sick and wounded soldiers.[58]

This statement was premature. By June 1917, the civilian waiting list had grown from just a few hundred in 1914 to over 1,700 patients, mostly surgical cases, waiting to be admitted, as a result of the wounded soldiers taking up beds and doctors' time.[59] To try and alleviate this, it was decided to transfer some of the beds reserved for medical cases over to surgical, rather than diminish their capacity to treat wounded soldiers.[60] It indicates, however understandably, that the hospital prioritised the treatment of wounded soldiers over patients from its own community. This could have been for a number of reasons, not least of which was that the soldiers mostly arrived in need of urgent treatment, whereas the patients on the waiting list frequently required non-emergency procedures. In 1917 and 1918 over half of the emergency cases admitted were from military convoys.[61] Nonetheless, Nottingham decided to continue to accept increasing levels of wounded soldiers. In the three months at the end of 1914, 445 wounded soldiers were admitted. In 1915, the number had risen to 893, and 1,344 in 1916, peaking in 1917 at 1,590.[62] Elsewhere this was not the case. Chesterfield Hospital temporarily diverted its wounded cases elsewhere until the civilian waiting list had been alleviated, sending a letter of refusal to the War Office to prevent more soldiers arriving by rail.[63] It is a testament to voluntary hospital independence, that they might reject the requests of overarching government (War Office) control and instead turn to their own communities instead.

In ways that would differ significantly from the Second World War, the War Office did not cover the full costs of providing additional accommodation and equipment. In 1914 it agreed to grant half of the £3,000 cost of temporary accommodation for the 150 wounded soldiers in Nottingham General Hospital, the balance covered by prominent local businessman William Player (£1,250) and James Forman (£250).[64] In 1915, William Player defrayed the cost of the new military ward balcony that accommodated 20 beds, for which the War Office covered the £1,218 cost of equipping the facility.[65] In Derby, local industrialist Charles Markham funded the establishment of a pavilion for

[58] Nottingham General Hospital Annual Report 1914.
[59] Nottingham General Hospital Monthly Board Minutes 20 June 1917.
[60] Nottingham General Hospital Monthly Board Minutes 20 June 1917.
[61] Nottingham General Hospital Annual Report 1916.; Nottingham General Hospital Annual Report 1917., Nottingham General Hospital Annual Report 1918.
[62] Nottingham General Annual Report 1914., Nottingham General Annual Report 1915., Nottingham General Annual Report 1916., Nottingham General Annual Report 1917.
[63] Chesterfield and North Derbyshire Hospital Annual Report 1915.
[64] Nottingham General Hospital Annual Report 1914.
[65] Nottingham General Hospital Annual Report 1914.; Nottingham General Hospital Annual Report 1915.

the use by the Red Cross on 12 April 1915, and then another on 23 January 1916.[66] A third 'Markham Pavilion' was opened in Chesterfield that same year on 9 November, which brought the hospital's military bed capacity up to fifty.[67] Charles Seely renovated Woodthorpe Lodge for the use of convalescing soldiers.[68] It should be noted that these donors were already actively involved in the local voluntary hospitals movement. The philanthropists were donating their resources for the use of the state, purely and simply, out of patriotic obligation through an already familiar channel. Ordinary people also became more active in their support, with donations increasing quickly in the first years of the war. So where did the balance sit between the state and the voluntary hospitals? Clearly, the War Office had some level of expectation that the voluntary hospitals were robust enough to cover some of the costs incurred, while supplementing them with grants. However, as has been shown, the actual costs were not being covered, even on enterprises that were solely for the war effort.

Chesterfield Hospital, in many ways mirroring its reluctance to enter into the designs of the War Office, received few donations from ordinary civilians or philanthropists; the exception being another bed pavilion paid for by Charles Markham. They were, in general, less generous to the war effort. As already alluded to, in August 1914 the Governing Board of Chesterfield decided to donate just 20 beds to the Red Cross Society for treatment of wounded men, which were duly filled by Belgian soldiers.[69] In addition to this, twelve British soldiers and an additional two Belgian soldiers were treated within the regular wards of the hospital.[70] However, this was a temporary donation of beds by the institution, although it did state that 'It is anticipated that during the ensuing year the accommodation offered will again be required'.[71] In 1915, Chesterfield raised its capacity for wounded beds to 40, but at one point in the year had to refuse further any more admissions by the armed forces due to the civilian waiting lists becoming too extensive.[72] Chesterfield was not as willing to help with the accommodation and treatment of war wounded as the larger institutions in the two counties; it managed its accommodation very conservatively, avoiding the stresses that the other hospitals put themselves under. Other institutions were more open, due to their size, to accommodate soldiers that would lengthen their waiting lists. This particular example illustrates the early limitations that the voluntary hospitals had in helping with the war effort. Ilkeston

[66] Derbyshire Royal Infirmary Annual Report 1914-1915.; Derbyshire Royal Infirmary Annual Report 1915-1916.
[67] Chesterfield and North Derbyshire Hospital Annual Report 1916.
[68] Nottingham General Hospital Annual Report 1916.
[69] Chesterfield and North Derbyshire Hospital Annual Report 1914.
[70] Chesterfield and North Derbyshire Hospital Annual Report 1914.
[71] Chesterfield and North Derbyshire Hospital Annual Report 1914.
[72] Chesterfield and North Derbyshire Hospital Annual Report 1915.

hospital and provided beds for the war wounded, and received fifty soldiers between 1914-1915.[73] But this had a marked negative impact on the hospital: 'Governors decided to fully equip one ward and offered free to the Government the use of 12 beds for wounded soldiers for one year, the whole of which has been borne during the current year and has helped to accentuate the large deficiency shown in the Balance Sheet'.[74] The burden on small-to-medium-sized institutions seemed to be more intense, with smaller cash and capital reserves to dip into if needed. When they still had just as many civilian patients on their doorstep, who had been donating to the hospitals for years and years, then it was difficult for the hospitals to bar their entry in favour of war wounded. It became quickly evident that they needed help.

Hospitals that received wounded soldiers could apply to the War Office for per-capita grants, as well as for grants related to other areas such as construction and furnishings, to help cover their costs.[75] These grants quickly became a large part of the hospital's income, as soldiers started to take up larger and larger proportions of the hospitals' accommodation. The following table displays the increasing nominal funds that Nottingham, Derby, Devonshire, and Chesterfield received for the treatment of soldiers. Cash grants soon strayed into the tens of thousands of pounds, as the shipments of soldiers increased in quantity and frequency.

Table 2.2: Total War Office grants to Nottingham General, Derbyshire Infirmary, Devonshire Hospital, Chesterfield Hospital, 1914-1919.

Year	Nottingham	Derby	Devonshire	Chesterfield
1914	0	0	745	0
1915	8360	2753	4720	0
1916	11739	4248	10523	819
1917	12457	7857	11114	1941
1918	18510	10906	13866	3846
1919	3519	7005	4116	2162

It will be shown how these huge sums of money changed the face of the voluntary hospitals in this study. Table 2.3 compares the payments from the War Office (excluding Ministry of Pensions) to total ordinary income for the hospitals, as well as the changing cost of inpatients.

[73] Ilkeston General Hospital Annual Report, 1915.
[74] Ilkeston General Hospital Annual Report, 1915.
[75] Macpherson, *History of the Great War Medical Services,* p.79.; Abel-Smith, *The Hospitals,* p.282.

Table 2.3: Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, Devonshire Hospital Total Income, War Office Income, 1913-1919.

	Nottingham General			Derbyshire Infirmary			Chesterfield Hospital			Devonshire Hospital		
	Total Ordinary Income	War Office	% of income	Total Ordinary Income	War Office	% of income	Total Ordinary Income	War Office	% of income	Total Ordinary Income	War Office	% of income
1914	15472	0	0	14007	0	0	8377	0	0	11136	745	7
1915	24109	8360	35	16734	2753	16	8482	0	0	13926	4720	34
1916	28291	11739	41	19903	4248	21	9179	819	9	12823	10523	82
1917	31977	12457	39	24452	7857	32	11130	1941	17	14270	11114	78
1918	40547	18510	46	31340	10906	35	15758	3846	24	19140	13866	72
1919	31691	3519	11	34791	7005	20	16079	2162	13	14210	4116	29
1920	56860	0	0	40314	38	0	19905	2590	13	13020	0	0

War Office payments came to be huge proportions of total ordinary income. The Devonshire Hospital especially benefitted, garnering 82% of their ordinary funds from the War Office as early as 1916. It suggests that the Devonshire, whose usual remit was not that of a general hospital (dealing with accident and emergencies and surgical cases) was able to turn most of its facilities over to the War Office. Very quickly, the Devonshire hospital was admitting above 1,000 soldier patients a year. By 1918, the hospital had treated a total of 5,119 rheumatic soldiers, and during the peak of 1917, soldiers accounted for half of total in-patients.

Figure 2.2: 'Apparatus For Loosening Stiff Joints', 1917. The patients pictured are soldiers, wearing the 'Hospital Blues' uniform worn for convalescence.

[76]

The Derbyshire Infirmary reached a peak in 1918 of 34%, and NGH in the same year reached its peak of 45% of its ordinary income. For the hospitals to receive this quantity funds – in fact any funds - from the central government was unprecedented and indicates that the demands on the hospitals were growing and proving difficult, beyond anything they had dealt with amongst their civilian populations. However, as the Table illustrates, this growth correlated to increasing numbers of soldiers being treated within civilian hospitals. If we compare this information with the number

[76] Devonshire Hospital and Buxton Bath Charity Annual Report 1917.

of soldiers treated within the hospitals, it also illustrates how wounded soldiers rose to become high proportions of total inpatients.

Table 2.4: Total Patients for Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, Devonshire Hospital, 1914-1920.

	Nottingham General			Derbyshire Infirmary			Chesterfield Hospital			Devonshire Hospital		
	In-	Out-	Army	In-	Out-	Army	In-	Out-	Army	In-	Out-	Army
1914	3401	15049	445	3223	8040	18	1398	4365	34	3902	462	279
1915	4041	12405	893	3167	7479	652	1397	3737	108	3106	871	832
1916	4576	12244	1344	3321	7227	707	1333	3083	147	3092	1135	1322
1917	4623	12467	1674	3733	7237	980	1435	3262	213	3796	1022	1767
1918	5120	12781	1590	3988	8263	1107	1664	2829	358	2998	924	919
1919	4193	14635	75	3529	8587	497	1589	3652	13	3174	910	197
1920	4344	15676	0	4181	10583	430	1808	4197	0	3772	734	0

The peak years for the reception of wounded soldiers was 1918 for the Derbyshire Infirmary at 27% of total inpatients, and 1917 for the Nottingham General and the Devonshire Hospital at 36% and 46% respectively. Military cases constituted large proportions of total patients admitted for these institutions – as much as a quarter to a third - with even greater proportions of money granted to the hospitals for their upkeep. It meant that any single voluntary income (be it annual subscriptions, donations, Saturday Funds, even legacies) became the smaller proportions of hospital income, and resultantly the local voluntary hospitals inevitably shifted their focus away from their civilian population and on to the military cases. Mohan and Gorsky, although they reference the rise in state funding, fail to recognise or quantify the impact that this had on how the hospitals functioned.[77] War Office grants and the influx of soldiers warped the finances and functions of the voluntary hospitals. The new conditions of war swelled the hospital incomes and expenditures while not necessarily swelling their capacity; that is, their ability to treat more patients. As can be seen from the patient figures, the difference between total in-patients treated from the start of the war to the end of the war was not drastically different, and only roughly the difference between the civilian patients and the wounded soldiers treated. The only added facility for treatment that the hospitals were provided with was extra beds, and in a few cases extra wards. Doctors, nurses, and other staff were either roughly the same, or in the case of the doctors, often reduced.

[77] Mohan and Gorsky, *Don't Look Back*, pp.40-42.

Table 2.5: Total incomes, War Office grants, and percentages for Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, Devonshire Hospital, 1914-1920.

	Nottingham General			Derbyshire Infirmary			Chesterfield Hospital			Devonshire Hospital		
	Total Ordinary Income	War Office	%	Total Ordinary Income	War Office	%	Total Ordinary Income	War Office	% of income	Total Ordinary Income	War Office	%
1914	15472	0	0	14007	0	0	8377	0	0	11136	745	7
1915	24109	8360	35	16734	2753	16	8482	0	0	13926	4720	34
1916	28291	11739	41	19903	4248	21	9179	819	9	12823	10523	82
1917	31977	12457	39	24452	7857	32	11130	1941	17	14270	11114	78
1918	40547	18510	46	31340	10906	35	15758	3846	24	19140	13866	72
1919	31691	3519	11	34791	7005	20	16079	2162	13	14210	4116	29
1920	56860	0	0	40314	38	0	19905	2590	13	13020	0	0

Table 2.6: Total in-patients, war patients, and percentages for Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, Devonshire Hospital, 1914-1920

	Nottingham General			Derbyshire Infirmary			Chesterfield Hospital			Devonshire Hospital		
	Total In-patients	Total War Patients	%	Total In-patients	Total War Patients	%	Total In-patients	Total War Patients	%	Total In-patients	Total War Patients	%
1914	3401	445	13	3223	18	1	1398	34	2	3902	279	7
1915	4041	893	22	3167	652	21	1397	108	8	3106	832	27
1916	4576	1344	29	3321	707	21	1333	147	11	3092	1322	43
1917	4623	1674	36	3733	980	26	1435	213	15	3796	1767	47
1918	5120	1590	31	3988	1107	28	1664	358	22	2998	919	31
1919	4193	75	2	3529	497	14	1589	13	1	3174	197	6
1920	4344	0	0	4181	430	10	1808	0	0	3772	0	0

Abel-Smith indicates that a few hospitals were willing to provide their services for free during wartime, though many did apply to the War Office for available grants.[78] He identified a new relationship forming between the staunchly independent voluntary hospitals and a government that expanding its powers to cope with the war, where the latter had to rely on the voluntary hospitals to a degree that would have been unimaginable before the war. Their willingness and ability was being tested. Chesterfield Hospital was one of the hospitals that explicitly offered to cover the cost of treating wounded soldiers. This free cover lasted for the first two years of the war, until it was decided that the burden was becoming too great. [79] The consequence was that for

[78] Abel-Smith, *The Hospitals*, p.257.
[79] Chesterfield and North Derbyshire Hospital Annual Report 1916.

1915 it had an immense deficit, as salaries and general supply costs rocketed beyond its control.[80] This position became unsustainable, forcing Chesterfield to radically reprioritise its focus. It refused further war wounded convoys until it could get to a more manageable situation with its civilian patients. Its balance was thrown off by the war, opening a proverbial floodgate to demands upon its services that Chesterfield was ill-prepared to handle. In spite of the grants available,

But the difficulties were surely no surprise. As already mentioned, the War Office grants themselves were not necessarily adequate. The flat 2/- per in-patient per day at the start of the war (raised to 3/- in November 1914) took no account of the varying costs within the different hospitals, and there is evidence that hospitals had to negotiate with the War Office to gain adequate compensation.[81] The flat rate , too, continued to rise to take account of inflationary cost, first to 3/3, and then finally 3/6 in June 1918.[82] But if then, it still fell well short of covering actual costs, especially for the Nottingham General's case. In 1914 and 1915, the hospital was operating at a nominal in-patient daily cost of 3/9 which rose to 4/2 in 1916, 4/4 in 1917, and finally 5/6 in 1918. At the end of 1914, Nottingham negotiated an arranged grant of 4/- per soldier per day from the War Office to try and avoid falling into arrears – over and above the rates that had Macpherson identified. [83] In fact, Nottingham also received compensation to 'medical men' for their services in the hospital. The equipment to furnish the Jubilee Ward was provided by the four city Voluntary Aid Detachments in Nottingham, and the accommodation along the Ropewalk was placed free at the disposal of the War Office, who provided the cost of equipment required.[84] This sort of arrangement was relatively common, with a number of houses also being given over to the Derbyshire Infirmary's overarching administration for the treatment of war wounded. However, in spite of the extra grants, the furnishing of wards and theatres, and the increased use of VADs, in Nottingham heavy deficits developed by 1917, indicating that the system of grants did not create a true balance in the finances of the hospitals providing care for wounded soldiers.

As already noted, the Devonshire Hospital all but slashed its civilian beds in half in an effort to provide as many military beds as possible. Its occupancy rate before the war was far lower than during the war: the average number of inpatients daily in the hospital in 1905 was 200, but this

[80] Chesterfield and North Derbyshire Hospital Annual Report 1914. Chesterfield and North Derbyshire Hospital Annual Report 1915.
[81] Nottingham General Hospital Monthly Board Minutes 6 December 1916.; MacPherson, *Medical Services,* p.85.
[82] MacPherson, *History of the Great War,* p.86.
[83] Nottingham General Annual Report 1914.
[84] Nottingham General Annual Report 1914.

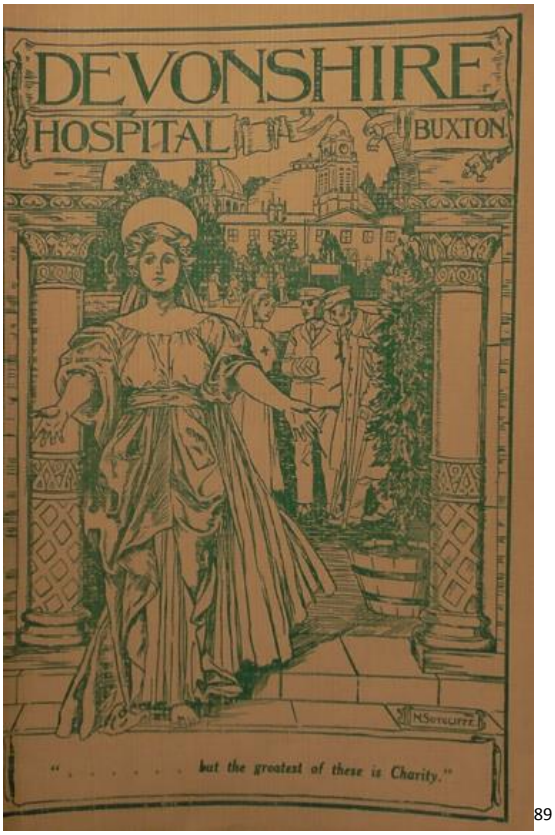
soared to 270 in 1914, and 290 in 1918.[85] It was better able to accommodate considerable numbers of service patients because of this, and also the fact that their services (consisting of spring baths and hot water treatments, as well as physiotherapy and other similar treatments) were also less costly and less labour-intensive than other hospitals. There was a set standard length of time that the hospital provided treatment, usually a maximum of three weeks, in which the patient would receive a course of treatment.[86] It was far more explicit than Nottingham in its decision to prioritise wounded soldiers:

> The Committee apologize for the inconvenience and disappointment caused to many Subscribers and civilian Patients during the year 1915 by the long periods of waiting and even of inability to admit Patients. They have many evidences, however, that they took the proper course in giving priority to Rheumatic Soldiers, and they thank the Subscribers for their co-operation.[87]

The Devonshire was under less pressure than the other voluntary general hospitals because the treatments it continued to provide allowed for planned admissions. The War Office wanted treatment for rheumatic servicemen from the hospital, not emergency treatment for recently wounded soldiers. Furthermore, the relationship that the Devonshire Hospital had with its hospital community was much looser than other hospitals. Traditionally, it took patients and attracted subscribers from across the country, not its immediate neighbourhood. Lancashire, not Derbyshire, was the largest subscriber region from which it drew its patients prior to the war.[88] In that respect, it was easier to adjust its intake because it did not have people turning up on its doorstep; treatments were arranged ahead of time, with often considerable transport to the hospital in the remote town of Buxton (in the middle of the Peak District).

[85] Devonshire Hospital and Buxton Bath Charity Annual Report 1905., Devonshire Hospital and Buxton Bath Charity Annual Report 1914., Devonshire Hospital and Buxton Bath Charity Annual Report 1918.
[86] Devonshire Hospital and Buxton Bath Charity Annual Report 1902.; Unknown Author, *Three Weeks In the Devonshire By An In-Patient*, (Buxton Advertiser: Buxton, 1874) pp.1-14.
[87] Devonshire Hospital and Buxton Bath Charity Annual Report 1915.
[88] Devonshire Hospital and Buxton Bath Charity Annual Report 1908.

Figure 2.3: Cover of Devonshire Hospital Annual Report, 1917.



[89]

Staff at War

The war also presented another, different problem to the hospitals. Medical professionals (that includes not just doctors, but nurses, dispensers, laboratory attendants, masseurs, sanitary inspectors, even splint makers and electro mechanics, etc.) were required to bulk out the relatively small standing army of the RAMC. The death toll on doctors and medical professionals was high. Throughout the war, 7,000 doctors were killed and a further 17,000 more wounded across the nation.[90] Doctors left the civilian voluntary hospitals in droves to join up with the RAMC, and nurses equally were being either called up from current staffs by the Queen Alexandra's Imperial Military Nursing Service or the Territorial Force Nursing Reserve (an organisation established in 1908, similar to the Territorial Army, where reserves would sign up and be called upon in the event of war), or being streamed from the nurse training schools straight into active military service. Doctors and other medical professionals were also part of the Territorial Force, and as a result were required to opt for service in the RAMC when the war broke out. However, in all other circumstances, medical professionals were not 'compelled' into service like normal civilians were,

[89] Devonshire Hospital and Buxton Bath Charity Annual Report 1917 (Front Cover).
[90] Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical power in the First World War*, (Oxford Univeristy Press: Oxford, 2014) p.94.

and were never conscripted. However, the RAMC did make efforts to recruit at the beginning of the war, and between 24th October and 4th November 1914, 8,639 medical recruits.[91]

Figure 2.4: 'Join the RAMC' recruitment poster, c.1914, IWM.

[92]

However, the enthusiastic reception to the call for recruits from the RAMC was not without its drawbacks for the home front. According to MacPherson, there was early recognition that the

[91] MacPherson, *History of the Great War,* p.138.
[92] 'Join the RAMC' poster, Imperial War Museum, Art.IWM PST 13486, https://www.iwm.org.uk/collections/item/object/31546 [accessed 11/4/20]

filling of officer ranks with civil medical professionals would create difficulties on the home front. The removal of medical practitioners, especially from more remote (and poorly served) areas like Scotland, would create strife and difficulty for the civilian sick.[93] Beginning in Scotland, then London, and finally extending all over the United Kingdom, the British Medical Association made efforts to rationalise the removal of medical professionals from the civilian population, forming committees in an attempt to mediate between the individual doctors and the RAMC.[94] Although initial demand for medical professionals slackened near the end of 1914 and into 1915, by October 1915 the RAMC was calling for 2,000 more medical officers, a number that caused concern among the body of medical professionals across the country, and prompted the formation of the Central Medical War Committee (CMWC) by the Royal Colleges of Physicians and Surgeons. Eventually, by November 1915 the entire recruitment of the RAMC was handed over to the CMWC, which was able to organise recruitment into groupings according to local needs of retention and the needs of the RAMC.[95] However, in spite of these efforts to organise and administer, the situations in civilian voluntary hospitals became acutely difficult.

In just the few months at war in 1914, the Derbyshire Royal Infirmary lost three surgeons and ten nurses to war service.[96] Further, large numbers of domestic staff, both male and female, either enrolled for military service or opted for the higher wages of war work.[97] The Infirmary in Derby was receiving large numbers of troops by the end of 1914, with three of its wards and its convalescent home turned over to war service.[98] But despite concerns over de-staffing, the Infirmary was still proud to offer its staff members for service. Four other nurses were said to be ready to join the war effort if required, and the Infirmary managed to replace the surgeons recruited with local medical men lending their time.[99] By 1915, an anesthetist and another doctor had also joined the RAMC, with a total of two sisters and 18 nurses having left the Infirmary staff, eight of whom were currently serving abroad, the rest serving in the military hospitals, the Queen Alexandra Royal Nursing Reserve, and the Queen Alexandra Royal Military Nursing Reserve.[100] Newspapers were also adding to the demands. Compliments about the bravery of wounded soldiers were interspersed with stories of doctors performing their duty at the front, and calls that

[93] MacPherson, *History of the Great War,* p.144.
[94] MacPherson, *History of the Great War,* p.145.
[95] MacPherson, *History of the Great War,* pp.145-6.
[96] Derbyshire Royal Infirmary Annual Report, 1913-1914.
[97] Bonnie J White, 'Volunteerism and Early Recruitment Efforts in Devonshire, August 1914-December 1915', The Historical Journal, 52:3 (2009) p.653.; Angela Wollacott, *On Her Their Lives Depend: Munitions Workers in the Great War*, (University of California Press: Berkeley, 1994) p.1., p.7., pp.17-18.
[98] 'The Annual Meeting', *Derby Daily Telegraph,* 25 November 1914.
[99] Derbyshire Royal Infirmary Annual Report, 1913-1914.
[100] Derbyshire Royal Infirmary Annual Report, 1914-1915.

'Doctors and attendants are wanted at the front'.[101]The fact that these nurses and doctors volunteered was clearly a mark of pride for the Infirmary, as difficult a position as it put the hospital in. The Weekly Board received a letter from Queen Alexandra personally, stating her thanks for the 'assistance given by the Infirmary in supplying Nurses'.[102] But regardless of the patriotic duty the hospitals were adhering to by giving up their staffs, how were they able to function when their ability to provide care to was nominally diminished?

Other hospitals were presented with the same demands. Nottingham General Hospital had, some years previously to the war:

> …agreed to supplement Queen Alexandra's Imperial Military Nursing Service by supplying six fully trained certified Nurses in case of War or National Emergency, and this promise has been renewed from year to year.[103]

When war was declared, six nurses left for 'war duty'. Several other nurses who were members of the Territorial Force Nursing Service were also 'called up and have left for duty'.[104] Four members of the honorary medical staff were also recruited, being replaced by an ad hoc agreement with known qualified medical professionals from the local area.[105] The General Board of Management explicitly expressed its concern at the difficulty of securing Resident Medical Officers due to the high demands of the Army and Navy.[106] Work that was once carried out by five men was in 1915 carried out by only three, and then later two, as another doctor left to join the RAMC. All long holidays during the war were suspended in favour of week-ends, or short holidays, resident salaries were increased on the understanding that, unless they were volunteering for active service, 'no officer receiving such increased salary shall seek to obtain any appointment in any other institution during the war'.[107]

Chesterfield was also able to tap into the network of local practicing medical professionals in the local area, but was similarly unable to retain its full body of medical, surgical, and nursing staff from early on in the war, losing nine staff, including three doctors, five nurses, and a porter.[108] This indicates that these honorary staff members were not – initially at least- replaced. Mansfield

---

[101] 'British Fortitude. The Bravery of the Wounded', *Nottingham Evening Post,* 30 September 1914.; 'A Nottingham Doctor. With the Troops in France. Happy and Confident.', *Nottingham Evening Post*, 2 October 1914.
[102] Derbyshire Royal Infirmary Annual Report, 1914-1915.
[103] Nottingham General Hospital Annual Report, 1914.
[104] Nottingham General Hospital Annual Report, 1914.
[105] Nottingham General Hospital Annual Report, 1914.
[106] Nottingham General Hospital Annual Report 1915.
[107] Nottingham General Hospital Annual Report 1915.
[108] Chesterfield and North Derbyshire Hospital Annual Report 1914.

District General lost both its matron and one of its sisters to the military hospitals in Lincoln and London.[109] Even the small cottage hospital at Ripley had its nurse called up to Sheffield to help in the care of wounded Belgian troops.[110] Large hospitals and small hospitals had their staff diminished quite quickly, with more staff being called up year on year. However, the Devonshire Hospital did not lose any of its staff in 1914, though it did receive aid from the members of the local St John's Ambulance Voluntary Aid Detachment, having been given 'practical training in Nursing' and subsequently helped with the influx of British and Belgian troops being treated for rheumatic ailments.[111] Derbyshire Royal Infirmary, in response to its diminished staff, had to persuade a retiring surgeon to stay on for the duration of the war.[112]

While doctors were discouraged from moving institutions, they couldn't be discouraged from war service. In 1916 one doctor left for the RAMC and 'permanently severed his connection with Chesterfield', with the implication that these doctors were not simply leaving temporarily, but that they did not envisage returning to the institutions from which they were previously connected.[113] The hospitals were put in a very tricky situation; one that they did not expect. Receipt of wounded soldiers was understood, and a direct responsibility of the hospital in agreement with the War Office. But the large losses of qualified staff to the RAMC was a consequence of the war, and yet they in turn were having to still deal with its direct consequences at home. It was not directly as a result of the scheme put in place for the care of wounded soldiers by the War Office, but a part of the other demands of war. In fact, it worked against that scheme, stripping those auxiliary hospitals of the capacity to treat wounded soldiers. Chesterfield did have two doctors return, though there was an expectation that more doctors would be called up by the RAMC early in the next year.[114]

By January 1917, more than half of the medical profession had joined up for military service, which had caused considerable conflicts of interest between the military demand for war doctors and the civilian need for the treatment of the sick populace on the home front.[115] The military authorities made attempts to alleviate this, by reducing the number of medical officers used in places like field ambulances and hospitals, and allowing medical students to finish their full course of study.[116] Compounding the difficulty of the early years of the war, on the 18th and 19th April 1917, the War Office started to compel all doctors under the age of 41 to enlist in the armed forces, and directed

[109] 'Mansfield Hospital for Wounded', *Nottingham Evening Post,* 1 November 1915.
[110] 'War Items', *Nottingham Evening Post,* 21 October 1914.
[111] Devonshire Hospital Annual Report, 1914.
[112] Derbyshire Royal Infirmary Annual Report 1916-1917.
[113] Chesterfield and North Derbyshire Royal Hospital 1916.
[114] Chesterfield and North Derbyshire Royal Hospital 1916.
[115] MacPherson, *History of the Great War,* p.146.
[116] MacPherson, *History of the Great War,* p.147.

local recruiting stations to 'compile an accurate list of all qualified medical and surgical practitioners resident in their sub-areas, and forwarding a copy of the letter printed below from the Secretary of State to all doctors of military age, which was to be immediately distributed through sub-area offices to all doctors affected'.[117] Dr Crooks of Nottingham General responded directly to this call, and Derbyshire Royal Infirmary lost Dr Barber to military duty, taking that hospital's total of absent serving doctor to four.[118] In fact, at the Derbyshire Infirmary the staffing issues became so acute that they had to appeal to the Central War Committee to try and fulfil their desperate need for a competent surgeon.[119] The RAMC had stripped the institution's outpatient department, so that there was only one surgeon left, Dr Vaudrey - who had already postponed his retirement - carrying out the work of the department, and only two surgeons remained in the entire surgical department.[120]

Much like the rest of the nation struggling under the yoke of war, hospitals had to make-do with what they had. In 1916 Chesterfield drew on the skills of the honorary anaesthetist to work as a surgeon, as well as the medical superintendent of the Derbyshire Sanatorium – trained doctors, but not specialist surgeons.[121] Controversially, Nottingham enlisted the services of Dr Ethel Baker in 1917 to help alleviate the difficulties they were facing with the lack of 'medical men'.[122] It hired more women as assistant physicians throughout the war, such that their medical staff was filled out by female members.[123] An unexpected consequence of the war meant that usually strict rules about female medical professionals were softened, but not without some reluctance on the part of the Board of Management.[124] In Nottingham, alongside the chronic reduction in medical and domestic staffs, those staff who did still work were having to be paid more. Wages and salary expenditures (in all institutions, not just at Nottingham) rose through the war years, such that even engineers, coal stokers, and porters were applying for 'war bonus' payments of 4/- to try and keep

[117] 'The Calling Up Notice', *British Medical Journal*, 1:2939 (1917) p.551.; 'War Office Call On All Medical Men Under 41', *Supplement to the British Medical Journal*, (1917) pp.67-9.
[118] Nottingham General Hospital Monthly Board Minutes 25 April 1917; Derbyshire Royal Infirmary Annual Report 1917.
[119] Derbyshire Royal Infirmary, 'Letter to Mr Forster from E Collier Green Hon. Sec. of Medical Staff, with regards calling up of staff to RAMC', 1917.
[120] Derbyshire Royal Infirmary, 'Letter to Mr Forster from E Collier Green Hon. Sec. of Medical Staff, with regards calling up of staff to RAMC', 1917.
[121] Chesterfield and North Derbyshire Royal Hospital 1916.
[122] Nottingham General Hospital Annual Report 1917.
[123] Nottingham General Hospital Monthly Board Minutes 25 April 1917; Nottingham General Hospital Monthly Board Minutes 9 May 1917. The latter records three new female Assistant House Surgeons taken on at £250 year each.
[124] Janet S K Watson, 'Wars in the Wards: The Social Construction of Medical Work in First World War Britain', *Journal of British Studies*, 41:4 (2002) pp.488-489.

up with their individual cost of living – which they were awarded.[125] Further, hospitals were beginning to compete for staff. Nottingham General's Dispenser, Miss Prince, was offered a job for higher salary in the South of England, and Nottingham's Monthly Board, upon hearing this, decided to match that salary to persuade her to stay, '…In view of the scarcity of qualified Dispensers and the difficulty that would be experienced in finding a suitable successor…'.[126] The hospital had to apply for the exemption from military service of their engineer, porter, and plumber, and the Nottingham Children's Hospital also had to appeal to the authorities to prevent its key medical practitioner being called up, after three of its doctors were already serving.[127] Without him, the Children's Hospital in Nottingham would have had to close, unable to safely cope with the amount of patients it had.

The effects of the war were felt even by the administrative staff. In Derby the Secretary Superintendent resigned as a result of the stresses heaped upon the position by the war. The Board took the opportunity to illuminate the difficulties presented:

> 'The work of the Hospital, always arduous, had been increased enormously since the wounded soldiers began to arrive in autumn of 1914. The arrival of convoys at short notice, and often in the dark, the military correspondence, the increase in the number of beds, frequent changes on the Resident Staff, the depletion of the male staff by the calling up of men for military service and formerly the anxiety about food supplies, have all added to Mr Forster's [Secretary Superintendent] cares and responsibilities'.[128]

The hospitals publicly claimed that they were still able to function, but other than the arrangements for exterior professionals to help within the hospitals when needed, how were the hospitals able to cope with such reduced levels of staff? The Voluntary Aid Detachments from the Red Cross and St John's ran wards, but only those wards filled with wounded servicemen.[129] Chesterfield did not cope adequately. It had to temporarily prevent the military authorities in Sheffield from sending any more wounded troops until the civilian waiting list was dealt with; apparently the hospital was able to tackle this and recommence its duties with the wounded before the end of the year.[130] But it is indicative of the desperate situation these extra patients put

[125] Nottingham General Hospital Monthly Board Minutes 29 November 1916. They were awarded an extra 4- a week.
[126] Nottingham General Hospital Monthly Board Minutes 3 January 1917.
[127] Nottingham General Hospital Monthly Board Minutes 25 April 1917; Nottingham Children's Hospital Monthly Board Minutes 6 June 1917.
[128] Derbyshire Royal infirmary Annual Report 1917-1918.
[129] Nottingham General Hospital Annual Report, 1914.
[130] Chesterfield and North Derbyshire Royal Hospital Annual Report 1915.

the hospitals in. Where they did have the bed space, their smaller staff did not have the ability to deal with all of the military and civilian patients effectively. Waiting lists within the Chesterfield Hospital, reduced by their temporary hiatus from war duties, were still sitting well above pre-war levels.[131] Nottingham General and Derbyshire Infirmary also had far longer waiting lists, which Nottingham General Board of Management directly connected by the reduction of staff, and thus the inability to perform scheduled operations without adequate surgeons, surgical nurses, and anaesthetists.[132]

These difficulties serve to show that the voluntary hospitals had little to no power over the amount of staff they were able to retain. Fewer staff meant a reduced ability of an institution to treat the sick. At its most basic level, the war caused longer civilian waiting lists, but looking at a more complex level it exposed how the disjointed nature of the overall system (that is to say, hospitals being independent from government) meant that there wasn't able to be a more rational approach to the recruitment of staff into the armed forces until later in the war. It is hard to deny that the war negatively impacted the civilian sick. Their doctors, nurses, and porters were gone, and the beds filled with wounded soldiers.

Hospital Voluntarism during the Great War.

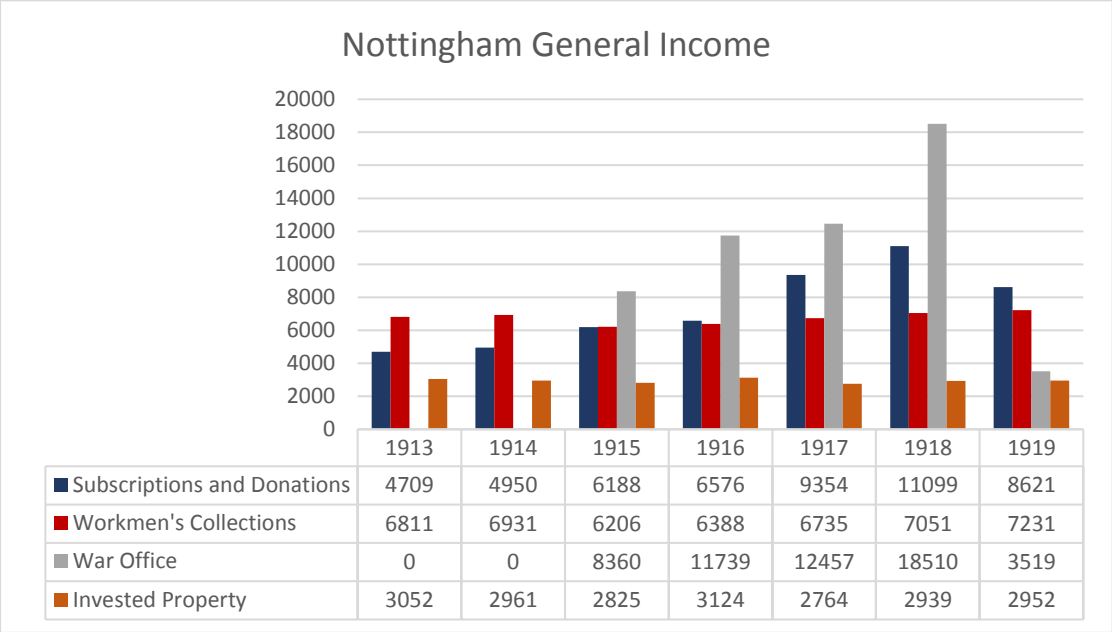
While the war raged at the front and the wards were being filled with wounded soldiers, the hospitals still had to attend not only to their civilian patients, but their financial position as well. The voluntary system required constant renewal and vigilance to remain viable, but the war made this increasingly difficult, not least because government payments for treatments were not meeting costs. Smaller fundraising attempts like the Mayoress of Derby's Ladies Committee and the Chesterfield Trader's Bazaar continued in their limited but successful capacity, but the larger elements such as subscriptions started to suffer.[133] In 1918 Nottingham General's Weekly Board expressed concern that its subscriptions had shown no increase for many years, for which they established a special sub-committee which was successful at raising some extra funds.[134] The extra money raised indicates the hospital community's buoyancy in a difficult time. However, the Weekly Board's concerns were not without foundation. Subscriptions had dropped in real terms from 1914

[131] Chesterfield and North Derbyshire Royal Hospital Annual Report 1916., Chesterfield and North Derbyshire Royal Hospital Annual Report 1917.
[132] Nottingham General Hospital Annual Report 1915., Nottingham General Hospital Annual Report 1917.; Derbyshire Royal Infirmary Annual Report 1917.
[133] Chesterfield and North Derbyshire Hospital Annual Report 1917.; Mayoress of Derby's Ladies Committee Minutes 1914-1918. The committee managed to raise similar levels of money throughout these war years, compared to peacetime.
[134] Nottingham General Hospital 1918. £1,200 in extra annual subscriptions and £849 in donations.

to 1918 from £2,866 to £1,650, Workmen's and Saturday Collections had dropped in that same period from £6,951 in 1914, to a low of £3,481 in 1918 and £3,253 in 1919. The following table and chart give a full illustration of certain key income streams.

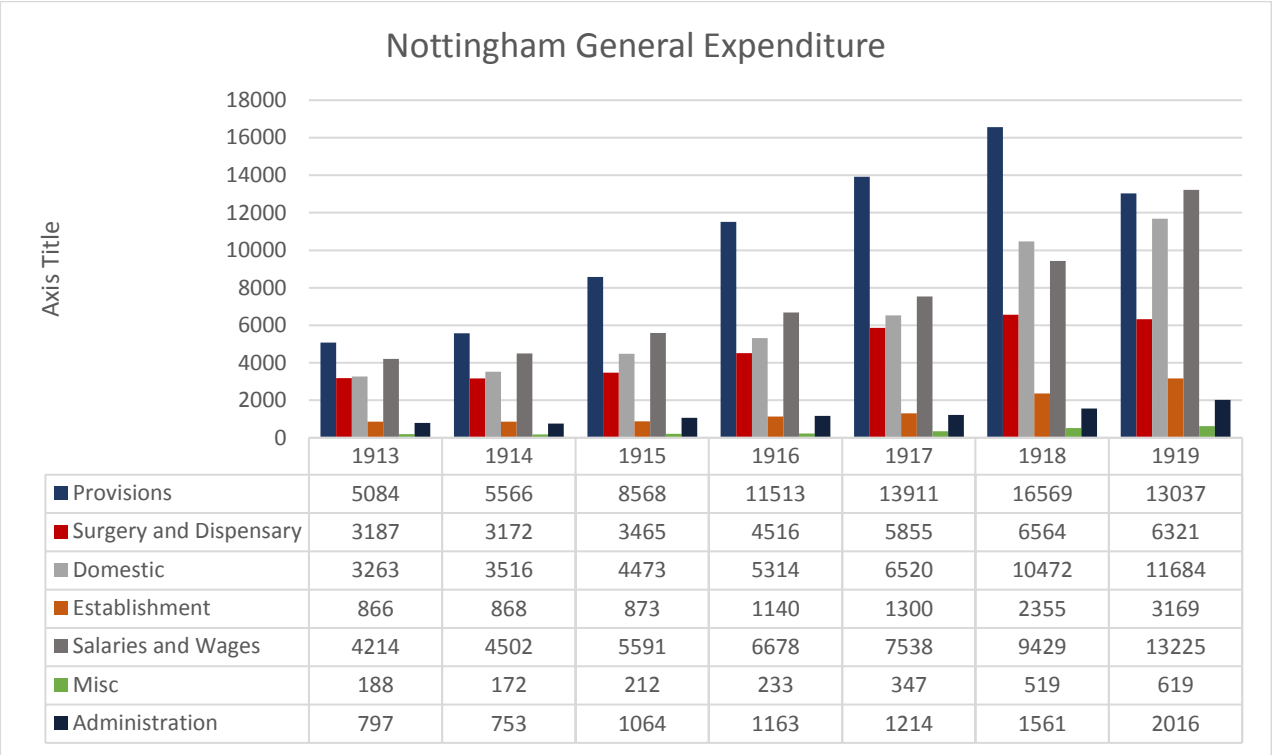
The following are the condensed data tables for Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, and the Devonshire Hospital incomes and expenditures. They indicate that while there were some consistent patterns among the hospitals, there were exceptions.

Graph 2.1: Nottingham General Income 1913-1919



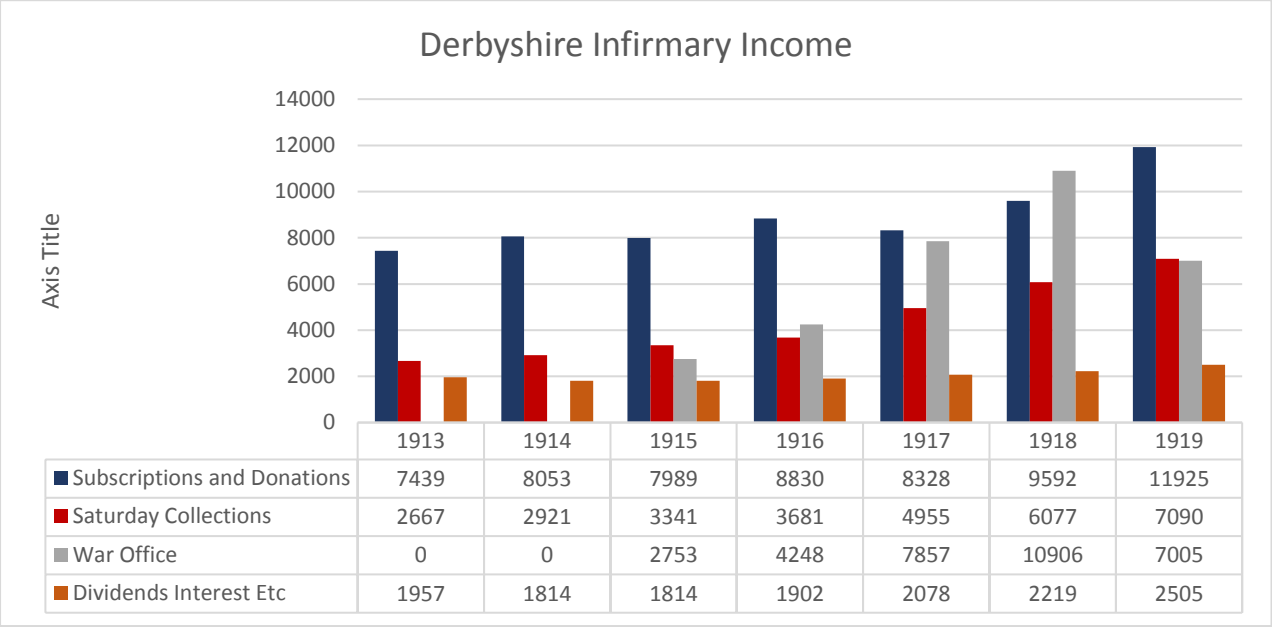
	1913	1914	1915	1916	1917	1918	1919
Subscriptions and Donations	4709	4950	6188	6576	9354	11099	8621
Workmen's Collections	6811	6931	6206	6388	6735	7051	7231
War Office	0	0	8360	11739	12457	18510	3519
Invested Property	3052	2961	2825	3124	2764	2939	2952

Graph 2.2: Nottingham General Expenditure, 1913-1919.



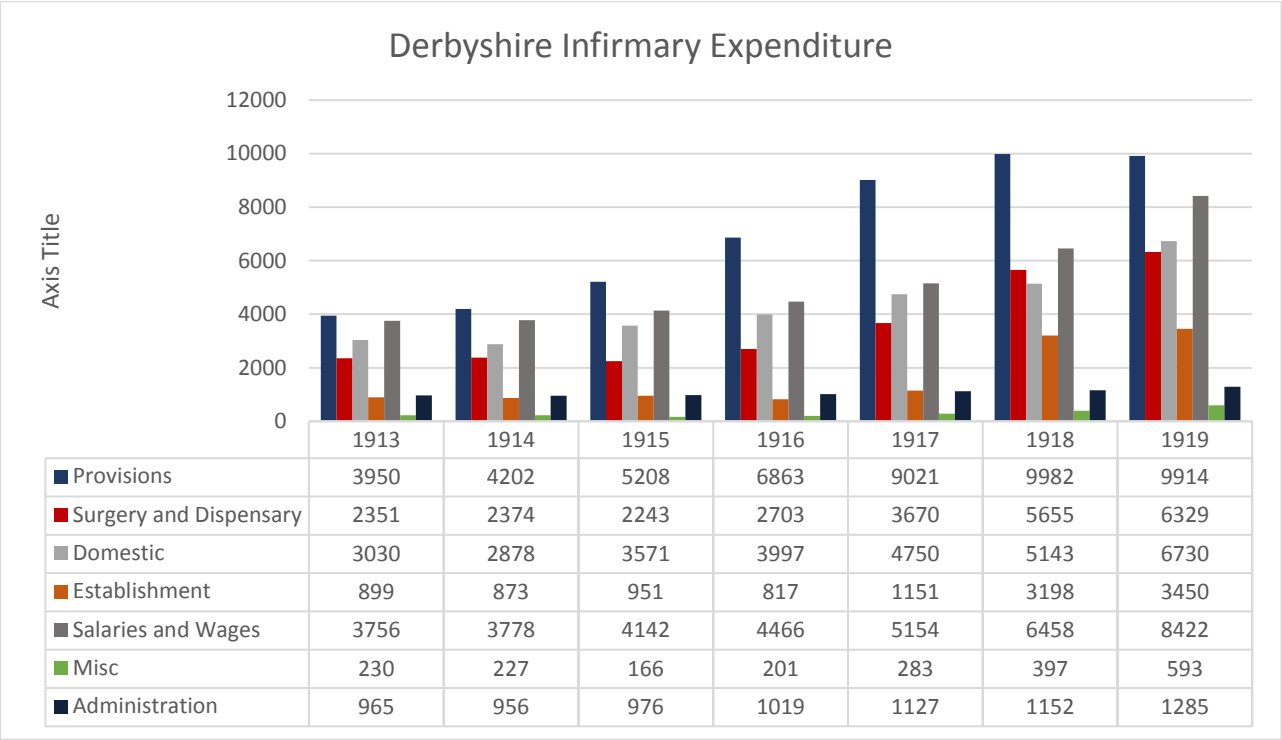
	1913	1914	1915	1916	1917	1918	1919
Provisions	5084	5566	8568	11513	13911	16569	13037
Surgery and Dispensary	3187	3172	3465	4516	5855	6564	6321
Domestic	3263	3516	4473	5314	6520	10472	11684
Establishment	866	868	873	1140	1300	2355	3169
Salaries and Wages	4214	4502	5591	6678	7538	9429	13225
Misc	188	172	212	233	347	519	619
Administration	797	753	1064	1163	1214	1561	2016

Graph 2.3: Derbyshire Infirmary Income, 1913-1919



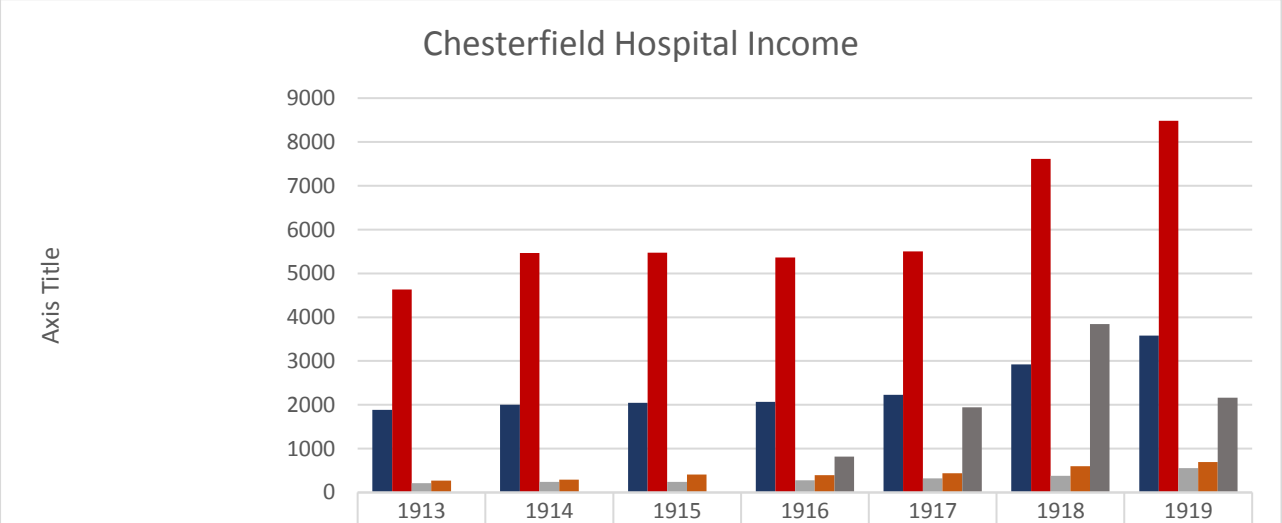
	1913	1914	1915	1916	1917	1918	1919
Subscriptions and Donations	7439	8053	7989	8830	8328	9592	11925
Saturday Collections	2667	2921	3341	3681	4955	6077	7090
War Office	0	0	2753	4248	7857	10906	7005
Dividends Interest Etc	1957	1814	1814	1902	2078	2219	2505

Graph 2.4: Derbyshire Infirmary Expenditure, 1913-1919



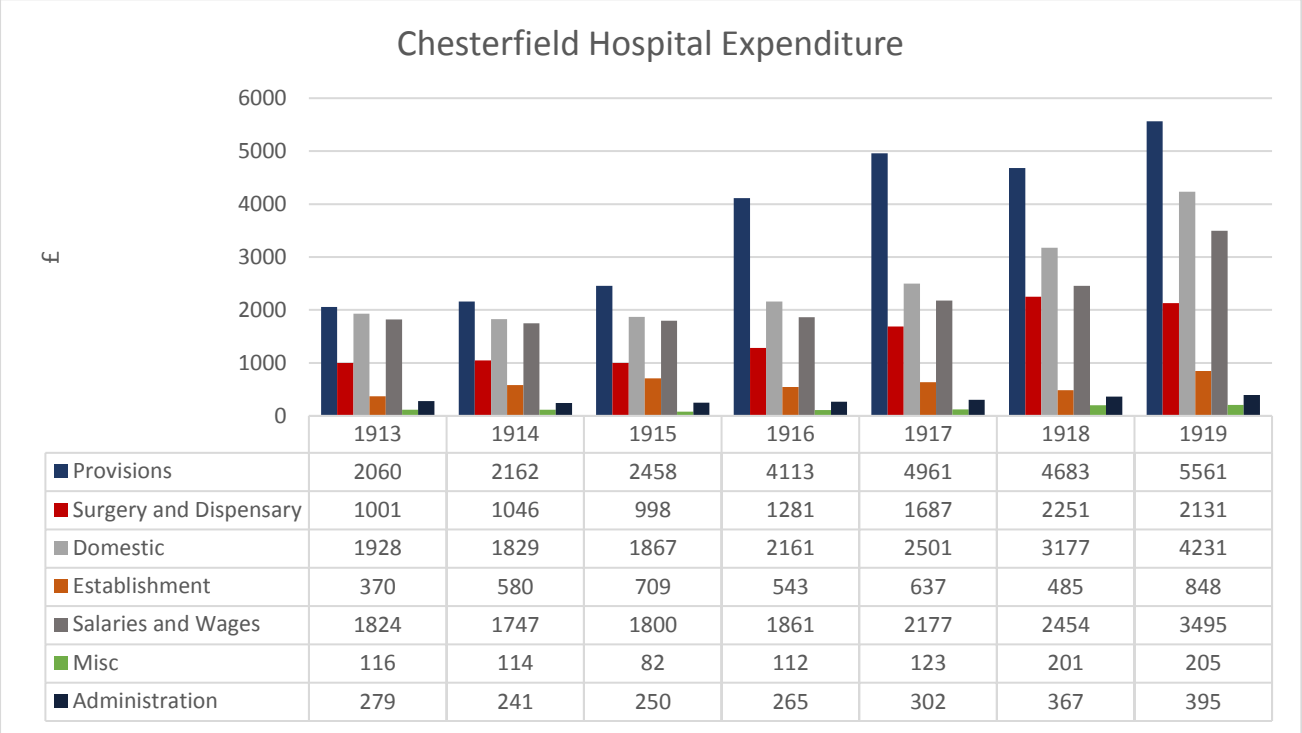
	1913	1914	1915	1916	1917	1918	1919
Provisions	3950	4202	5208	6863	9021	9982	9914
Surgery and Dispensary	2351	2374	2243	2703	3670	5655	6329
Domestic	3030	2878	3571	3997	4750	5143	6730
Establishment	899	873	951	817	1151	3198	3450
Salaries and Wages	3756	3778	4142	4466	5154	6458	8422
Misc	230	227	166	201	283	397	593
Administration	965	956	976	1019	1127	1152	1285

Graph 2.5: Chesterfield Hospital Income, 1913-1919



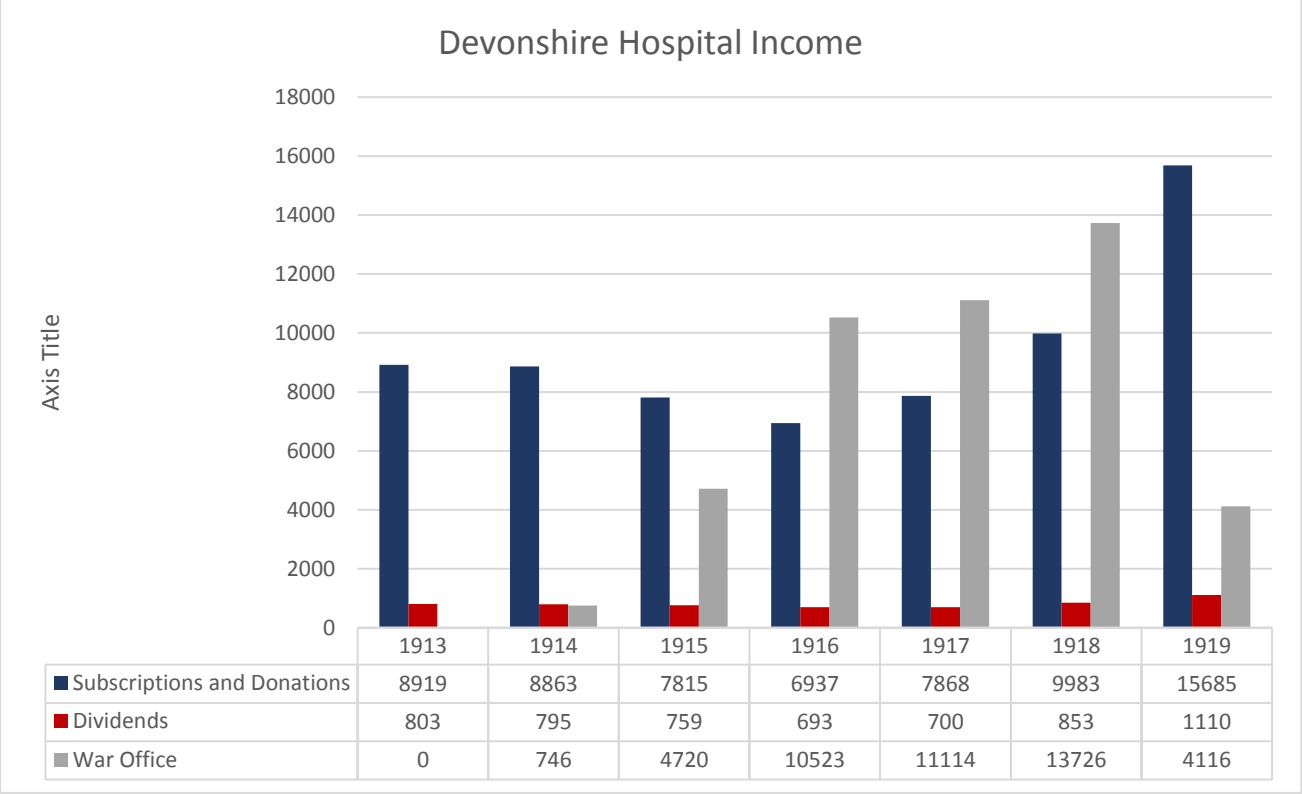
	1913	1914	1915	1916	1917	1918	1919
Subscriptions and Donations	1889	2001	2047	2066	2231	2921	3578
Workpeople's Collections	4630	5464	5474	5366	5504	7614	8486
Hospital Committees	211	243	240	278	322	382	558
Investments	273	292	409	393	440	599	696
War Office	0	0	0	819	1941	3846	2162

Graph 2.6: Chesterfield Hospital Expenditure, 1913-1919



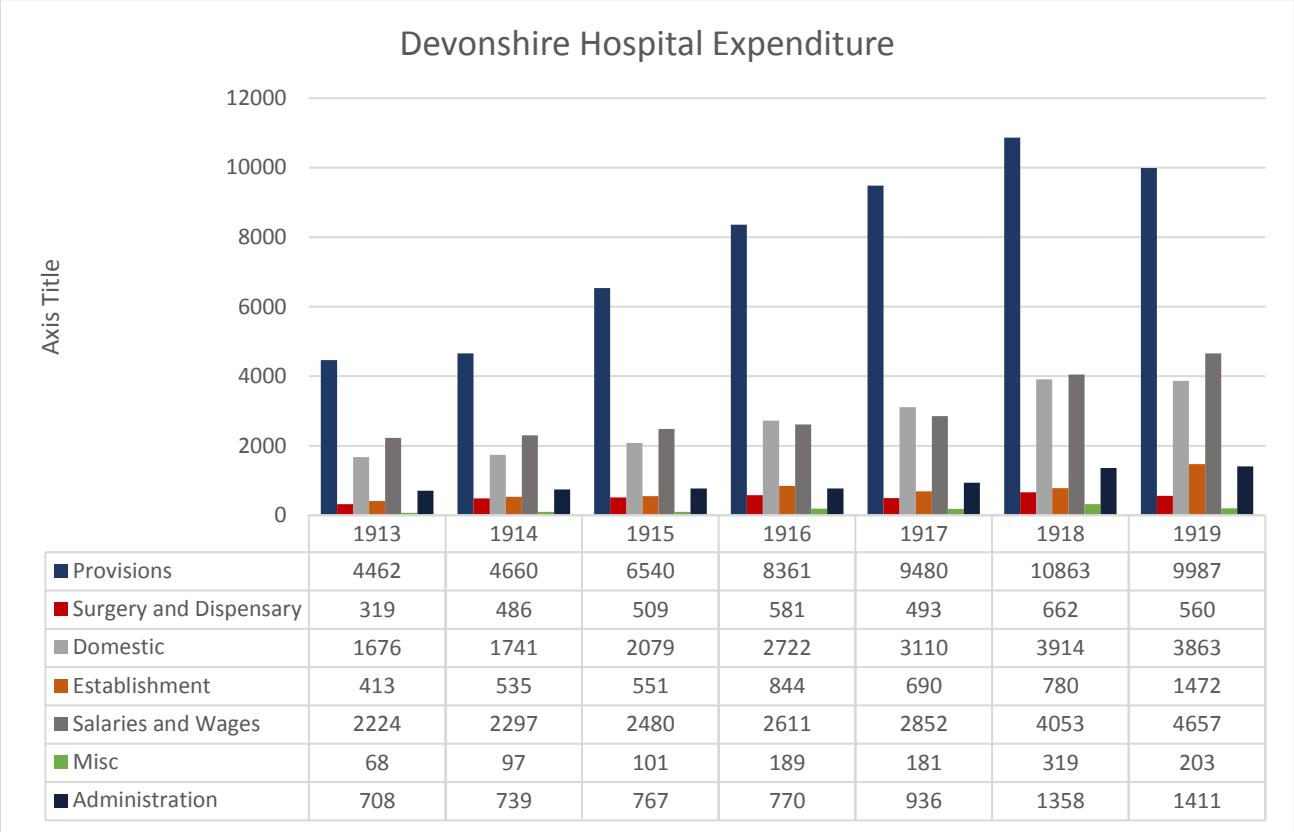
	1913	1914	1915	1916	1917	1918	1919
Provisions	2060	2162	2458	4113	4961	4683	5561
Surgery and Dispensary	1001	1046	998	1281	1687	2251	2131
Domestic	1928	1829	1867	2161	2501	3177	4231
Establishment	370	580	709	543	637	485	848
Salaries and Wages	1824	1747	1800	1861	2177	2454	3495
Misc	116	114	82	112	123	201	205
Administration	279	241	250	265	302	367	395

Graph 2.7: Devonshire Hospital Income, 1913-1919



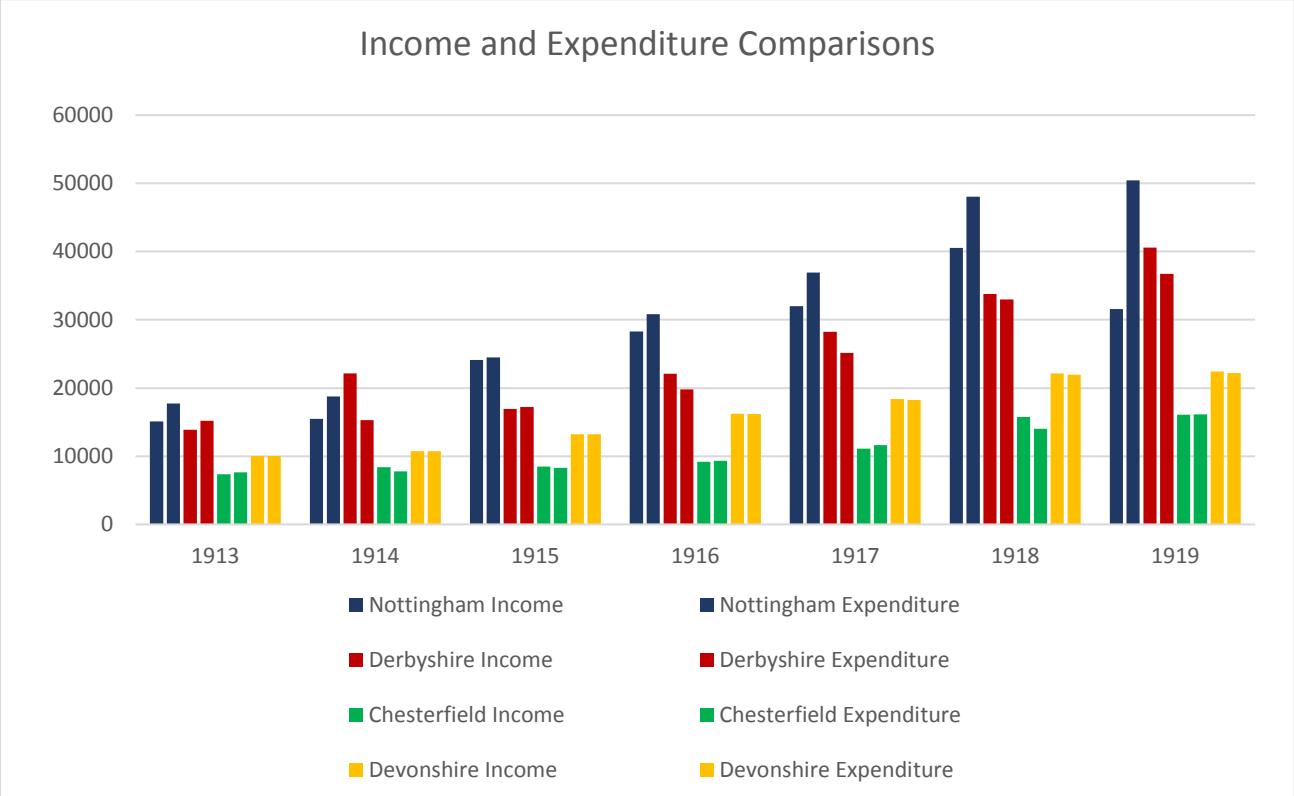
	1913	1914	1915	1916	1917	1918	1919
Subscriptions and Donations	8919	8863	7815	6937	7868	9983	15685
Dividends	803	795	759	693	700	853	1110
War Office	0	746	4720	10523	11114	13726	4116

Graph 2.8: Devonshire Hospital Income, 1913-1919



	1913	1914	1915	1916	1917	1918	1919
Provisions	4462	4660	6540	8361	9480	10863	9987
Surgery and Dispensary	319	486	509	581	493	662	560
Domestic	1676	1741	2079	2722	3110	3914	3863
Establishment	413	535	551	844	690	780	1472
Salaries and Wages	2224	2297	2480	2611	2852	4053	4657
Misc	68	97	101	189	181	319	203
Administration	708	739	767	770	936	1358	1411

Graph 2.9: Income and Expenditure Comparison, 1913-1919.



General trends from this data show that expenses increased through the war; no surprise there. Inflation, as well as a larger remit, meant that the hospitals were having to spend more to carry on their work. Similarly, incomes increased too, as more funds came from the War Office, and hospitals made efforts to raise more funds via their usual means to try and stay on top of the increasing expenditures.

However, where this becomes important is exactly what the hospitals are having to spend more on, and whether they were able to maintain their incomes in line with their expenditures. Nottingham General had far more difficulty in growing its income in a competitive way than Derbyshire Infirmary, Chesterfield Hospital, and the Devonshire Hospital. The issue chiefly lies in two elements: firstly, its expenditure on 'domestic' elements within the institution doubled from 1916 to 1918, and secondly, its subscriptions and donations grew only sluggishly, failing to fill the deficit made by increasing expenditures. All hospitals taking on wartime duties, regardless of their size, were finding increases in two aspects of their expenditure: provisions and salaries/wages. Larger numbers of patients being treated per year, alongside the need to both retain and hire new staff (and government recommended increases to nurse's wages) meant that there was a logical increase to the money spent on buying food and paying staff. But Nottingham's increase in domestic expenditures was unique among these four hospitals and stands out amongst its other increased expenditures. Its large facilities and extensive campus meant that it was particularly badly hit by increases to fuel, which was the largest single expenditure within its domestic services.[135] In 1914, Nottingham General was spending £3,516 on domestic services, with £2,005 of that on fuel. In comparison, Derbyshire Infirmary was spending £2,878 on domestic services, and £1,704 on fuel. By 1918, Nottingham was spending £10,472 on domestic, £5,062 on fuel, and Derbyshire Infirmary £5,143 on domestic, and £3,020 on fuel. Furthermore, its expenditure on linen and bedding quadrupled from the beginning of the war to the end, from £560 to £2,163. Summarily, Nottingham General was spending three-times as much on domestic expenses in 1918 than 1914; conversely, Derbyshire Infirmary, Chesterfield Hospital, and the Devonshire Hospital were spending just under twice as much.

The largest hospital of the study was suffering from its own size. It is logical that a larger hospital would have larger domestic expenses. But the extent to which Nottingham General saw an explosion in domestic expenses outstripped its ability to fundraise and resulted in a deficit. This would perhaps have been overcome, much like the other hospitals overcame their expenditure

[135] Nottingham General Hospital Annual Report 1918.

increases. However, Nottingham saw a lacklustre increase in its usual incomes. A quick glance at the total income versus total expenditure in Graph 2.2 and 2.9 show that Nottingham lost pace with its expenditures, with income falling as far behind as £7,500. Its pattern of deficits were far more severe that any of the other hospitals, all of which managed to either manage surpluses, or deficits of only a few hundred pounds. The Derbyshire Infirmary's expenditure grew by 59% from 1913-1919, and the Nottingham General's 65% - comparable levels of expenditure growth. However, Nottingham's percentage income increase over the period was just 52%, whereas the Derbyshire Infirmary's was 75%. Similarly, Chesterfield and the Devonshire, whose expenditures both grow by 53% and 55% respectively, both manage to equally increase their incomes by 55%. There is a disparity in the Nottingham General between the growth in expenditure and growth in income; a disparity that does not occur so starkly in other hospitals. The Devonshire Hospital had a similarly sluggish increase in its subscriptions and donations to Nottingham General. However, it was neither a general hospital, nor saddled with the expensive burden of providing acute care to large numbers of soldiers. The care it provided was therapeutic, and as such required less expensive treatments. Therefore, neither its expenditure nor its income had exponential increases.

Nottingham's subscriptions and donations managed to grow, with donations actually doubling in 1917 and 1918. But chief among the issues was the stagnation of the Saturday/Workmen's Fund, From 1914, the Nottingham General Saturday Fund Executive Committee lost track of the number of individual subscribing to the fund as their numbers – and contributions – reduced.[136] The Saturday Fund organisers also ran into difficulties when their events were prevented from taking place. For example, a concert booked for the 22 August 1915 had to be cancelled due to a Recruitment Demonstration that was taking place at the same time and location.[137] Where subscriptions and donations more than doubled from 1914 to 1918 (£4,950 to £11,099) the Saturday Fund actually dropped from 1914 to 1915 by £700, only climbing back up to pre-war levels in 1918. Conversely, the Derbyshire Infirmary saw gradual (though not radical) growth in its Saturday Fund, until by 1918 it had doubled. Chesterfield to saw more success in its workmen's scheme, where after a sluggish period from 1914-1916, saw an increase of £2,000. Flag Days saw some success, however, and largely accounted for the increase in the general donations received by fundraisers, raising £3,843 in 1918 compared to £2,678 in 1916.[138] But the loss from the reduction in Saturday fund donations was not balanced out by the increase in donations. By far the largest income was from the War Office, which suggests a dependence on government grants as

[136] Nottingham General Hospital Saturday Fund Executive Committee Minutes 1 December 1914, Nottingham General Hospital Saturday Fund Executive Committee Minutes 5 October 1915
[137] Nottingham General Hospital Saturday Fund Executive Committee Minutes 7 September 1915.
[138] Nottingham General Hospital Annual Report 1916., Nottingham General Hospital Annual Report 1918.

the hospital's voluntary incomes reduced. Derbyshire Royal Infirmary seemingly remained more robust, with less of a reduction in voluntary incomes. With the reduction in the work done for the government, subscriptions increased again as civilians returned to work and once again required treatment for their rheumatic ailments. The patterns displayed thus far in the voluntary hospitals in the war largely agree with the patterns identified by Gorsky and Mohan, who found that subscriptions started to falter or decline between 1914-1918, a turning point at which subsequent growth in income was sustained by a changed mix of funding sources.[139] The war meant that the links between a hospital and its community had been complicated by a new link with the War Office. The introduction of new patients from the services meant that the hospital was having divert some of its attention away from its community.

A cursory glance at Chesterfield's finances would indicate that there was little issue. Subscriptions remained constant, and grew towards the end of the war, a pattern matched by the Working Men's fund, and other incomes such as investments and external hospital committees. However, Chesterfield had developed a large deficit on its balance sheet. A debt that had started to accrue before the war had been exacerbated, and although it had managed a balanced budget on its ordinary expenses, it was not able to cultivate a surplus that could cancel out its debts.[140] By 1917, the debt had reached roughly £8,000.[141] They did not, as already illustrated, receive as many soldiers as the other institutions and resultantly also never received War Office Grants in anywhere near the same quantities as Derby, Nottingham, or the Devonshire, although .

Frequently in the war, it was down to the traditional leaders of the hospitals to initiate progress and change. William Player, in 1915, supplied the radiography department's new apparatus, as well as constructing and furnishing the new balcony extension for open-air treatment at considerable cost.[142] Furthermore, William Player was a leading member in the new reconstruction sub-committee created at the Nottingham General Hospital before the end of the war, whose object was to look towards the future requirements of the institution when the war ended. This was not a break from the past, but a continuation of it. However, the hospitals were not really able to expand as they might have seen fit: applications for expansion and construction had to be approved by the War Office, who were as likely to deny them as approve them. Building funds were largely suspended and special appeals very limited, because hospitals were unable to find volunteers to run events, and were limited with rationing and location as to what they could host; so often the

[139] Mohan and Gorsky, *Don't Look Back*, p.42.
[140] Chesterfield and North Derbyshire Hospital Annual Report 1913.
[141] Chesterfield and North Derbyshire Hospital Annual Report 1917.
[142] Nottingham General Hospital Annual Report 1914; Nottingham General Hospital Annual Report 1915.

reason was simply stated as 'due to the circumstances of the war'.[143] The Derbyshire Infirmary was carrying out various negotiations with local authorities to have a VD clinic opened in the institution, but these turned out to be almost totally theoretical, because despite the clinic finding approval and having a medical officer appointed, the clinic itself was not opened until well after the war.[144] Other endeavours of the sort were limited also through the fact that Derby's Special Appeal Fund (used for expansions and furnishings) was denuded of volunteers and was unable to secure any entertainers due to the War.[145]

Despite the restrictions of war, and the dispersal of the nation's population into the army and into the factories, there were some large fundraising efforts. The flag days in Nottingham were successful, war-related efforts, but few of the carnivals seen growing in the countryside were seen to continue in the war. Only one large example of mass-fundraising appears in the two counties: in Chesterfield. In 1917, the 'Traders of Chesterfield and District' launch a huge bazaar in an effort to ameliorate the deficit and debts of the hospital in one large effort.[146] The aim was for £4,000 to be cleared. What actually happened was that over £8,000 was raised; £4,300 of which was handed over to the Hospital Board for the sake of the deficit, and the remaining £4,000 handed to the hospital for 'capital purposes'.[147] They stated:

> For the first time for twenty years the Hospital was out of debt, and the Board feel that, coming as this does in the midst of the Great War, no words of theirs can adequately express their gratitude to the promoters and workers.[148]

The bazaar consisted of dozens upon dozens of stalls set up by tradespeople throughout the town, wherein traders would donate their wares for sale, or donate a proportion of their sales to the hospital. The bazaar lasted four days, with other smaller fundraising efforts such as the selling of flags also taking place. The local newspaper was shocked at the overwhelmed result, and reported on the surprising success, stating that:

[143] Derbyshire Royal infirmary Annual Report 1916-1917.
[144] Derbyshire Royal Infirmary Annual Report 1917-1918.
[145] Derbyshire Royal Infirmary Annual Report 1916-1917.
[146] Chesterfield Royal and North Derbyshire Hospital Annual Report 1917.
[147] Chesterfield Royal and North Derbyshire Hospital Annual Report 1917.
[148] Chesterfield Royal and North Derbyshire Hospital Annual Report 1917.

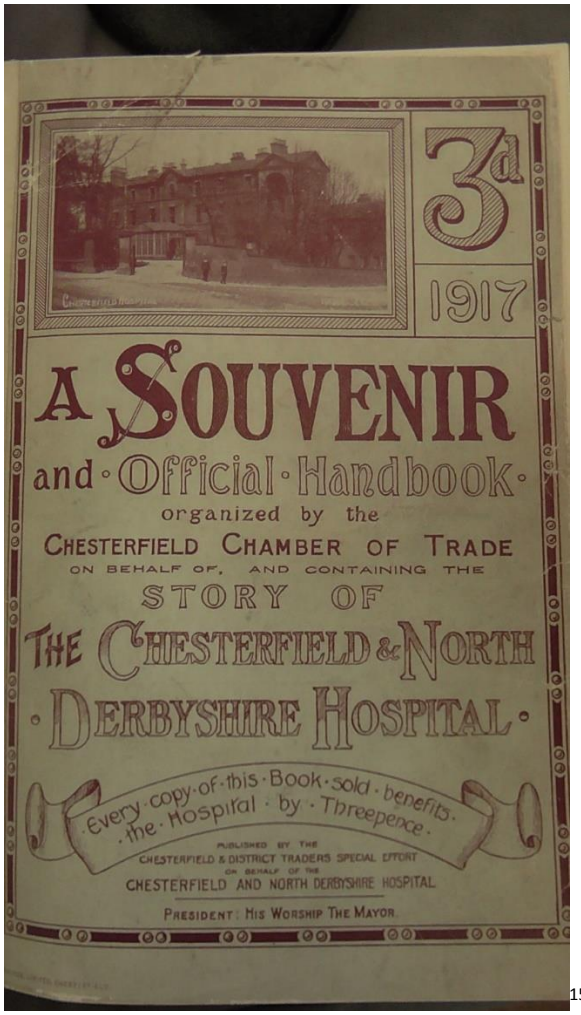
> The takings at the stalls were: - Wednesday £1,048 6s. 7d., Thursday £918 13s. 2d., Friday £831 9s. 1d., and Saturday £652 11s. 2d. Over £3,000 was received in donations, and a considerable amount has yet to come in….[149]

The newspaper agreed with Chesterfield M.P. Barnet Kenyon, who remarked that 'the bazaar had been one of the surprises of the year, and showed what a community of people could do, no matter how small they were numerically, if only they united and concentrated their energies on one great object'.[150] There was great positive feeling among the townspeople and fundraisers, and the hospital was the glad recipient of its manifestation. However, the hospital remained relatively unresponsive to the idea that it may need to diversify its incomes long-term. This was made clear when they made the statement:

> It is the earnest desire of the Board to keep out of debt for the future, and effort are being made in that direction by asking employers and working men in the district to increase their subscriptions. Already a very good response has been made to this request, and it is hoped that the sums realised will make the position secure for the future.[151]

[149] 'Chesterfield Hospital Bazaar, £8,000 Realised', *Derbyshire Times and Chesterfield Herald*, 29 September 1917.
[150] 'Chesterfield Hospital Bazaar, £8,000 Realised', *Derbyshire Times and Chesterfield Herald*, 29 September 1917
[151] Chesterfield Royal and North Derbyshire Hospital Annual Report 1917

Figure 2.10: A Souvenir and Official Handbook. Chesterfield Trader's Effort 1917.



[152]

It has been argued that the future key financial stability for provincial hospitals rested on constructing an interlocking blend of income streams, and that those which failed to do this found themselves in financial difficulty. Chesterfield Hospital was one of these institutions, who did not see the merit in diversifying its incomes by creating a tradition of large-scale singular fundraising. The hospital board of management was set on increasing the contribution and subscriptions of its workpeople, and although it saw benefit of the singular fundraising events like the bazaar in exceptional circumstances, its focus remained on sustainable, long-term incomes. The carnival remained relatively small, Alexandra Rose Day was rolled into the Saturday Fund because the two were so small, and there seems to be little else in the way of big entertainments that the hospital was organising.[153] The other smaller forms of fundraising such as Church and Sunday collections are little different to the amounts other hospitals were bringing in, but if we compare Chesterfield by

[152] *A Souvenir and Official Handbook. Chesterfield Trader's Effort 1917*.
[153] Alexandra Rose Day and the Saturday Fund never raised more than £200 respectively

proportion to the likes of Derby and Nottingham Sunday Collections for Chesterfield were really very low. The hospitals needed supplementary incomes to boost the money coming from the subscriptions. Despite the voluntary hospitals fulfilling a junior role in the large machinery of medical treatment for military personnel, the impact that the demands had upon the hospitals was monumental. Whole wards were turned over to military patients, and waiting lists increased drastically as a result. Doctors and nurses were called up, so that the hospitals were forced to run on a skeleton crew, at times fraught and under great tension. As well as these direct impacts, the inflation during the war meant that the hospitals, already preoccupied, were not able to increase much of their fundraising and subscription in a competitive fashion. Two million men from Britain and its Empire were wounded, and clearly the demands upon not only the Army Medical Services but also on the civilian medical services was huge.[154]

Even after the end of hostilities, the War Office continued to place high demands on the voluntary hospitals until well after the war. As a consequence, hospitals continued to receive significant percentages of their income from the War Office right into 1920 But, as has already been established, this came at a significant cost as the associated expenditure continued to rise exponentially, a condition only exacerbated by rapid increases in post-war boom and associated inflation. Food prices alone rose by 20% between 1919-20.[155] The burden of war wounded inpatients in the voluntary hospitals was largely lifted by 1919, with no more soldiers receiving wounds in the field anymore. But the burden of outpatients only swelled.[156] 'Pensioners', as the hospitals referred to them, were ex-servicemen discharged from the army but with entitlements to care for injuries or ailments developed during the war.[157] The Nottingham General's Outpatient Department was flooded in the years after the war, from 1919 to 1920, primarily due to the number of 'pensioners' now attending. In 1920, the numbers received were 139,300, compared to 89,375 in 1919.[158] This increase was almost wholly due to demand from injured ex-servicemen. The cost of treatment also rose significantly, largely because of the complexity and longevity of the cases: 7/9 in 1917, to 13/8 by 1920.[159] Derbyshire infirmary had a similar experience, with an increase of 32,548 outpatient visits in the same year.[160] Again, the lion's share were the typical 'pensioners' orthopaedic and medical cases.[161] Across the board, the number of new outpatients in

[154] Carden-Coyne, *Politics of Wounds*, p.4.
[155] Brian Mitchell, *Abstract of British Historical Statistics* (Cambridge University Press: Cambridge, 1962), 476.
[156] Chesterfield and North Derbyshire Hospital Annual Report 1919.
[157] MacPherson, *Medical Services,* p.223.
[158] Nottingham General Hospital Annual Report 1920.
[159] Nottingham General Hospital Annual Report 1920.
[160] Derbyshire Royal infirmary Annual Report 1919-1920.
[161] Derbyshire Royal infirmary Annual Report 1919-1920.

the hospitals increased by the thousands after the war as soldiers returned home. From 1918 to 1920, Chesterfield Hospital had 545 more, Derbyshire Infirmary had 2,425, and Nottingham General had 2,895 extra outpatients, all very large increases in just two years.[162] In purely financial terms this continued to be a millstone around the necks of those departments, and the hospitals generally despite funding from the War Office (and the Ministry of Pensions). The staff hospitals lost during the war were slow to return, as many reports of honours bestowed upon their still absent staff members indicate how long the RAMC retained its wartime cohort.[163] Demobilisation from the RAMC was slower, because unlike the ordinary soldiers, the medical men and women still had work to do on wounded servicemen.[164] This factor was something that ran over into the next decade, as the hospitals, essentially floating on the tide of war for the last five years, were unable to return smoothly to civilian care.

With the war barely over, the rumblings of economic distress were starting to show themselves across the nation, and the hospitals were a key part of the focus. In many ways, the period of 1918-1920 was one not of transition from war to peace, but of war to crisis. Finances aside, the hospitals had coped well with the demands put upon them by war, given the extraordinary pressures and shortages. Yet this came at a price, and that was paid largely my civilian patients. The replacement or supplementary measures provided by the War Office (money, hutted wards, voluntary nurses, etc.) were not adequate to keep the hospitals running both their civilian services and military services effectively and efficiently. As a consequence civilian waiting lists rose sharply, as scheduled operations were reduced due to the influx of emergency wounded. The loss of staff, in some cases permanently, was perhaps the most strikingly difficult obstacle for the hospitals. It was slightly easier to replace nursing or domestic staff, but the loss of the highly skilled services of the surgeons, anaesthetists, and consultants not only made day-to-day functions of the hospital difficult, but often impossible. Without the doctors, there was no hospital. Abel Smith found that nationally the civilian hospital services lost half of their doctors to the RAMC, meaning hospitals across the nation were struggling to provide care for their own civilian populace, as well as any war wounded their received from the armed forces as well.[165] The Great War was a test for the hospitals. Questions about the viability of the voluntary system, in both peace and war, would start

[162] Chesterfield and North Derbyshire Royal Hospital Annual Report 1920.; Derbyshire Royal infirmary Annual Report 1919-1920.; Nottingham General Hospital Annual Report 1920.
[163] Nottingham General Hospital Annual Report 1919.; Nottingham General Hospital Annual Report 1920.; Derbyshire Royal Infirmary Annual Report 1918-1919.; Chesterfield and North Derbyshire Hospital Annual Report 1918.; Chesterfield and North Derbyshire Royal Hospital Annual Report 1920.
[164] MacPherson, *History of the Great War,* pp.223-226.
[165] Abel-Smith, *Hospitals,* p.283.

to be asked in the coming years; questions that had not been asked before. They would be tested again in the years to come, through financial crisis, social upheaval, and another war.

Chapter 3: 1919-1926 – Crises of faith and the future of voluntarism

Defined by Crisis: Part One.

The years following the Great War were among some of the most turbulent in modern British political history. For hospitals, it was defined by a short but severe economic crisis in the years just after the war. The conditions generated by war had created a post-war economic bubble, wherein high demand had driven up wages and prices, encouraged investment speculation, and spurred the government into approving incredible domestic budgets. Thousands of new companies were formed, domestic capital issues rose by hundreds of millions of pounds from 1913, and confidence in the market was at an all-time high.[1] As an example, 42% of the total cotton industry mills were bought and sold between 1919 and 1920, with similar happening in shipping, shipbuilding, and engineering. Collieries and steelworks amalgamated into larger companies, entwining the two industries and creating ever-larger concerns.[2] The drastic deflation that would have occurred if the government had decided to return to the gold standard near the end of the war would have meant early peacetime difficulties, which they sought to avoid.[3] The hospitals, during this time, enjoyed a brief respite, where the flurrying demands of the war subsided but they still received substantial grants from the government for treating a steady stream of former soldiers whose care was covered by the Ministry of Pensions (both as in-patients and out-patients). However, the government made a key mistake, raising the bank rate from six to seven per cent, in the hopes that it would curb what it saw as such reckless amalgamation and speculation in the markets; instead, it halted trading altogether.[4]

The resultant crash was devastating to ordinary people. Taylor points out that the economy that the war produced was almost wholly unsuited to peacetime, promoting industries which Britain already had too much of, doing little to promote industries that were required for the future economic stability of the nation.[5] Unemployment almost instantly rose to above one million persons – what came to be known as the 'intractable million' that continued to plague governments for the next twenty years until the Second World War.[6] For the first time, real fears of widespread civil unrest and

[1] Charles Loch Mowat, *Britain Between the Wars 1918-1940*, (Methuen & Co. Ltd: London, 1955) p.25.; Derek Aldroft, *The British Economy: The Years of Turmo8il 1920-1951* (Harvester: London, 1984), pp. 1-7; Abel-Smith, *Hospitals,* pp. 307-10.
[2] Mowat, *Britain Between the Wars,* p.26.
[3] Robert Skidelsky, *Politicians and the Slump. The Labour Government of 1929-1931* (Penguin Books Ltd: Harmondsworth, 1970) p.15.
[4] Mowat, *Britain Between the Wars,* p.26.
[5] A J P Taylor, *English History 1914-1945* (Book Club Associates: London, 1977) p.123.
[6] Skidelsky, *Politicians and the Slump*, p.15.

even revolution meant that the Lloyd George government went from balancing the forces of war, to riding brief economic boom, to managing the turbulence of unemployment and economic recession.[7] There was concern from the likes of Basil Thornton, Home Office Director of Intelligence, haunted by the events of 1917 in Russia, that Britain may soon witness the spread of Bolshevism on its shores.[8] Lloyd George, having considered the fate of the rigid and reactionary Tsarist regime, decided to opt instead for an ambitious social policy, and as Fraser points out, Lloyd George saw generous social policy as creating social unity, thus heading off revolution in favour of positive social change.[9] He also saw the 'playing of the Red Card' as a way of achieving those social objectives and bolstering his own position.[10] By 1920, unemployment reached over one million, and from then until the summer of 1940, it never went below that point.[11] While mining was not the sole employer for the two counties, it did account for a large swathe of the population, and the many of the hospitals, especially Chesterfield and Mansfield, were very dependent on income from mineworkers. This wider crisis was believed to have had a doubly hard negative effect on the hospitals. At one end, in the immediate post-war years, they experienced higher running costs than they had done even through the war, and at the other they were open to difficulties from securing funds from communities that might have a high level of unemployed (and thus non-contributing) workers.

The voluntary hospitals were, in many respects, apolitical. Although within their ranks of volunteers stood local politicians and keen party members, the hospitals themselves remained theoretically non-partisan. They were conservative insofar as they were vehemently opposed to government funding or peacetime government control. However, they did find support (where they were successful at providing a good service) from the left, especially in the national trades unions and in the leftist strongholds of the northern cities.[12] But the more radical intelligentsia of the left saw voluntary hospitals as inadequate for their task, and instead sought a nationalised or municipalised system, publicly funded and administered. This view was compounded when the hospitals crisis was realised in the wake of the market crash of 1920, having been brewing from the very end of the war.[13] It was brought to the attention of the government that many voluntary hospitals, especially in

[7] Chris Wrigley, *Lloyd George and the Challenge of Labour: The Post War Coalition 1918*-1922 (Harvester: Hemel Hempstead, 1990); Derek Fraser, *The Evolution of the British Welfare State* (Palgrave: Basingstoke, 1984). P.181.
[8] Fraser, *Evolution of the Welfare State*. P.181.
[9] Fraser, *Evolution of the Welfare State*. Pp.180-181.
[10] Wrigley, *Lloyd George,* p.306-8.
[11] Fraser, *Evolution of the Welfare State* p.183.
[12] Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010) p.375., p.381.
[13] John Mohan and Martin Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001) p.40.

London and the larger cities, having weathered the war, were now heavily in debt and struggling to catch up with updating their hospitals. The war had all but prevented meaningful expansion of the hospitals. Many had had new wards built – both temporary and permanent - to provide space for war wounded, but few other facilities to service them. Many, too, were finding that they could not envisage ameliorating their debts without outside help. The London Hospital alone had a £65,000 deficit for 1919 and estimated that subscriptions would need to rise by one hundred per cent or more to be able to carry on the hospital's work.[14] An undetected problem had developed.

In the debate around voluntary hospitals, this era is defined by the Voluntary Hospitals Commission, which was set up in response to a growing crisis of funding within many of the hospitals across the nation. It was formed from the meeting chaired by Viscount Cave (and later to be nicknamed the Cave Committee) to investigate just why the hospitals were in difficulties. After calling forward many witnesses from the London Hospitals and national bodies, and just a few representatives of the provincial institutions, the Committee came to the conclusion that the hospitals were in need of help, and that a Voluntary Hospitals Commission, under the auspices of the government, should be established to address this.[15] It was decided that a pot of money in the form of grants would be given out the hospitals who were in need of financial bailout or stimulation.[16] Where the Committee originally recommended that £1,000,000 be earmarked by the government for such a plan, 'Gedde's Axe' cutting social expenditure soon fell upon the Cave Committee, much like it did for many other government plans in this time of renewed economy, and just £500,000 was made available.[17] Yet a key point made by the Committee, and indeed the representatives of the voluntary hospitals far and wide, was the central tenet that hospitals should not become dependent on the government for handouts, which would effectively destroying the voluntary system as it presently stood.[18] It sought to return the hospitals to their pre-war viability before wartime inflationary pressures had driven running costs relentlessly upwards. They rightly predicted that the costs of running hospitals would soon fall. What was needed, therefore, was temporary aid. Instead of just straight grants, hospitals had to match funding with their own fundraising efforts in order to unlock the grant from the

[14] A E Clark Kennedy, *London Pride The Story of a Voluntary Hospital*, (Hutchinson Benham: London, 1979) p.192.
[15] MH58/203 'Constitution and Terms of Appointment'.
[16] 'Voluntary Hospitals Commission', *British Medical Journal,* 2:81, 16 July 1921.
[17] J E Stone, *Hospital Organization and Management (Including Planning and Construction)*, (Faber & Gwyer Ltd: London, 1927) p.46.; Charles Loch Mowat, *Britain Between the Wars 1918-1940*, (Methuen & Co. Ltd: London, 1955) p.130.; Rodney Lowe, 'The Erosion of State Intervention in Britain, 1917-24', *The Economic History Review,* New Series 31:2 (1978) pp.277-281.
[18] Voluntary Hospitals Commission, *Full Report* (HMSO: London, 1921), pp.7-8.

Voluntary Hospitals Commission.[19] It meant that the primary raison d'etre of the Voluntary Hospitals Commission was to approve a system of grants to hospitals in the London and the provinces.

Before anything else, the Commission had to actually define what a voluntary hospital was, in order that the grants could be given to the appropriate institutions. After some debate, it was decided that voluntary hospitals were to be interpreted as only hospitals who were wholly or mainly supported from voluntary sources.[20] This excluded: 1. Nursing homes run wholly or mainly for profit; 2. Hospitals established or maintained by Ministry of Pensions; 3. Infectious hospitals and asylums maintained by local authorities; 4. Sanatoria for the treatment of tuberculosis (maintained as they were by regular exchequer grants).[21] Cottage hospitals, although quite obviously run on a voluntary basis but being viewed as being insignificant in size, were blocked from receiving grants in initial decision-making. However, they were included in the final remit because the Committee regarded them as equally vital to providing hospital care within sparsely populated areas as were larger hospitals in urban areas.[22] Also included were convalescent homes (often associated with large hospitals, but also often funded my patient payments) as well as homeopathic institutions, but also excluded homes for incurables and homes for the dying. It also of course excluded local authority institutions like Poor Law infirmaries and other hospitals funded via taxation and rates. Suffice to say, what the committee defined as a voluntary hospital was largely informed by the type of institution that they felt stood independent from local authority funding, but which would get most efficient use from government grants, reaching as many citizens with their care as possible. While this does not cause any conflict for the boundaries of this study, it does show that voluntarism itself was a broad and difficult to define spectrum, and often its practical application was what defined it in official terms. But in terms of definition, it took the committee some time before they realised that although ostensibly the London voluntary hospitals were structured the same as the provincial voluntary hospitals, they were victim to totally different circumstances, that would later define their policies.

Captain Stone, in his advisory text *Hospital Organisation and Management* published in 1927 looked back on the hospitals crisis through a prism that implied that the survival of the voluntary system was a foregone conclusion. The major threat he foresaw was with continued government involvement: the continued use of state funding for not just general maintenance, but for 'payment…of the full cost of work done'.[23] This, he argued, would stifle the voluntary ethic and

[19] Stone, *Hospital Organization*, p.46.
[20] MH58 178 Voluntary Hospitals Commission, 'Definition of the term Voluntary Hospital', 1921.
[21] MH58 178 Voluntary Hospitals Commission, 'Definition of the term Voluntary Hospital', 1921. p.8.
[22] MH58 178 VHC 'Definition of the term Voluntary Hospital', 1921, p.6.
[23] Stone, *Hospital Organization,* p.45., p.47.

prevent hospitals from expanding on voluntary lines. Why, for example, would people continue to donate or support a hospital when the state (either local or central) was funding an institution? Thus, for Stone the biggest threat to the voluntary system was the continued expansion of government paid services.[24] In this, he confuses the voluntary systems' capacity to treat individual patients with the governments' ever-increasing mandate to uphold the public health. This is articulated by the investigative committee's questioning of Sir Stanley (former chair of the Joint War Committee), when they inquire whether the suggestion of subsidising insured persons might affect their voluntary subscriptions.[25] It was a concern of the voluntary supporters in government and in the hospitals, who were increasingly nervous that the precedent set by the War Office in the Great War would develop into a state-led system, bastardising hospital provision to such an extent that it was no longer recognisable as a voluntary system.

Yet, the voluntary system was far from safe in the years just after the war. Many thought it terminally sick and philosophically flawed. Joseph Griffiths, a surgeon at Addenbrooke's Hospital in Cambridge, called for an effective end to hospitals as objects of charity, and instead for them to be objects of formal insurance.[26] Many on the left had been calling for a nationalised or public-funded service for some time, and indeed there was reluctance among the Voluntary Hospital Committees to even involve local trade unions in case they derailed the voluntary hospitals in their area. Yet at the same time during the Local Voluntary Hospitals Committees Conference held in 1921, Mr Davis of the Manchester Voluntary Hospitals Committee suggested that both the Federation of British Industries and the labour leaders be approached, so that they could perform a two-pronged attack to try and get the workmen to contribute, because the employers had been less than obliging in allowing their workers to be contacted.[27] In Norfolk, the voluntary hospitals had already enlisted the help of labour leaders and trade unions, and had had reasonable success in increasing contributions. These suggestions were met with hostility both from the Commission and from members of other local committees. At the conference called by the Cave Committee, Alderman Shepherd of the Bristol hospitals was very sceptical, and was fearful that while the personal views of the labour leaders might be pro-voluntarism on an individual basis, 'their politics was [sic] in support of nationalisation…[and] that it would be desirable to keep clear of the political atmosphere which would inevitably surround any official approach to labour leaders on this subject'.[28] Lord Onslow,

[24] Stone, *Hospital Organization,* p.47. This he means as the inclusion of 'venereal disease, maternity and child welfare, for the training of nurses…education…tuberculosis and other diseases'.
[25] MH58/204, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals', p.14.
[26] Joseph Griffiths, 'The Hospital Problem and a New Hospital Service', *The Lancet* XX:XX *(*1921), pp.633-634.
[27] MH58/189, 'Report of Conference with Local Voluntary Hospitals Committees', p.7.
[28] MH58/189, 'Report of Conference with Local Voluntary Hospitals Committees', p.7.

Parliamentary Secretary to the Ministry of Health and chair of the Cave Committee, summed it up with the following passage:

> …such modification as may be necessary from time to time become a permanent part of our hospital system, but its sole function would be to maintain intact the voluntary principle, and if it were calculated to lead either to municipalisation or nationalisation, he, for one, would like to see its immediate demise.[29]

It was clear that the 'official' view of the government and the commission was that the voluntary system should be preserved at all costs, and this was echoed by the local committees of voluntary hospitals established by the Cave Committee.

Two significant actors in the formation of attitudes towards the voluntary system were Sir Arthur Stanley and Sir Napier Burnett. Sir Arthur was a lifelong philanthropist, Conservative MP for Ormskirk until 1918, chair of the Joint War Committee of the Red Cross and St John's Society from 1914, a joint founder of the Royal College of Nursing in 1916, and treasurer at St Thomas's Hospital, London, from 1917.[30] Sir Napier Burnett was equally prolific, a doctor, a chief proponent of preventative medicine, and friend of Sir Arthur from their meeting at St Thomas's Hospital. He went on to become chief executive officer of the Joint War Committee, working closely with Sir Arthur.[31] When they were both called before the Cave Committee, they commented on the condition of the 108 London hospitals and the 728 large and small hospitals across England and Wales.[32] Estimates placed before the committee placed the average maintenance cost per bed before the war was 'about' £2, whereas at the time of the inquiry the average cost was £4.[33] From this figure it was estimated that the grand total cost of maintaining the voluntary hospitals had risen from £5,200,000 per year to £10,400,000.[34] However, such figures do not take into account the significant regional variations between London and the provinces. Expenditure per bed in London hospitals was at least fifty per cent higher than spending in the other regions, and sometimes significantly more.[35] Geoffrey Rivett

---

[29] MH58/189, 'Report of Conference with Local Voluntary Hospitals Committees', p.9.
[30] H M Palmer, S E Wynn-Jones, 'Stanley, Sir Arthur 1869-1947', https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-36242 [accessed 27/12/2019]
[31] Sydney Walton, 'Sir Napier Burnett: An Appreciation', *The Hospital and Health Review*, 3:54 (1924) p.54.
[32] MH58/204, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals, First Day, 26th January 1921', p.2.
[33] MH58/204, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals', p.3. Based on the years 1919-1920.
[34] MH58/204, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals', p.3.
[35] John Mohan, 'The caprice of charity": Geographical variations in the finances of British voluntary hospitals before the NHS', in Martin Gorsky and Sally Sheard (eds.), *Financing Medicine: The British experience since 1750* (Routledge: London, 2006), p. 83.

also identifies a decline in middle-class giving in London boroughs at this time which exacerbated the financial problems faced by the hospitals.[36] The secretary of the Great Northern [London] Hospital, Mr Gilbert G Panter, claimed that 'We suffer in London from that lack of local patriotism which exists in the principal [provincial] towns and which ensures for the hospital so much more support'.[37] But it has to be remembered that conditions in London were very different, with much higher population density. How different were provincial hospital communities? Certainly, there were few complaints in Derbyshire and Nottinghamshire about the willingness of the local population to actively support their local hospitals. Provincial hospitals (still open to fluctuations in their fortunes) were generally more stable, and more optimistic. Large London hospitals with medical schools received far less money from annual subscriptions and general donations as a proportion of income than, say, the large northern hospitals with medical schools like Manchester Royal Infirmary, Leeds General Infirmary, and Newcastle Royal Victoria Infirmary.[38] This applied also to hospitals without attached medical schools. General donations were larger in London, but annual subscriptions were far less as a proportion of income for the London institutions. The London Saturday Funds were also significantly underdeveloped, with somewhere like the Nottingham General dwarfing the London Metropolitan Hospital's fund. In part this was because of the sheer number of competing institutions in the capital[39] But the government was mostly preoccupied with London, which coloured their view of the whole nation's hospitals and of voluntarism as a concept.

In fact, the inquiry's scope paid scant attention to provincial hospitals. This was in spite of the fact that the provincial institutions vastly outnumbered the London hospitals in both the number of institutions and the number of patients treated. Fundamentally this was really down to the confirmation bias of the committee; the hospitals with the loudest complaints were those that they focussed upon, and those hospitals were the London hospitals. The final report claimed that 'In the case of the provincial hospitals…the time at our disposal precluded us from attempting to take evidence from all the more important hospitals, and we have selected typical institutions situated in various parts of the country'.[40] However, the number of 'provincial' institutions consulted from across England, Wales, and Scotland was fewer than those from London alone.[41] In this sense the

[36] Geoffrey Rivett*, The Development of the London Hospital System 1823-1982* (King Edward's Hospital Fund for London: London, 1986), p.186.
[37] MHf5/204, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals, Fourth day, 9 February 1921', p.56
[38] *Burdett's Hospitals and Charities 1921* (St John's Ambulance Society: London, 1921), p.142.
[39] *Burdett's Hospitals and Charities*, p.143.; Gorsky, Mohan, Willis, *Mutualism*, p.29.
[40] *Voluntary Hospitals Commission Final Report*, 1921, p.4.
[41] MH58/204, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals', Days 1-10.; MH58/205'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals', Days 11-17.

Commission was hardly national but instead London-centric. This metropolitan focus has been reflected in both contemporary and subsequent evaluation.[42] A line of inquiry started by Cherry and refined by Gorsky, Mohan, & Powell found that traditional charitable income sustained proportionally in the London hospitals, but declined in the provincial hospitals, replaced by more dynamic Saturday and other mutualist funds.[43]

The Voluntary Hospitals Commission proffered a series of 'Recommendations' (for the government), and 'Suggestions' (for the voluntary hospitals). The 'Recommendations' hinged on the government and local authorities becoming more proactive in its study of and involvement in the voluntary hospitals.[44] The 'Suggestions' focussed on tighter financial controls, and, particularly, methods by which income could be increased: namely promoting hospital appeals, and taking payment, directly or indirectly, from patients, wage-earners, and employers.[45] Many witnesses from London institutions called by the Cave Committee, where tradition seemed to outweigh expedience, expressed frustration or consternation at their own institution's intransigence towards broadening its horizons.[46] Gilbert Panter, aforementioned secretary of the Great Northern Hospital, pointed out that despite there being no real philanthropic class in the hospital's district, there had been no real efforts made to start earnest collections from working people either.[47] Another witness argued that the sheer density of population in a limited space, with an overlap of hospital authority, had meant that any attempts to get a broader mutualist-type scheme off of the ground had failed, because the central organising authority required to do so did not exist.[48] The essence of the findings of the Voluntary Hospitals Commission and Viscount Cave was that to survive, the voluntary hospitals had to shift away from the old 'safety' of the philanthropic message to the modern innovations of mass contribution, or at least mass subscription.[49] Mass schemes/worker's contributions remained a tiny

---

[42] John E Pater*, The Making of the National Health Service*, (King Edward's Hospital Fund for London: London, 1981) pp.12-13.; A Delbert Evans, L G Redmond Howard, *The Romance of the British Voluntary Hospital Movement*, (Hutchinson & Co Ltd: London, 1930) p.286.

[43] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review,* LV: 3 (2002) p.548.; John Mohan, Martin Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001) pp.40-43.; Steven Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *The Economic History Review*, 50:2 (1997) pp.320-322.

[44] Stone, *Hospital Organization*, p.46.

[45] Stone, *Hospital Organization*, pp.45-47

[46] MH58/204 'Voluntary Hospitals Department Committee to Investigate Financial Position, Evidence 1-9 July 1921'.; MH58/205 'Voluntary Hospitals Department Committee to Investigate Financial Position, Evidence 10-25 July 1921'.; MH58/207 'Voluntary Hospitals Financial Position Report of Committee 1921'.

[47] MH58/204 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals, Fourth day, 9 February 1921'.

[48] MH58/204 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals, First Day, 26th January 1921'

[49] M Gorsky, J Mohan, T Willis, 'Hospital Contributory Schemes and the NHS Debates 1937-1946: The Rejection of Social Insurance in the British State?', *Twentieth Century British History*, 16:2 (2005) p.177.

part of hospital income in the London hospitals (1-2%) right up to and through the Great War compared to the provincial hospitals (10-15%).[50] Chesterfield, Mansfield, and Nottingham all had mass subscription schemes (if not technically 'contributory' schemes) and Derby and other smaller hospitals like Ripley, Wirksworth, Ashbourne, and Newark were already starting to focus on mass fundraising events rather than focussing on individual philanthropic donations from local patrons. These were significant steps towards mutualism that the London hospitals simply were not taking. But it should not be overlooked that for provincial hospitals other forms of generating income were just as important as the large schemes.

The crisis prompted calls for reform from outside the hospital sector.[51] Somerville Hastings, surgeon and Labour M.P., argued that it was far too much of a risk to have such a vital service placed at the whims of charity, and instead called for a more stable system based on taxation or rates.[52] Labour argued for a more centralised system whereby the hospitals received either grants from their local authorities (rate-paid) or the Ministry of Health (tax-paid), or otherwise were simply under the total control of their local health authorities.[53]

> It seemed to the Labour Party that the only way…was for the State to accept the responsibility of providing hospital treatment for all who needed it. Labour looked upon health as a national concern, and believed that it was not without danger to have such an important adjunct to national health as hospitals dependent upon charity or private enterprise.[54]

It was not an unreasonable point. At times, hospitals were at the mercy of so many external factors that funding was never totally guaranteed year on year. There were fluctuations depending on local and national industry, the ability of their volunteers to organise and galvanise the local community, or the affluence of the local populace. Even something like the weather could end up affecting income of hospital fundraising events. If the Voluntary Hospitals Commission favoured the advance of contributory and workmen's schemes, Labour favoured a system funded by direct taxation as a right of citizenship. As it turned out, however, the Labour government in 1924 had no stomach for

---

[50] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.30.
[51] The Labour Party, *The Hospital Problem*, p.1.; The Labour Party, *The Hospital Problem: The Report of a Special Conference of Labour, Hospital, Medical and kindred Societies, held in Caxton Hall, Westminster, on April 28th and 29th, 1924* (The Labour Party: London, 1924). p.1.
[52] The Labour Party, *The Hospital Problem,* p.3.
[53] The Labour Party, *The Hospital Problem,* p.3.
[54] The Labour Party, *The Hospital Problem*, p.3.

such radical upheavals, especially as the brunt of the crisis had seemed to pass (especially in the provinces) even before grants could be distributed. The Voluntary Hospital Committee determined quite early on that 'it is desirable, in the public interest, to maintain the voluntary system of hospital management', alongside recognising that it was in a dire condition.[55] Voices from the left were addressing a government and populace that did not feel inclined to give up their voluntary hospitals just yet.

Gorsky, Mohan, and Powell argue that these years were the only real 'palpable' crisis that the voluntary hospitals had to face in the 20th Century.[56] London certainly did contain a large proportion of total voluntary hospital beds in England and Wales – just over a quarter at 12,797 beds out of the total of 44,062.[57] Seventy three of the 113 (65%) London hospitals in 1920 showed deficits of expenditure over income amounting to £463,606, whereas only 248 out of 452 (55%) provincial hospitals showed deficits totalling £501,282.[58] After the Great War, the average deficit per bed for the provinces was £16, but in London it was as high as £36/4/-. The average deficit of London hospitals stood at £6,350, whereas provincial hospital only had an average deficit of £2,021. Clearly not only were a smaller proportion of hospitals in the provinces were running deficits, but the level of that deficit in London was significantly higher. It is understandable that the Voluntary Hospitals Committee focussed mainly on the issues in London, but it begs the question as to whether the measures decided upon by central government were applicable or as useful for the provinces as they were for London.

Those hospitals that contained a medical school had the most overwhelming deficits, both in London and the provinces, and again it was the metropolitan teaching hospitals that carried the largest debt.[59] Those largest London hospitals in expenditure deficit had an average of £27,587 of debts. To put this into some context, this was higher than the average wartime annual ordinary income (1914-1919) for the Derbyshire Infirmary, and only just below that of Nottingham General.[60] With this in mind, what did the Derbyshire and Nottinghamshire voluntary hospitals do in this time to react to

[55] Ministry of Health/Viscount Cave, *Voluntary Hospitals Committee – Interim Report,* (His Majesty's Stationery Office: London, 1921) p.2.
[56] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', Economic History Review, Economic History Review, 3, (2002) p.535.
[57] Ministry of Health, *Voluntary Hospitals Committee Final Report*, (His Majesty's Stationery Office: London, 1921) p.5. Scotland also contained 8,132 beds, bringing the total for Great Britain not including Ireland to 52,194.
[58] Ministry of Health, *Voluntary Hospitals Committee Final Report*, (His Majesty's Stationery Office: London, 1921) pp.5-7.
[59] Ministry of Health, *Voluntary Hospitals Committee Final Report*, (His Majesty's Stationery Office: London, 1921) p.41.
[60] Derbyshire Infirmary: £23,144. Nottingham General: £29,181.

this crisis as well as reach out to the help that came as a result of the report? The wider ambitions of the Voluntary Hospitals Commission were never truly realised within the voluntary system, and the local committees petered out into the mid-twenties.

Provincial Hospitals in a time of 'Hospital Crisis'

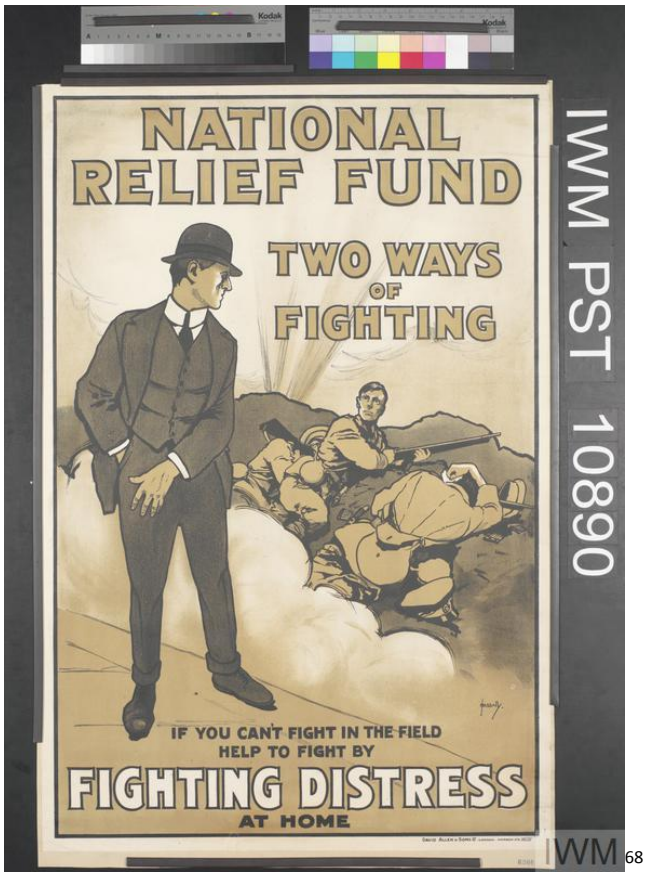
The Voluntary Hospitals Commission set up local bodies – Voluntary Hospital Committees – for local hospitals to meet and discuss their problems, as well as apply for a piece of the emergency fund offered up by the government. It also called large-scale conferences for the hospitals of the nation, including London, to essentially do the same as the provincial committees had been doing. It was a way for the government, having seen the immediate crises pass, to keep an eye on the progress of the voluntary system. The Voluntary Hospitals Commission called on the voluntary hospitals to form county-committees that would consult with the hospitals, represent them to the government, and most importantly administer grants. Representatives from Derbyshire turned up to both conferences, but no one from the Nottinghamshire hospitals attended.[61] Indeed, while Derbyshire was keen to be a formative constituent piece of a local committee and engage with the Commission, Nottinghamshire neither formed a committee, nor received any funds from the Commission. Its non-attendance was likely because it had already received a significant sum of £18,500 from the National Relief Fund in 1921, for which it had applied the previous year through direct channels. [62] Nottingham General, did, however host the local conference for the British Hospitals Association, which was attended not only by Derbyshire and Nottinghamshire hospitals, but by representatives from Lincolnshire, Leicestershire and Rutland, and Northamptonshire.[63] This was an attempt to corral the hospitals in the East Midlands counties into some sort of loose league of hospitals that could better communicate and rationalise their services.[64] Indeed, attempts nationally to truly unite hospitals along voluntary lines in the form of regional and county committees never came to fruition.

The National Relief Fund was an amalgamation of two national appeals established at the start of the Great War, one being organised by Queen Alexandra for the SSFA (Soldiers and Sailors Families Association), and the other by the Prince of Wales for more direct civilian relief purposes. While its chief focus was helping disabled veterans of the war, it also had the more general object of

[61] MH58/187 'Conference with Local Voluntary Hospital Committees' 1924; MH58/188 'Conference with Local Voluntary Hospital Committees' 1924; MH58/189 'Report of Conference with Local Voluntary Hospitals Committees'.
[62] Nottingham General Hospital Monthly Board Minutes and House Committee Minutes, 19 January 1921.
[63] Derbyshire Royal Infirmary Minutes and Order Book, 25 October 1920.
[64] Derbyshire Royal Infirmary Minutes and Order Book, 25 October 1920.

alleviating conditions on the home front, which included the amelioration of voluntary hospital deficits accrued during the war. In the first year of the war alone, the Fund (under the agency of the SSFA) managed to raise and pay out £1,281,814 to causes across the nation, having grown its army of voluntary workers to as many as 50,000.[65] From the initial call for donations at the start of the war, by 1916, £2,500,000 had been raised, and by 30 June 1919, the fund had accumulated £6,565,533.[66] It was a much larger and more ambitious organisation than the Cave Committee was ever able to be. The magnitude of the Fund meant that it was less concerned with posting up certain requirements for its recipients to meet. It viewed the War as a catchall problem that naturally caused financial hardship, and therefore readily gave grants to institutions on the assumption that temporary subsidies would solve the issue until the crises passed.[67]

Figure 3.1: *National War Relief Fund,* Imperial War Museums.



[68]

[65] Alison Barnes, *The History of the SSAFA, Part Two: First World War*, (SSAFA, 1985) https://www.ssafa.org.uk/media/z2kf3ij5/ssafa-history-part-two.pdf [accessed 09/08/19], p.1.
[66] 'The National Relief Fund', *The Hospital*, 12 June 1920, p.272.; 'National Relief Fund', *Hansard,* Vol 85, 14 August 1916 https://hansard.parliament.uk/commons/1916-08-14/debates/11326aab-ad1f-44e3-a802-5ea23217b50a/NationalReliefFund [accessed 22/08/19]
[67] 'The National Relief Fund', *The Hospital*, 12 June 1920, p.272.
[68] Imperial War Museum, Posters, https://www.iwm.org.uk/collections/item/object/12339, [accessed 09/08/2019]

It was decided that £760,000 from the National relief Fund would be set aside for the aid of the voluntary hospitals: £200,000 for Scotland, and £560,000 in total for England and Wales, with £360,000 of that going to provincial hospitals, with the rest to London.[69] There were none of the conditions upon securing the grant from the National Relief Fund demanded by the Voluntary Hospitals Commission, most noticeably the requirement to match funding with voluntary funds. Whatever qualms the voluntary hospitals had about government grants, they were far less concerned when the money came from huge-scale charities.[70]

After the formation of the Local Voluntary Hospital Committees, two further national conferences were held: one in 1922 after the initial administration of the grants to the various hospitals across the country, and another in 1924 that discussed current and future plans, as well as what had been achieved to date. Over this time, the Derbyshire Voluntary Hospitals Committee met on numerous occasions to try and formulate a set of applications for grants from the Commission. The committee comprised a mixture of Lords, ex-military men, doctors, and councillors.[71] First meeting in December 1921, by mid-February 1922 the committee forwarded four institutions that it felt were deserving of grants.[72] Derbyshire Royal Infirmary requested £2,926, Chesterfield and North Derbyshire Hospital applied for £1,396, the Derbyshire Royal Infirmary Convalescent Home wanted a meagre £171, and finally the Buxton Devonshire Hospital, which requested £1,570.[73] There remained some doubt as to whether any of these institutions would be able to raise appropriate matched funds required to secure the grant.[74]

After more than a year of deliberation, the Commission decided that only the Derbyshire Royal Infirmary should receive the grants. Chesterfield Hospital and the Devonshire Hospital were refused on the grounds that their existing financial situations did not require external intervention.[75] As a consequence the grant made to the Derbyshire Infirmary was almost doubled, to £2,925. It is certainly the case that out of all the hospitals in the two counties, the Derbyshire Infirmary found itself in the most perilous position with a substantial annual deficit on the maintenance account of between £5,000-£7,000 after the war (its ordinary expenditure had jumped by £20,000 from 1917-1920).[76] Regardless, the Commission saw that the hospital needed a modest injection of funds to

[69] Sir George Newman, 'The Health of the People' in Harold Laski (ed.), *A Century of Municipal Progress* (George Allen & Unwin Ltd: London, 1935) p.298.
[70] 'Future of Hospitals', *The British Medical Journal*, 4 December 1920, p.873.
[71] Derbyshire Voluntary Hospitals Committee Minutes, 2 December 1921
[72] Derbyshire Voluntary Hospitals Committee Minutes, 2 December 1921; Derbyshire Voluntary Hospitals Committee Minutes, 13 February 1922.
[73] Derbyshire Voluntary Hospitals Committee Minutes, 13 February 1922.
[74] Derbyshire Voluntary Hospitals Committee Minutes, 13 February 1922.
[75] Derbyshire Voluntary Hospitals Committee Minutes, 13 April 1923.
[76] Derbyshire Royal Infirmary Annual Report 1920.

underpin its future updating and expansion, acknowledging that the unpredictability of legacies upon which the hospital had increasingly relied to clear the deficit. However, it took more than two years before following the publication of the Cave Committee report for this money to be paid, by which time crisis had already passed. By September 1923, Derbyshire Infirmary actually had a surplus on its maintenance account of £2,244.[77]The Commission also tried to incentivise further coordinated fundraising by offering an extra £1,000 to the county if the local committee were to raise the equivalent funds.[78] It was decided by the committee, and passed on as recommendation to the Commission, that this £1,000 should be split evenly between the unsuccessful candidates for the original grants – Chesterfield and Devonshire Hospitals.[79] Again, there were significant delays before the money was paid over.

One of the key findings of the Voluntary Hospitals Commission was that soaring costs in certain areas of the hospitals' finances were causing disproportionate burdens for the hospitals. The following tables show how the expenditures for Nottingham General, Derbyshire Infirmary, and Chesterfield Royal fluctuated from 1913 to 1923, encapsulating their levels before the war, at the very end of the war, at the height of the hospital crisis, and just after the crisis.

Table 3.1: Expenditure Nottingham General 1913, 1918, 1920, 1923.

Nottingham General	1913	1918	1920	1923
Provisions	5084	16569	13351	7615
Surgery and Dispensary	3187	6564	9374	5801
Domestic	3263	10472	10570	6808
Establishment	866	2355	5279	2053
Salaries and Wages	4214	9429	15200	17685
Misc	188	519	751	401
Administration	797	1561	4236	2545
Total Ordinary	17728	48045	62535	44439

Table 3.2: Expenditure Derbyshire Infirmary 1913, 1918, 1920, 1923.

Derbyshire Infirmary	1913	1918	1920	1923
Provisions	3950	9982	10385	7977
Surgery and Dispensary	2351	5655	7842	5860
Domestic	3030	5143	9210	7790
Establishment	899	3198	4053	3705
Salaries and Wages	3756	6458	11620	14472

[77] Derbyshire Royal Infirmary Annual Report 1923.
[78] Derbyshire Voluntary Hospitals Committee Minutes, 13 April 1923.
[79] Derbyshire Voluntary Hospitals Committee Minutes, 25 May 1923

Misc	230	397	723	486
Administration	965	1152	1013	1239
Total Ordinary	15183	32985	45071	41929

Table 3.3: Expenditure Chesterfield Royal 1913, 1918, 1920, 1923.

Chesterfield Royal	1913	1918	1920	1923
Provisions	2060	4683	5561	3517
Surgery and Dispensary	1001	2251	3114	3503
Domestic	1928	3177	3879	4370
Establishment	370	485	1416	917
Salaries and Wages	1824	2454	4600	6944
Misc	116	201	265	395
Administration	279	367	464	644
Total Ordinary	7633	14027	21333	19950

Not all costs saw a dramatic rise, but there were some areas in which the hospitals experienced huge increases in costs over the twenty years. Salaries and wages, once on par with other costs, by 1920 became the most significant expenditure in most cases. Nurses pay, for example, averaged £55 per annum before the war, but this had almost doubled by 1924 to £106 per annum, and continued to rise.[80] The growing size and diversity of the hospitals as individual institutions meant that more and more staff (including domestic, medical, surgical, and nursing) were being hired on far more favourable pay than before 1914, which was a response to the high demand that staff were in during the war years. Wages generally spiked after the war, and then settled to what was still nearly double the rate than ten years previously.[81] Derbyshire Infirmary raised the wages of various different staff. In October 1919 the laundresses were given a raise of £5 per annum, and the maids a raise of £1 per annum. In December the same year the porters received two consecutive pay increases, and Dispensers got a significant raise in salary of £65.[82] In January and February 1920, the lady clerk received significant raises.[83] This was a pattern that continued on a near-monthly basis, so that these small sums of money eventually added up to quite a significant spike in costs for wages and salaries. All this as provisions, and especially fuel, were also increasing. This increase in wages and salaries accounted for the acute deficit in the Derbyshire Infirmary in 1921, where expenditure on salaries

[80] Guy Routh, *Occupation and Pay in Great Britain 1906-79* (Macmillan: London, 1980), p.70.
[81] Harry W Richardson, Derek H Aldcroft, *Building in the British Economy Between the Wars*, (George Allen & Unwin: London, 1968) p.130.
[82] Derbyshire Royal Infirmary Minutes and Order Book, 13 October 1919; 23 October 1919; 1 December 1919; 15 December 1919; 22 December 1919.
[83] Derbyshire Royal Infirmary Minutes and Order Book, 19 January 1920; 2 February 1920; 9 February 1920

and wages leapt £2,000 on the previous year, becoming the single largest expenditure category for the institution.[84] The Nottingham General, struggling to secure 'the right type of Probationer Nurses', decided to increase annual salaries quite significantly, by as much as £7 for first year probationers, and by £5 for second, third, and fourth year probationers.[85] It estimated this would be an increased expenditure of £400 a year. This followed from significant wartime increases in pay as it battled to attract medical staff to the institution at a time when they were competing heavily with other hospitals (and the RAMC) for qualified staff.[86] Such salaries of between £25 and £45 for probationer nurses was roughly in line with the salaries in general hospitals across the nation (including London).[87]

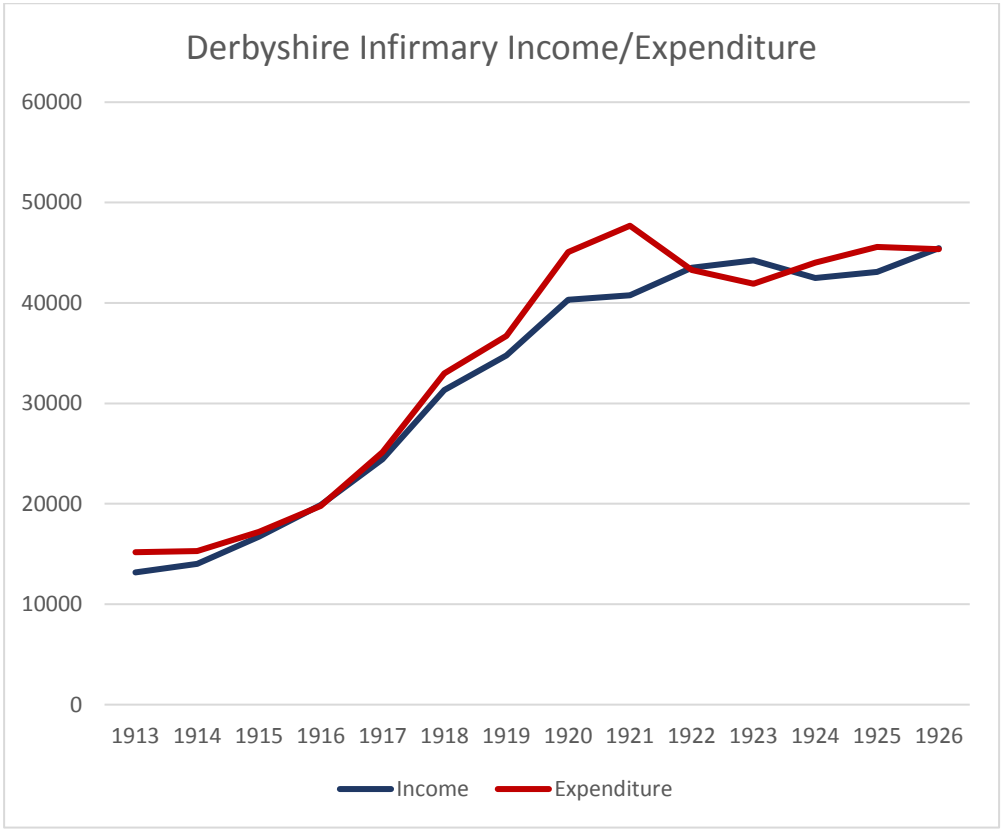
In 1921, as the deficit of the Derbyshire Infirmary peaked at £8,217, much to the consternation of the Board: 'The expenditure has shown an increase, but it is hoped that the high-water mark has been reached and that next year there will be a decrease'.[88] The deficit was exacerbated by the fact that they decided to keep the entirety of the hospital functioning, rather than limit services to save money. Industrial unrest further intensified the problem:

> 'During the coal dispute the Board felt it would be undesirable to close any of the Wards, but the purchase of fuel at greatly increased prices and of poor quality cost an additional £800'.[89]

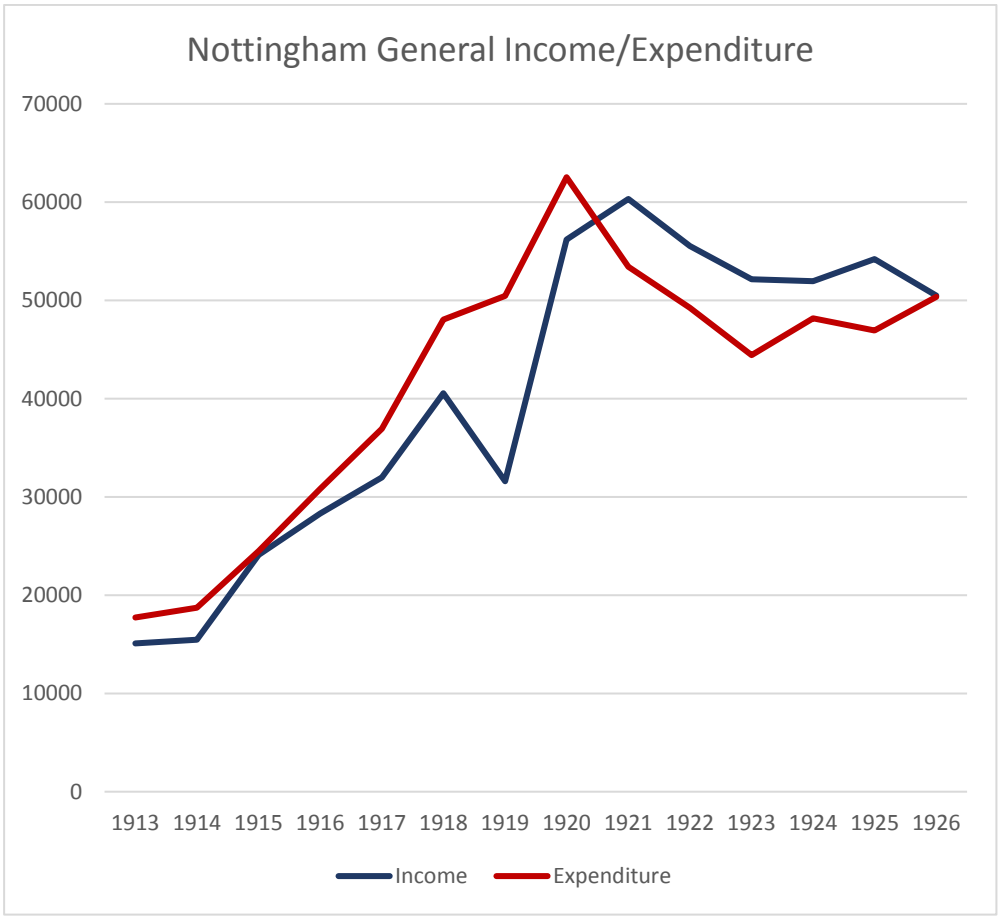
The impact of the post-war shortages and general economic difficulties was clearly being felt. In 1921, it held its first Hospital Day in Derby town, which raised in excess of £4,000.[90] The Board reports that despite the deficit, there was an increase in income on the previous year. This may have been true for the maintenance account, but for total income there was actually a decrease of £6,742. The following graph gives a view of the Hospital's income and expenditure, alongside the deficit/surplus encountered.

[84] Derbyshire Royal Infirmary Annual Report 1921.
[85] Nottingham General Hospital Annual Report 1925.
[86] See Chapter 2, 'Hospitals in the Great War'.
[87] Stone, *Hospital Management*, p.444.
[88] Derbyshire Royal Infirmary Annual Report 1921.
[89] Derbyshire Royal Infirmary Annual Report 1921.
[90] Derbyshire Royal Infirmary Annual Report 1920-1.

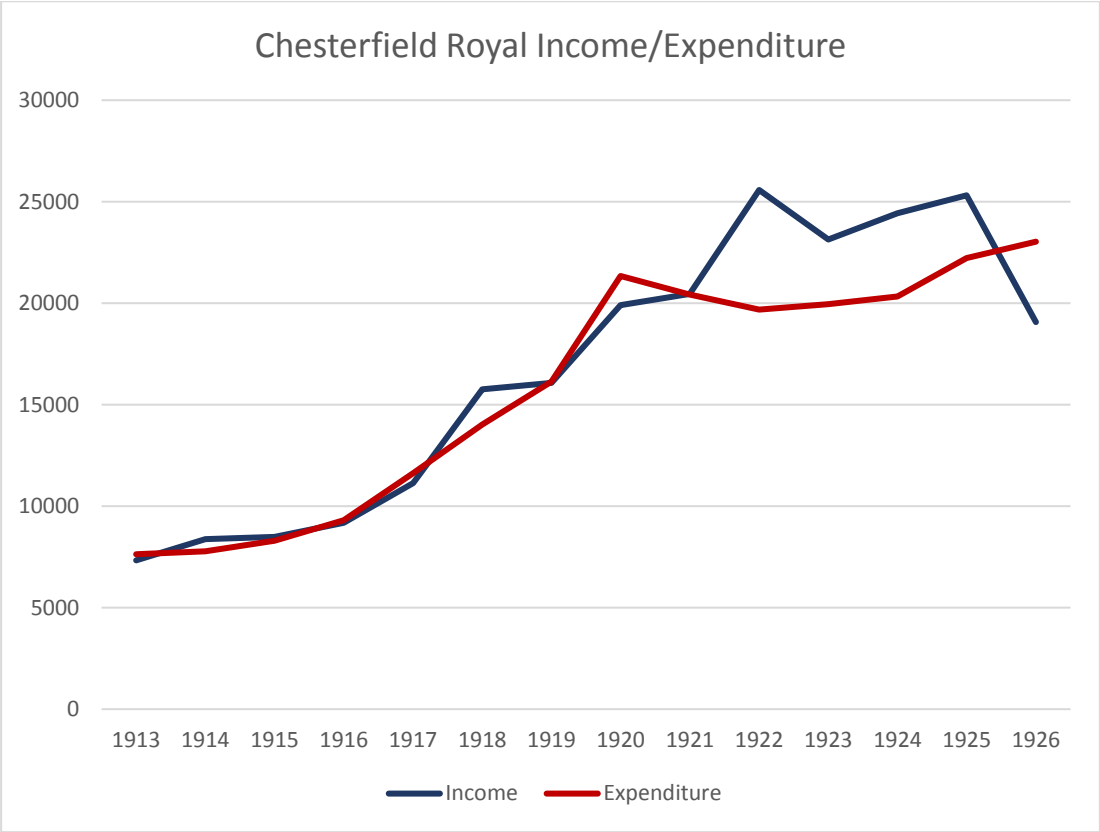
Graph 3.1: Derbyshire Royal Infirmary Income/Expenditure, 1913-1926



Graph 3.2: Nottingham General Income/Expenditure, 1913-1926



Graph 3.3: Chesterfield Royal Income/Expenditure, 1913-1926



Nottingham appears to have had the most acute problem, with income dropping considerably in 1919 when the War Office payments were withdrawn. As explained in the previous chapter, Nottingham General did not maintain its voluntary incomes as effectively as they hoped, a situation exacerbated by the disparity between War Office payments and the actual costs of treatment. However, ignoring the difficult situation in 1919, Nottingham General follows a similar trend to Derbyshire Infirmary and Chesterfield Royal; specifically, that incomes struggled to catch up with the rapid exponential increases in expenditures until after 1921/2. With the help of the Hospital Day, and other efforts, Derbyshire Royal Infirmary managed to balance its books for 1922, climbing to decent surpluses by 1924.[91] Its network of donors and fundraisers, significant bequests, as well as the healthy subscriptions and contributions (and an injection from the Derbyshire Voluntary Hospitals Commission), meant that Derby managed to overcome the financial difficulties presented by the First World War.[92] Subscriptions increased as the Mayoress' Ladies Committee got encouraging results after the war ended, donations increased even from their wartime highs, and the Infirmary started to look towards new, mutualist methods of increasing income.[93] The Hospital

[91] Derbyshire Royal Infirmary Annual Report 1923-4.
[92] *Derbyshire Voluntary Hospitals Commission Minutes, 1923*.
[93] Derbyshire Royal Infirmary Annual Report 1919-20.; Derbyshire Royal Infirmary Annual Report 1921-2.; Mayoress of Derby Ladies Committee Minutes 2 November 1922.; Mayoress of Derby Ladies Committee Minutes 25 October 1923.

Board attributed much of the success of the hospital to the work of the Saturday Committee, and stated that 'the self-sacrificing efforts of its members who voluntarily gave their services to plead the cause of the Infirmary is worthy of all praise'.[94] The Hospital rightly saw the Saturday Committee as the ambassadors of the institution out in the community. J H H Grant, chair of the Derbyshire Infirmary Saturday Committee, writing in the 1924 Jubilee Saturday Committee booklet noted that:

> 'In every organization there are certain choice and beautiful characters, men whose sole object in life is to serve their fellows, to make the path of those who may be less fortunate, more smooth, and to give courage and help to those who need it. The Infirmary Saturday Committee has never been without its quota of such men, there are left amongst us still men who can look back upon their early struggles at a time when it was an up-hill fight to further the work of the Derbyshire Infirmary (it was not Royal then), to stimulate the interest of the multitude in the processes of medical and surgical skill, and to cultivate the duty of systematic sacrifice in aid of the splendid Institution whose hospitality no man can say he may not need. We do not claim to read the varied motives which have led people to give time and money to the work of our hospitals, but we do know that there are noble souls in creation who, in thankfulness to God for the blessings they enjoy, contribute their share to the common good of humanity.'[95]

He went on to say:

> The joy of working for the Infirmary grows on men. It is a thing which cannot be explained; but in all the history of the movement scarcely one having joined it has looked back from the plough. The pioneers of the Saturday Fund did a great work in Derby. Whether we have interpreted their spirit and their intentions aright we leave our readers to judge. The years that have followed the War have brought new difficulties demanding to be met with courage, no less than the War itself. How far we ourselves have risen to face these difficulties is not for us to say. This only we know. Many hospitals in other parts of the country, during this period, closed down wards and turned thousands of our fellow creatures away, some of them to die, whilst our own Infirmary was able to meet an unprecedented demand upon it services…Our intention is that no human being should go without medical or surgical aid if it at all possible to provide it.[96]

---

[94] Derbyshire Royal Infirmary Annual Report 1921-22

[95] *Derby & Derbyshire Royal Infirmary Saturday Committee Jubilee Year 1874-1924: An Interesting Souvenir of 50 Years' Work,* 1924, p.5.

[96] *Derby & Derbyshire Royal Infirmary Saturday Committee Jubilee Year 1874-1924: An Interesting Souvenir of 50 Years' Work,* 1924, p.7.

Grant's main point was that the Infirmary was there to serve the community, and although financial rectitude was important, first and foremost the consideration should not be for the account books, but for the patients. The General Committee was itself made up from 'representatives drawn from various works of the town and county'.[97] But perhaps most interesting is that all those members were also Governors of the Infirmary. The Saturday Committee was an exercise in democratic mutualist voluntarism and meant that the hospital had among its leadership some members of the community it served. It was not simply another fundraising body, nor one that was excluded from the financial administration of the hospital once the money was handed over – it was an integral part of the running of the hospital, as well as an integral part of its income.

The Saturday fund at the Derbyshire Infirmary increased as a proportion of income just as annual subscriptions decreased as a proportion of income. From 1910 to 1925, Subscriptions fell from 36% of income to 14%, and the Saturday fund rose from 20% to 35% of income. The explosion of income after the First World War indicates just how popular it became as a means to securing affordable coverage for potential patients all over Derbyshire and elsewhere. Within the Saturday funds there became a growing implicit promise of treatment, though this was denied by the actual rules of the funds. The Saturday Fund Committee had connections all over Derbyshire, and organised collections from its contributors in regular intervals. The key to success was the presence of works funds in individual companies. The Saturday Fund would take subscriptions on pay day, and then when a certain amount had accrued, would then pass this on to the Infirmary.[98] Often works funds would also have extra collections for other causes within the hospitals, indicating that the organisation of workers was not just beneficial to the funds themselves, but had knock-on effects. By the end of the 1920s, the collective endowment of beds from works funds had proven incredibly successful for the institution, and alleviated much of the financial strains on the costs of inpatients.[99]

The flashpoint of 1921 of large deficits was soon ameliorated when the hospitals managed to settle into the new post-war Saturday fund routine of yearly increases, as well as a stabilising of expenditures to more manageable levels and wage and material prices stabilised after the period of steep post-war inflation. Nottingham General was already celebrating the marked increases in

[97] *Derby and Derbyshire Royal Infirmary Saturday Committee 1933*; *Derby and Derbyshire Royal Infirmary Saturday Committee 1939.*
[98] *Derby and Derbyshire Royal Infirmary Saturday Committee 1933*
[99] *Derby and Derbyshire Royal Infirmary Saturday Committee 1927*

subscriptions and Saturday funds from 1920 to 1921, and seemed to express few concerns over the expenditure, which had increased less than it had in previous years.[100] It had ambitions for garnering at least £20,000 in contributions, but also aimed to induce firms to 'double their previous subscriptions, and wherever possible, inducing the Employer to add a percentage or double the Employee contributions'.[101] Gratifyingly, and despite the fact that there was a supposed hospital crisis and national financial crash, it exceeded its goal and brought in £24,375 that year, with subscriptions taking a spike from £7,040 to £8,239 from 1920-1921. The committee's determination, after a despondent start to the previous decade, clearly paid dividends when it set clear goals and committed their volunteer workforce. The key, then, was planning. Furthermore, the Saturday fund was expanded out to the other hospitals around Nottingham. While Nottingham General always kept the lion's share, smaller figures were handed to the children's and women's hospitals in the form of a donation.[102]

The smaller hospitals in the two counties did not struggle as others did. Their smaller size and running costs meant that even modest windfalls (such as donations or fundraising initiatives from exterior groups) kept the hospitals out of trouble. In 1920, Ashbourne Hospital had a small deficit of £28, which was soon resolved with the help of a letter appeal from the local newspaper, the *Ashbourne Telegraph*.[103] In 1921, at the height of the economic crisis, it had a considerable surplus of £187 on an income of £1,056, owing to the significant increase in patient payments.[104] Wirksworth Hospital found itself with a small and growing deficit by 1920 of £239, but which it was all but able to expunge with the help of a legacy left by a local woman, as well as an increase in donations and a very successful Saturday collection in the town.[105] Wirksworth and Ashbourne Hospitals recognised their more isolated position, and made efforts throughout the 1920s to try and bolster their financial situation. They both had a busy social calendar, where events were complex and needed considerable organisation and commitment. Examples from the 1920s show that there were two large events – nights of 'Dramatic Entertainment', and the second the 'Hospital Carnival Wakes', in September, which was very large, with a very large committee of individuals not only associated with the hospital, but representatives from the hospital's outlying districts. [106] The intensity of activity around this period is perhaps in no small part due to the drive to open a new hospital to replace the old, inadequate buildings. The local clergyman praised the work of the hospital, stating that 'patients had repeatedly expressed their appreciation of the treatment and of the

[100] Nottingham General Hospital Annual Report 1921.
[101] 'Proposed Report of the Hospital Saturday Committee to the Monthly Board of the Nottingham General Hospital', 2 April 1921.
[102] Nottingham General Hospital Saturday Fund Minutes, Agenda, 26 March 1927.
[103] Ashbourne Victoria Memorial Cottage Hospital Annual Report 1920.
[104] Ashbourne Victoria Memorial Cottage Hospital Annual Report 1921.
[105] Wirksworth Cottage Hospital Annual Report 1920.
[106] Wirksworth Cottage Hospital Carnival Wakes Official Programme, 1927.

staff'.[107] In Ashbourne, three 'Flag Days' were held in 1920, and Whist Drives and dances were introduced in 1922.[108] Egg collections were brought in in 1927, collected via the local schools.[109] Local bands were employed for the myriad dances that were becoming more and more popular.[110] These events helped to alleviate what was otherwise a very difficult situation.

Newark had great success in 1920 and 1921, in which years they had effectively reorganised their 'Voluntary Levy' (worker's subscription scheme) which had yielded very good results.[111] It meant that it went into 1922 with a surplus of £111. In essence, it was quite oblivious to any 'crisis' that might or might not be unfolding in the bigger hospitals. At this time the Bakewell Cottage Hospital was founded. There had been discussions of founding a hospital in Bakewell for some thirty years, since 1891. But in 1918, preparations began in earnest. It was a memorial for the Great War, and far from the necessity of gaining widespread financial support from local people, it managed to receive a considerable grant:

> 'The Institution, which has been founded by voluntary contributions with the aid of a grant from the Joint War Committee of the British Red Cross Society and the Order of St John of Jerusalem, in commemoration of self-sacrifice, particularly that of the men from this neighbourhood who laid down their lives in the Great War…'

In 1918, it was estimated that the huge sum of £10,000 would be needed to erect the institution, largely because of escalating building costs at the time – although they did state that they wished to make the hospital easily-extendable, and so '…it involved a larger outlay than might have been necessary for the present requirements'.[112] By 1919, it was clear that this amount was not going to be achieved. Local subscriptions fell far short of the desired amount.[113] However, the offer of money came quite unexpectedly:

> 'The Committee appointed for the demobilisation of the Auxiliary Hospitals in Derbyshire a the end of the War were officially informed that the Joint War Committee of the British Red Cross Society and Order of St. John had decided to distribute a portion of the surplus funds

[107] 'Wirksworth Hospital. Successful Effort at Wirksworth', *Derbyshire Times*, 20 June 1928.
[108] Ashbourne Hospital Ladies Committee Minutes, 5 May 1920; Ashbourne Hospital Ladies Committee Minutes, November 1922.
[109] Ashbourne Hospital Ladies Committee Minutes, 24 March 1927
[110] Ashbourne Hospital Ladies Committee Minutes, 2 November 1923.
[111] Newark Town and District Hospital and Dispensary Annual Report 1921.
[112] *Bakewell and District Memorial Hospital General Report,* p.2.; p.5.
[113] *Bakewell and District Memorial Hospital General Report,* p.2.

in their hands for the benefit of existing hospitals and to assist in the erection of others in the Country and were invited to make recommendations in Derbyshire for consideration'.[114]

The committee was warned that to postpone the construction of the buildings would mean that the prices of building materials would drastically increase, and so to keep the costs to a minimum, the stone, bricks, slates and earthenware piping was purchased and kept in hand.[115] Not all hospitals were so fortunate. Heanor's plans to found a memorial cottage hospital in 1918 were delayed until 1925. It indicates that with the right connections and right funding, a cottage hospital could be quite easily erected, even without the widespread support of a community. Buxton and District Cottage Hospital had considerable extension works carried out in 1923, after securing funds from the local Rotary Club and other significant donations and were only £500 shy of securing the cost of the building work without a loan.[116] Again it is indicative of the ability of a small hospital to grow if just a few key donors are willing to fund it. The smaller hospitals had weathered the 'crisis' quite well, without too much issue. But then again, the burden placed upon them during the war was very small. Without the greater expenditures of the larger institutions like Derby or Nottingham, they were not victim to the swelling costs of the ailing economy.

However, the period presented new demand for fundraising, which in itself sparked new innovations. Derby Hospital Day was started after the Great War to both galvanise the community to support the hospital and raise as much money in a single organised event as possible. It tapped into the many recreations and pass-times of contemporary society, chiefly spectating and participating in sporting activities.[117] Large-scale competitions and sporting tournaments were very popular, and a seemingly 'easy' way to draw competitors and crowds alike. In Derby, 'Hospital Day', organised by the Mayor's Hospital Fund (associated with the Derbyshire Royal Infirmary) had a large repertoire of sporting events held for its benefit.[118] In attendance were the Derby and District Lawn Tennis Association, the Derby Angling Association, the Derby Swimming Association, as well as various competing golfers, bowls and cricket clubs. Such was the turn-out for the Cricket that the day came to be known more commonly as the 'Hospital Cricket Day'.[119] Particularly popular were the firemen from the various company fire-brigades, who would compete in their own way to ready their

[114] *Bakewell and District Memorial Hospital General Report,* p.2.
[115] *Bakewell and District Memorial Hospital General Report,* p.5.
[116] Buxton and District Cottage Hospital Annual Report 1923.
[117] Robert Snape, 'The New Leisure, Voluntarism and Social Reconstruction in Inter-War Britain', *Contemporary British History* 29:1 (2015) pp.52-53.
[118] 'Sports and Charity. Local Effort for Mayor's Hospital Fund.', *Derby Daily Telegraph*, 9 June 1923.
[119] 'Sports and Charity. Local Effort for Mayor's Hospital Fund.', *Derby Daily Telegraph*, 9 June 1923.

equipment, dress in their uniforms, and man their stations the fastest and with least fault.[120] Angling competitions continued for some years also, organised in part by the Derbyshire Infirmary's Hospital Saturday Fund, and came to be an established tradition.[121] A Swimming Gala was held at Darley Park, and different groups and clubs associated either with a recreational association, or via a workplace (e.g. St. John's Ladies volunteers) would compete in a wide range of swimming challenges.[122] There was a large competition at Markeaton Golf Club, in which no less than 88 competitors entered for the 'Carnival Challenge Cup', and on the River Derwent they had a large rowing competition. The day, as well as hosting these events, became a massive 'Flag Day Demonstration' and collecting scheme, with a ton of potatoes collected, as well as thousands of pounds in cash, which was supplemented as donations came in after the event, so that the initial target of £5,000 was very nearly reached.[123] One of the many prizes for the events were a special edition Crown Derby china cup, mounted on 'plinths of Derbyshire Oak', and a 'monster smoking concert is to be arranged for the purpose of the public presentation of the trophies' (smoking concerts were usually male-only). People were willing to donate, participate and work through the day for the sake of the hospital, and it was not necessarily confined to one class, gender, or occupational group. Carnival, pageantry, celebration; visible displays of support were important to the public image and public outreach of the hospitals. The traditions formed by hospital fundraisers came about due to the demands of the hospital at that present time.[124]

[120] 'Derby hospital Day. Private Fire Brigades to Compete.', *Derby Daily Telegraph*, 25 August 1920.
[121] Annual Reports DRI
[122] 'Hospital Day at Derby. The Mayor and the Day. Final Figures Not Yet Available.', *Derby Daily Telegraph*, 6 September 1920,
[123] 'Derby Hospital Fund. Mayor's Cheques for £4,000.', *Derby Daily Telegraph*, 25 September 1920.
[124] David Cannadine, 'The Transformation of Civic Ritual in Modern Britain: The Colchester Oyster Feast', *Past and Present*, 94:1 (1982). pp.119-122., p.128.

Figure 3.2: Royal Crown Derby Hospital Day Cup, this example from 1939.

[125]

Setting aside the positive effects of these events in raising good-natured support for the hospital, what was the financial benefit? After all, it is very well garnering awareness among the populace of the importance of the hospital's work, but these events were primarily fundraisers. The Hospital Day in Derby raised some £4,000 for the Infirmary in 1920, or roughly ten per cent of its total ordinary income of £43,221.[126] This was a substantial sum – equivalent to nearly half of the money raised by Derby's Hospital Saturday Fund which came in at £10,826/8/8. Moreover, this figure takes not into account the gifts in kind that such events attracted:

> Thanks are due to the friends (far too numerous to mention individually) who have sent gifts of fruit, vegetables, game, rabbits, eggs, books, papers, periodicals, old linen, etc.; also to the numerous Churches, Chapels, and Allotment Holders' Associations for their gifts in kind; to the Derbyshire Royal Infirmary Comforts and Linen League, for its invaluable help; to the Derby and Derbyshire Needlework Guild, for its gift of garments; to Messrs. Frost Bros. of Derby for the gift of a Refrigerator; and to innumerable friends for little acts of kindness which help the work of the Infirmary, and are much appreciated by the Board.[127]

[125] Royal Crown Derby Hospital Day Cup, dated 1939, https://rcdcollections.com/royal-crown-derby-presentation-pieces [accessed 27/12/2019]
[126] Derbyshire Royal Infirmary Annual Report 1921 (the Hospital Day was held too late for its benefits to be recorded in the 1920 accounts)
[127] Derbyshire Royal Infirmary Annual Report 1921.

It suggests that the hospital became a new rallying point for concerned citizens, after the tumult and dispersal of the war years. The Mayor of Derby, Councillor A J Eggleston, was integral to this success.[128] Eggleston disparaged collections, and wanted to avoid the style of the house-to-house canvass already conducted by the Mayoress of Derby's Ladies Committee.[129] Instead, he took note of the 'pageant of Hospital Day' in Lancashire and Yorkshire.[130] In doing this, Eggleston recognised the necessity for entertainment. Arrangements were made for 'fancy dress carnival, battle of flowers, gala, sports, regatta, swimming contests, and private fire brigades competitions'.[131] Events such as the Battle of the Flowers, a peace celebration tied up with charity and benevolence in the city of Derby, were an indication that citizens were trying to turn the horrors and privations of the war years into something positive.[132] The benefits of the Hospital Day was going to different institutions – the Derbyshire Royal Infirmary, the Derby Children's Hospital, the Derby Women's Hospital, and the Derby Home of Rest.[133] Dozens of organisers, led each year by the new Mayor of Derby (an annually renewed position) and supported by the Management Committee, worked hard to coordinate the various clubs and groups around the town in effective fundraising methods. The activity on the day was significant. Newspapers described the events in detail, reporting the results of the competitions and describing the fancy-dress costumes.[134] It took an immense amount of organisation, and could not have been achieved without the dedication of not only the Hospital Day Committee, but also other townspeople and local residents. Thousands of pounds were raised each years, 'this amount being divided in proportions agreed upon by representatives of the charitable institutions which it is intended to benefit'.[135] The Derbyshire Royal Infirmary was incredibly pleased with the effort, heaping praise on the chief instigator and coordinator, the Mayor:

> A debt of gratitude is due to His Worship the Mayor of Derby (Mr Councillor A. J. Eggleston) who by extended personal effort, has initiated an annual "Hospital Day" in Derby which is not only a great help in the present hour of need, but will be of considerable benefit in future years. A first instalment of £2,800 has been received…[136]

[128] '£5,000 Day. Big Appeal for Derby Hospitals', *Derby Daily Telegraph*, 4 September 1920.
[129] '£5,000 Day. Big Appeal for Derby Hospitals', *Derby Daily Telegraph*, 4 September 1920.
[130] '£5,000 Day. Big Appeal for Derby Hospitals', *Derby Daily Telegraph*, 4 September 1920
[131] '£5,000 Day. Big Appeal for Derby Hospitals', *Derby Daily Telegraph*, 4 September 1920.
[132] Chris Gately, '"Peace Day" Celebrations in Derby', *East Midlands History and Heritage,* 8 (2019) pp.10-12.
[133] 'Hospital Day. Gay Carnival Scene at Derby', *Derby Daily Telegraph*, 17 September 1921.
[134] 'Hospital Day at Derby. The Mayor and the Day. Final Figures Not Yet Available', *Derby Daily Telegraph*, 6 September 1920.
[135] 'Derby Hospital Fund. Mayor's Cheques for £4,000', *Derby Daily Telegraph*, 25 September 1920.
[136] Derbyshire Royal Infirmary Annual Report 1920.

Eggleston was a leader among many volunteers who put considerable time, effort, and initiative behind the Hospital Day.[137] The Derbyshire Children's Hospital was also very supportive, offering thanks to Councillor Eggleston and also 'to all those who so willingly and ungrudgingly gave their services for the sick and suffering on that occasion'.[138] In 1922, again the Mayor and Mayoress (by this time Councillor and Mrs W. R. Raynes) are thanked for 'the zealous manner in which they have brought the needs of the infirmary to the notice of the public'.[139] Events like this did not replace traditional fundraising sources – subscriptions and Saturday Funds were definitely the integral fibres of hospital finances – but they did bolster what might have otherwise been a very difficult year. The Derby Hospital Day was a prime example of the transgression between philanthropic charity, municipal support, and self-help. The volunteers that helped, the rich and poor that donated, and the townspeople that participated in events, were all there for ultimately unifying reasons: self-satisfaction at giving to a good cause, and shoring up institutions that they themselves may have to use or had used. But such occasions were also objects of pleasure. The close connection of the hospital to its community was formed through such events. Townspeople came out in their thousands to support a local institution with which they were all familiar, and which many of them had doubtless attended or knew people who had attended. While a box donation on hospital day did not have the same direct reciprocal benefit that a subscription or Saturday fund donation did, it did directly strengthen the townspeople's' local health services, and they knew it. The object was charity, but the functions of the events were inherently mutualist.

Heanor had some success in this period, managing to erect a modest cottage hospital. The plan, from the very end of the Great War, was to erect a hospital as the town's public memorial. It cost £5,000, of which by the time it opened, only £4,200 had been raised.[140] The effects of economic upheaval in the 1920s took their toll – construction and general maintenance of the hospitals was more expensive, certainly ordinary incomes were limited.[141] National income rose significantly at the end of the war, but so did costs, and incomes dropped towards the middle of the 1920s.[142] It is testament to the difficulties of the early twenties that despite such local enthusiasm, there was no possibility of the hospital being built until after the immediate crisis had passed. Although £150 was initially

[137] Derbyshire Royal Infirmary Annual Report 1920.
[138] Derbyshire Children's Hospital Annual Report, 1921
[139] Derbyshire Royal Infirmary, 1922.
[140] 'Local Happenings', *Nottingham Evening Post*, 30 November 1925
[141] Harry W Richardson, Derek H Aldcroft, *Building in the British Economy Between the Wars*, (George Allen & Unwin: London, 1968) p.42., p.65.
[142] A J P Taylor, *English History 1914-1945*, (Book Club Associates: London, 1965) pp.xxv-xxvi

donated by the Coppice and Waterloo mines of the Shipley Colliery Company, there was some doubt as to whether the town would ever get its memorial cottage hospital.[143]

> 'At last night's meeting of the Heanor War Memorial Hospital Committee there was much discussion as the whether the scheme for a cottage hospital should be changed for that of a motor ambulance, owing to lack of support to the original proposal'.[144]

Similar to Ripley, fundraisers and volunteers in Heanor were torn between struggling towards a fully-fledged memorial hospital or taking what seemed to be a more pragmatic approach in lean times, and paying instead for an ambulance to convey patients to other hospitals. What was surprising was that workers had, by this time, already contributed £1,098 to the establishment of the hospital. Much less so the shopkeepers and other small businesses in the area. As the committee noted, 'the trading classes', had 'failed to support the scheme to any appreciable extent'.[145] There were concerns (again, mirroring that or Ripley's establishment) that the founding of the new hospital might harm the Nottingham and Derby institutions to which they already subscribed to. Yet, the miner's representatives from the Shipley and Butterley Companies were determined to see a new hospital erected and maintained, and bemoaned the fact that an injured person might have to pay the cost of travel via ambulance with what little compensation money they might receive – the essence of their argument being that a local hospital would be more cost-effective for the local patients.[146] The miners may have been very enthusiastic to have an institution of their own, yet by February 1923, only £2,281 had only been raised from their efforts, or only half the amount needed. There were even suggestions to expand the plan to include a maternity home to try and drum up extra community support.[147] By February 1925, despite still only £3,000 being raised, the committee decided to advertise for tenders, 'with a view to an early commencement of building operations' – they had managed to secure £750 of the £1,000 per annum required for the upkeep of the hospital.[148] In November 1925, it was announced that 'after five years of effort in obtaining of the necessary funds, Heanor is at last in possession of a War Memorial Hospital. Only £800 still needed to be raised.[149] Heanor had far more trouble in founding a hospital than Ripley; it was more

[143] *Nottingham Evening Post*, 15 September 1919.
[144] 'Hospital or Ambulance? War Memorial Problem at Heanor', *Nottingham Evening Post,* 20 May 1920
[145] 'Hospital or Ambulance? War Memorial Problem at Heanor', *Nottingham Evening Post,* 20 May 1920
[146] 'Hospital or Ambulance? War Memorial Problem at Heanor', *Nottingham Evening Post,* 20 May 1920
[147] 'Benefit in Delay. Slow Progress with Heanor Memorial', *Nottingham Evening Post*, 18 November 1921.; 'Local Happenings', *Nottingham Evening Post, 21 February 1923.*
[148] 'Local Happenings', *Nottingham Evening Post*, 7 February 1925.
[149] 'Local Happenings', *Nottingham Evening Post,* 30 November 1925.

expensive, it took longer to raise funds, and required far more time to rally the community around the cause.

The hospitals were barely able to draw breath from the strains of the Great War before they were presented with yet more difficulties. Yet the 'Hospitals Crisis' for the hospitals in the two counties was nowhere near so pronounced or desperate as it was for the London hospitals. The Voluntary Hospitals Commission, with its modest grants, did not herald the salvation of the Nottinghamshire and Derbyshire Hospitals – they did not need saving. They, unlike the metropolitan hospitals, were already moving towards the suggestions that the Commission formulated, Derbyshire Infirmary experienced the biggest difficulties out of any of the hospitals in this study, though Nottingham General may have experienced the same problems had they not received the considerable sum from the National Relief Fund in 1921. But climbing out of this flashpoint of hardship the hospitals were about to experience perhaps a far more arduous and anxiety-ridden few years around the General Strike.

Defined by Crisis: Part Two – the General Strike.

The difficulties of 1926 and 1927 came during and after a tumultuous social, economic, and political period.[150] Parliamentary elections had ranged between Liberal, Conservative, and Labour governments, in a mixture of coalition and 'National' governments. Labour's brief stint in power in 1924 had done little to advance progress or the demands of the trade unions, and the years since the war had all but been dominated by a conservative economic ethos, where demands for increased benefits for the unemployed and more regulation of employers had been all but ignored by Bonar Law and Baldwin.[151] As the export market stagnated, so did the growth of the economy overall. On the 30th July 1925, Baldwin proclaimed that, in order to be able to create greater export demand via cheaper goods: 'All the workers of this country have got to take reductions in wages to help put industry on its feet'.[152] Aside from the outraged response this provoked from the trades unions, it was an indicator that for ordinary working people, times were going to start to get even harder than they already were.[153] The extent to which voluntary hospital provision developed depended largely

[150] Chris Wrigley, *Lloyd George and the Challenge of Labour: The Post War Coalition 1918-1922* (Harvester Wheatsheaf: Hemel Hampstead, 1990).
[151] J A Dowie, '1919-20 is in Need of Attention', *The Economic History Review*, 28:3 (1975) p.431., pp.434-435.; Taylor, *English History*, pp.236-7.
[152] Taylor, *English History*, p.239.
[153] Peter Scott and Anna Spadavecchia, 'Did the 48-hour week damage Britain's industrial competitiveness?', *Economic History Review*, 64:4 (2011) pp.1268-1270.

on the locally available financial resources, and thus the state of the local economy.[154] Hospitals would be understandably concerned about the potential detriment that things like reduced wages or unemployment could have to their ability to treat patients and their independence from the state.

By 1925, the Hospitals Crisis had all but been left behind, and the hospitals were forging ahead with their growing mass contribution funds. Derbyshire Infirmary, Nottingham General, and Chesterfield Hospital were all on much steadier foundations after the strained times of 1920-1922. Income versus expenditure was far more balanced, and the deficits that the war had created were now either dealt with via the grants from the National Relief Fund or the Voluntary Hospitals Commission, or otherwise had been worked out by the hospitals themselves.[155] Patterns of voluntarism, disrupted through the war, were becoming commonplace once again, and bigger than ever before. Derby Hospital Day grew and grew, and by 1926 was bringing in thousands upon thousands of pounds to the hospital and other charities around Derbyshire, something which the Infirmary was incredibly pleased about and heralded it as proof that the voluntary system was thriving.[156] Only a few beds were now reserved by Ministry of Pensions for discharged soldiers, and the wards, though full, were well staffed.[157] Despite the drop-off in financial remuneration from the Ministry of Pensions, the hospitals were not suffering.

However, as the broader economic conditions for the populace grew worse, whatever equipoise had been reached in the early 1920s was soon to be shattered. 1926 was a clash between labour and capital, worker and employer, citizen and government. Much romanticised in the subsequent years, either for the heroism of the strikers or the selflessness of the Organisation for Maintenance of Supplies (OMS) volunteers, the year of the General Strike was divisive and damaging to the nation. Much like the economic crisis of the early 1920s, the strike was not spontaneous. The government had known for a year or more that such an action might be taken by the Trades Union Council, and began preparing local officers in the provinces for the outbreak of a strike and the breakdown of infrastructure.[158] The sequence of events started largely from the return to the gold standard instigated by Churchill, then Chancellor of the Exchequer.[159] This resulted in coal exports becoming far more expensive, and combined with the import of coal under the Dawes plan (the system of reparations by the post-war German government) meant that the coalowners found themselves in a

[154] John Mohan, *Planning, markets and hospitals* (Routledge: London, 2002).
[155] Chesterfield and North Derbyshire Royal Hospital Annual Report 1924; Derbyshire Royal Infirmary Annual Report 1924-25; Nottingham General Hospital Annual Report 1925.
[156] Derbyshire Royal Infirmary Annual Report 1923.
[157] Nottingham General Hospital Annual Report 1921; Derbyshire Royal Infirmary Annual Report 1923.
[158] Peter Wyncoll, 'The East Midlands', in Jeffrey Skelley (ed.), *1926 The General Strike* (Lawrence and Wishart: London, 1976) p.174.
[159] Taylor, *English History*, pp.236-7.

difficult situation.[160] This was the trigger, and the unacceptable point as far as the TUC was concerned, whereby the coalowners decided to cut the wages of workers.[161] And the cuts were not minor. On a national average, the miners lost 32 shillings 2 pence a week; in many places it was far worse.[162] This brought wages down in Nottinghamshire and Derbyshire to roughly 34 shillings per week for the average below-ground mineworker. Baldwin and the TUC leaders were in negotiations right up until 2nd May, the point where Baldwin, informed that the TUC had already issued orders to begin strike preparations, broke off discussions. As a result, the strike began in earnest on 3rd May. Derbyshire and Nottinghamshire had already witnessed hard times with strikes occurring for a number of years since the war, with various clashes between the leftist Miner's Federation of Great Britain allied to the Labour Party and the right-wing 'non-political' British Workers League. The Labour Party sat in an odd position in the middle, trying but failing to extract concessions from the coalowners and simultaneously trying to reign in the excesses of the more radical unions, with the government employing an essentially hands-off attitude towards coal prices and any other potentially anti-market policies.[163] This was a boil that either needed to be lanced, or else it would pop. In the end, it popped.

Stevenson argues that the General Strike was a relatively straight forward process of back-and-forth between unions and employers, with a government unwilling or unable to step in.[164] However, the broader pictures was that of great upheaval for society and the economy. Across the year, 162,233,000 working days were lost to strikes – the highest previous being 85,872,00 in the difficult economic year of 1921.[165] The year after, 1927, the number of strike days dropped dramatically to only 1,174,000 days – lower than any year since 1914.[166] But for many of the miners in the north and in the Midlands, the strike continued for roughly seven months, and not just the infamous nine days. The failure of the General Strike to reach the goals that the TUC leaders had hoped, meant that the workers and the unions at large lost both their appetite for strike, and the ability to. The General Strike had all but bankrupted the unions, whose accounts had run dry through the unprecedented payment of strike pay to the striking workers (although Williams argues that Derbyshire and Nottinghamshire unions were in far better financial states than many of their counterparts across the country, and were among the only unions actually able to withstand a strike without going

[160] Eric Hopkins, *A Social History of the English Working Classes 1815-1945* (Hodder & Stoughton: London, 1979) p.247.
[161] Hopkins, *A Social History of the English Working Classes*, p.247.
[162] Hopkins, *A Social History of the English Working Classes*, p.248.
[163] A R Griffin, *Mining in the East Midlands 1550-1947*, (Frank Cass & Company Limited: London, 1971) p.226.
[164] Stevenson, *British Society,* p.198.
[165] John Stevenson, *British Society 1914-1945,* (Penguin Books Ltd: London, 1984). p.197.
[166] Stevenson, *British Society*, p.197.

bankrupt).[167] The conflicts between the unions and the workers, and the employers, had been rumbling along all the way from the start of the Great War. Stevenson argues that the General Strike was a relatively straight forward process of back-and-forth between unions and employers, with a government unwilling or unable to step in.[168]

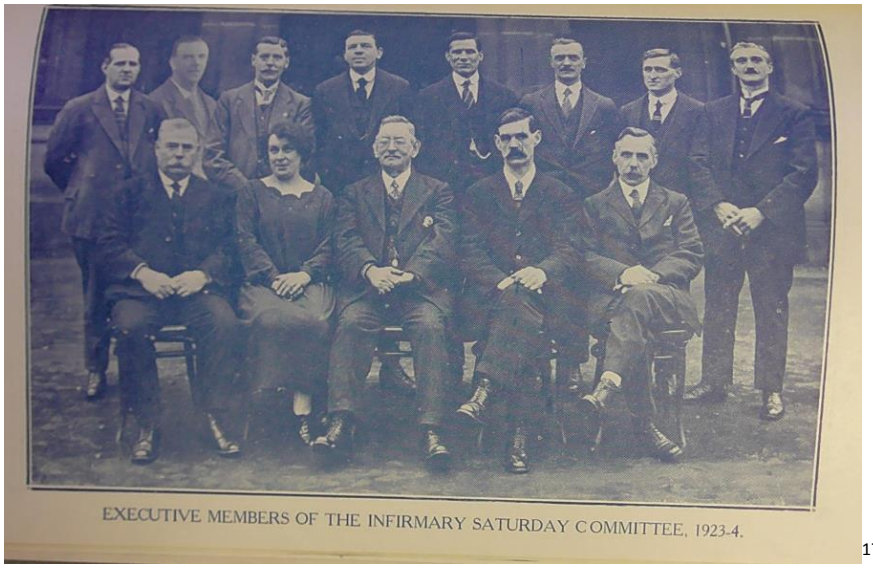
With all this in mind, what impact did such an upheaval have on the hospitals of Derbyshire and Nottinghamshire? The Strike offers an effective case study, much like the Great War, for illustrating how voluntary hospitals responded to influential events that were beyond their control but very much affected their day-to-day administration. While other areas, like the south, east, and around London might not have seen much impact upon their local hospitals from the strike, Derbyshire and Nottinghamshire certainly did. In areas like Chesterfield and Mansfield, whose population relied chiefly on coalmining, ironworks, and the railways (three industries involved in the strike) then it is actually a very good test of the hospitals' ability to weather extenuating events. It has to be remembered that the coal industry and its workers suffered far longer periods of strike and lockout than others (as early as 1921), exacerbated what was already a very difficult situation for their communities.[169] The 'Hospitals Crisis' was caused by a host of broader economic changes which directly affected the hospitals through prices and staffing. The General Strike, and the subsequent lock-out in the coal fields, created a number of situations, chief of which was the higher cost of coal – where in the short-term prices rose by 25% - and the unemployment of hospital contributors, that were essentially indirect consequences of the strike. The former was an inconvenience but nothing the hospitals had not had to deal with before, but the latter was a very worrying prospect for institutions that had made ambitious drives to shifting their hospitals away from subscriptions and donations and towards mass contribution. As A J P Taylor pointed out, '…coal entered into every branch of…life'.[170] Unemployment in the coal industry was relatively low in the mid-1920s, sitting at 5.8% in 1924, and 11.5% in 1925, but took a sharp increase after 1926 up to 19% in 1927 and as much as 24% in 1928.[171] In Derbyshire and Nottinghamshire, as elsewhere the situation was not quite so clear-cut as employed-versus-unemployed. There were serious problems throughout the two counties' coalfields with underemployment, where hours were cut to the bone but workers, still technically employed, were unable to receive unemployment benefit.[172]Statistically, unemployment

[167] J E Williams, *The Derbyshire Miners* (George Allen & Unwin: London, 1962) p.648.
[168] Stevenson, *British Society,* p.198.
[169] Williams, *The Derbyshire Miners,* pp.642-650.; Wal Hannington, *The Problem of the Distressed Areas* (Victor Gollancz Ltd: London, 1937) p.31.
[170] A J P Taylor*, English History 1914-1945* (Book Club Associates: London, 1977) p.239.
[171] B R Mitchell, *Abstract of British Historical Statistics*, (Cambridge University Press: London, 1962) p.67.
[172] Colin P Griffin, "Three Days Down the Pit and Three Days Play": Underemployment in the East Midlands Coalfields between the Wars, *International Review of Social History*, 38 (1993) p.329.

in the coalfields around Chesterfield and Mansfield was not necessarily high, but the extent to which the miners were underpaid was extreme.[173]

In many ways, a line could be drawn east to west across the two counties, dividing the northern mining and industrial towns and rural industrial villages from the cosmopolitan county capitals and their agricultural hinterlands that sat nestled in the southern sections of the counties. It means that, with the exception of the large railways depots and Rolls Royce engineering works in Derby, and the Derby and Nottingham Corporation transport systems, the real impact of the strike was felt most acutely in the northern parts of the counties. Thus in 1926 the hospitals of Chesterfield and Mansfield, solidly ensconced as they were in the Midlands/South Yorkshire coalfield were at the very 'coalface' of strike turbulence. On their doorstep operated the largest mines and ironworks in Derbyshire and Nottinghamshire, whose wage-workers were becoming the new key financiers of the hospital, a penny at a time, with their Saturday and works funds.

Figure 3.3: Executive members (representatives) of the Derbyshire Infirmary Saturday Committee, 1924.


EXECUTIVE MEMBERS OF THE INFIRMARY SATURDAY COMMITTEE, 1923-4.

[174]

Chesterfield workmen's hospital's system split its catchment region up into six (and later seven) districts, with focus on encouraging individual workplaces to sign up via popular decision from their employees.

[173] Griffin, '"Three Days Down the Pit"', p.334. ; Chesterfield Rural District Male Unemployment http://www.visionofbritain.org.uk/unit/10167152/rate/CENSUS_MALE_UNEM [accessed 28/12/2019]; Mansfield Municipal Borough Male Unemployment http://www.visionofbritain.org.uk/unit/10026817/rate/CENSUS_MALE_UNEM [accessed 28/12/2019].
[174] Saturday Committee Souvenir Booklet 1924, p.87.

Table 3.4: Chesterfield Royal Working Men's Subscription Scheme District incomes, 1920-1930.

District	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930
Chesterfield	1886	2361	2315	2320	2601	2736	2598	2733	2957	2984	3419
Sheepbridge	1094	1498	1657	1460	1398	1482	1210	1316	1626	1611	1895
Eckington	1526	1790	2277	2022	1849	2421	1600	2821	2390	2192	2321
Staveley	2152	2157	2265	1995	2768	2375	1257	2622	2513	2487	2903
Grassmoor	2400	2409	3217	3048	2791	2666	1625	2355	2141	2326	2367
Pilsley	1549	2030	2496	2251	2277	2231	1713	2822	2280	2346	2342
TOTAL	10607	12245	14227	13096	13684	13911	10003	14669	13907	13946	15247

The regions included Chesterfield itself, and the 'outlying' districts were Sheepbridge, Eckington, Staveley, Grassmoor, and Pilsley & Tibshelf. Surprisingly, until 1925 Chesterfield district was not the largest subscribing district. This honour fell to Staveley and Grassmoor, with its major metal, chemicals, quarrying, and mining industries, often dwarfing the contributions of the other four districts. Indeed, overall analysis of the industrial makeup of these districts reveals that they were dominated by just a few occupations.[175] Mining and colliery companies, and furnaces, forges, and ironworks were the chief contributors to the hospital. Eckington was the only exception, where the railways were the chief subscribers.

In 1926, as the impact of the strike started to take hold, the total workmen's subscriptions from the outlying districts dropped drastically. Grassmoor was the worst affected. It had twelve subscribing companies: nine were mines or collieries, one was a brickworks, and two were coke ovens.[176] Sheepbridge was the least affected. It had a more balanced industrial subscribing makeup. Of the 26 companies subscribing for that district, eight were mines or collieries, five were furnaces/forges/ironworks, one pottery, one mechanics works, one brickworks, one engineering works, two kilns, and a further seven unknown or miscellaneous.[177] Yet the fall in income was only temporary. The strikes, although impacting the subscription scheme for 1926, did not have lasting negative effects. Did the hospital's overall finances tell the same story? The maintenance account deficit in 1926 was £4,293, a significant only marginally lower than that of 1917, at the height of the hospital's financial troubles.[178] It was a direct consequence of the £3,907 drop in the workmen's

[175] Analysis conducted by looking at all the subscribing companies listed in the Annual Reports.
[176] Chesterfield and North Derbyshire Royal Hospital Annual Report, 1925.
[177] Chesterfield and North Derbyshire Royal Hospital Annual Report, 1925.
[178] Chesterfield and North Derbyshire Royal Hospital Annual Report, 1925.

subscriptions. By 1927, the hospital was once more able to balance its books as the working men's subscriptions readjusted to more normal levels.[179]

The Derbyshire Royal Infirmary was not hit as hard, for its subscriber base had a more balanced industrial structure. In 1925 the largest company donating to the Saturday Fund was the L.M.S Railways, followed (not closely) by the Butterley Company, that primarily owned collieries and steelworks in and around Ripley.[180] The total ordinary income of the Derbyshire Infirmary did not fall as a consequence of the strike, nor did that of its key components like the Saturday Fund or annual subscriptions.[181] Of the five largest contributing companies, four of them had workers from the main striking unions: that is to say engineering, transport, and mining. The strike and lockout in mining meant that payments from mineworkers remained low. There had been a strong upwards trend in Saturday fund income since the war's end (roughly £1,000 per annum), rising to £8,087 in 1925. In 1926 the takings for the fund were just a few hundred pounds higher - £8,466 – and growth was slow thereafter. This is hardly surprising. The railway and engineering companies in Derby (primarily LMSR and Rolls Royce) sacked all striking workers, and only slowly rehired them.[182] Some weeks after the official end of the strike, the LMSR was still not up to full running capacity on both its passenger and trade lines.[183] Compensation came with a significant increase in small donations, which all but doubled in 1926 compared to years either side as the public put its hands in its pockets to support the hospital in its troubled times. In fact, in shrewd anticipation of the coming troubles in the coal industry, the Infirmary had been stockpiling coal for the event of their being high prices or even shortages.[184] Further to this, as their stockpiled supply of coal dwindled, the Butterley Company (Ripley) and its miners arranged for a delivery to the hospital as a form of donation.[185] All these factors resulted in a tiny balance in the maintenance account of £2 – which the hospital was ecstatic at: 'The achievement is a fitting tribute to the wonderful support given during a time of industrial stress'.[186] They received the fortuitous windfall of legacies amounting to over £10,000 for the endowment of beds and for general purposes, which meant that they were able to shift their regular income to covering the increased expenditure on supplies.[187] The income from the Saturday Fund and the Hospital Day were both larger than previous years, and donations had a large jump of over

[179] Chesterfield and North Derbyshire Royal Hospital Annual Report, 1927.
[180] Derbyshire Royal Infirmary Annual Report 1925.
[181] Derbyshire Royal Infirmary Annual Reports 1925-1927.
[182] 'Derby After the Strike', Derbyshire Advertiser and Journal, 14 May 1926.
[183] '"Be A Little Patient". Mr C T Cramp's Advice to Railwaymen', *Derbyshire Advertiser and Journal*, 21 May 1926.
[184] Derbyshire Royal Infirmary Annual Report 1925-26.
[185] Derbyshire Royal Infirmary Annual Report, 1926-7.
[186] Derbyshire Royal Infirmary Annual Report, 1926-7.
[187] Derbyshire Royal Infirmary Annual Report 1925-26.

£1,000, similar to other hospitals (doubtless due to the increased charitable sympathy of straitened times). Annual Subscriptions maintained, as did income from box donations, patients' payments, and payments by local authorities for services rendered by the infirmary.[188] This meant that the hospital was able to avoid deficits that year.

Nottingham, although largely removed from the coalfield (save for a few pits in places like Wollaton and Bestwood), found itself struggling through 1926. Receipts from the Saturday Fund are reported as equalling the previous year in the November 1926 Monthly Board Report, but by March 1927 the hospital concluded that it had suffered 'great loss in earnings' – some £1,300 due to the coal disputes.[189] Donations fell by roughly £800, and although subscriptions rose roughly by £400, entertainments dropped by nearly £1,000 and patient payments by £600.[190] Without the 'Special Donations' (large philanthropic donations) received in the year, the positive balance could not have been achieved.[191] Suffice to say, even Nottingham General Hospital, the largest hospital in this study, was not impervious to the industrial difficulties of the mid-twenties. Mansfield Hospital also felt the impact of 1926. Like Chesterfield, its income decreased heavily in 1926 across the board: a £4,653 deficit on the Maintenance Account. Fortunately, regular subscriptions, donations, and other forms of voluntary income did not change.[192] Colliery owner's subscriptions dropped £1,014, and workmen's subscriptions dropped £3,175, which together largely account for the deficit.[193] As the hospital board put it, 'the receipts show a very considerable decrease, which may be largely accounted for owing to the unfortunate dispute in the Coal Industry'.[194]

A line needs to be drawn, however, between short- and long-term commitments from the mining communities. For example, in the aftermath of the strike mineworkers tried to make up for lost time by contributing extra to the hospital the in 1927, or some £600 extra over 1925 contributions.[195] Furthermore, despite the difficulties the colliery companies were experiencing as a whole, the hospital received a total of £15,000 from Bolsover Colliery Company and Sherwood Colliery Company for proposed extensions that had just been approved.[196] This illustrates how well organised industrial

[188] Derbyshire Royal Infirmary Annual Report 1925-26.
[189] Nottingham General Hospital Annual Report 1926.
[190] Donations: £3042 in 1925, £2,209 in 1926. Subscriptions: £10,685 in 1925, £11,121 in 1926.
[191] Nottingham General Hospital Annual Report 1926. Special Donations within the Extraordinary Income: £1,026 from the University College Students' Rag, and £1,000 from Mrs David Lawson.
[192] Mansfield District Hospital Annual Report 1925, 1926, and 1927. Donations: £47 in 1925, £147 in 1926, £58 in 1927. Congregational Collections: £118 in 1925, £202 in 1926, £231 in 1927.
[193] Mansfield District Hospital Annual Report 1925 and 1926.
[194] Mansfield District Hospital Annual Report 1926.
[195] Mansfield District Hospital Annual Reports 1924-1927.
[196] Mansfield District Hospital Annual Report 1926.

workers - and their employers - were keen to procure their own healthcare in the absence of any other provision, particularly in physically dangerous industries such as mining. It was a situation mirrored in Wales, where Curtis and Thompson's found that mineworkers, accepting the danger of their work, were keen to establish comprehensive systems of healthcare, recovery, and recuperation in their local areas.[197] In tightly knit mining communities healthcare provision was not an abstract concept but a thing of immediate necessity.

In 1925, there were 13 Colliery companies in and around Mansfield subscribing to the hospital. There were 25 Colliery Workmen's Subscriptions from a further 25 locations, amounting to £4722.[198] The Mansfield and District Saturday Fund, which catered for the non-mining working-class and lower-middle-class communities in the district, took only £1417, or only some 15 per cent of the workmen subscriptions.[199]

Table 3.5: Mansfield District Hospital Colliery and Saturday Subscriptions, 1921-1930.

Year	Colliery Company Subscriptions	No. of Colliery Companies	Colliery Workman's Subscriptions	No. of Colliery Workman's Locations	Hospital Saturday Fund	Total Ordinary Income
1921	1368	13	4722	25	1417	11210
1922	-	-	-	-	-	13528
1923	1587	11	7180	20	1053	11008
1924	1957	11	7737	23	1251	12573
1925	2382	13	7897	25	1428	13465
1926	1368	13	4722	25	1417	9175
1927	1632	14	8616	25	1524	13458
1928	2177	11	7729	26	1876	13304
1929	1552	7	7440	24	1973	12671
1930	2045	8	7461	23	1885	13072

[200]

After 1926, the colliery subscribers were able to stabilise the contributions to the hospital almost immediately, despite the unemployment and short-time working hours of the late 1920s and early 1930s. However, the General Strike had a very negative impact on the hospital beyond a temporary dip in income. The years up to 1926 were ones of healthy surpluses. By 1926, Mansfield, like other towns in Derbyshire and Nottinghamshire was already suffering privations among its population.[201]

[197] Ben Curtis, Steven Thompson, '"This is the Country of Premature Old Men" Ageing and Aged Miners in the South Wales Coalfield, C. 1880-1947', *Cultural and Social History*, 12:4 (2015) pp.592-593.
[198] Mansfield District Hospital Annual Report 1926
[199] Mansfield District Hospital Annual Report 1926.
[200] Mansfield District Hospital Annual Reports, 1921, 1923-1930.
[201] Peter Wyncoll, 'The East Midlands', in Jeffrey Skelley (ed.), *1926 The General Strike* (Lawrence and Wishart: London, 1976) p.173.

Nonetheless, in 1927 the retiring president, Mrs T Warner, argued that it was time to switch to a 'penny-in-the-pound' scheme instead, to move away from focussing just on the miners and trying to enfranchise more of the community.[202] This, she argued, would enable more workers to contribute, and so the hospital was not at the whim of the industrial conflicts in the mining industry and at the same time broaden its contributory base.[203] The crisis had sparked calls for innovation, but the calls made by Mrs Warner were not acted upon until later in the 1930s. Colliery Company subscriptions also remained erratic, fluctuating significantly from year to year. It is worth noting also that at no stage did company contribution come near to matching that of the workforce, despite the employers gaining significant benefit from the medical services provided by local hospitals.

The smaller cottage hospitals of Ashbourne and Wirksworth in the Derbyshire Dales and High Peak respectively, sat in a corridor devoid of coalmining activity.[204] Aside from agriculture, the chief employers of the area were quarrying and transport, both occupations which had member unions of the TUC.[205] Total income for Ashbourne actually increases from 1925-6, with patient payments nearly doubling, and then drastically decreasing again.[206] The hospital had a sliding scale of patient fees, so that over the year 20 patients received free treatment, and 115 patients paid between two shillings and six pence, to over twenty one shillings.[207] It was, the hospital noted, 'very variable [income source], and largely depends on the number of private patients in Hospital during the year'.[208] Income levels after 1926 returned to those before the strike.[209] Wirksworth hospital, smaller than Ashbourne, also saw a spike in private patient payments, in proportion to that seen in Ashbourne - a jump of 19.5%.[210] Only a very small minority of patient payments actually came from Approved Societies - £28 out of £545 in 1926. The rest were individual patient payments. It seems likely that, in a year peppered by strikes, employees were unable to approach their employers to request a hospital ticket from their subscriptions, or moreover the employers refused to give striking

[202] Charles Loch Mowat, *Britain Between the Wars 1918-1940* (Methuen & Co Ltd: London, 1955) pp.326-7. The two strikes occurring in 1926 – the main General Strike and the consequent second strike – Mowat shows how this situation dragged on with great difficulty faced by workers.; 'Effect of Coal Stoppage. Mansfield Hospital's Decreased Contributions', *Nottingham Evening Post*, 22 March 1927.
[203] 'Effect of Coal Stoppage. Mansfield Hospital's Decreased Contributions', *Nottingham Evening Post*, 22 March 1927.
[204] John Leach, *Coalmining Around Whaley Bridge*, (Derbyshire Library Service: Matlock, 1992) pp.1-5.
[205] 1921 Census of England and Wales, County Report, http://www.visionofbritain.org.uk/census/table/EW1921COU_M17 [accessed 15/08/19]
[206] Ashbourne Victoria Cottage Hospital Annual Report 1926.
[207] Ashbourne Victoria Cottage Hospital Annual Report 1926. 'Weekly Sums are as follows – 2 at 2/6; 2 at 3/-; 3 at 3/6; 14 at 5/-; 2 at 5/6; 1 at 7/-; 23 at 7/6; 14 at 10/-; 25 at 10/6; 2 at 12/-; 1 at 12/6; 8 at 15/-; 1 at 17/6; 6 at 21/-; and 11 paid over 21/-'.
[208] Ashbourne Victoria Cottage Hospital Annual Report 1926.
[209] Ashbourne Victoria Cottage Hospital Annual Report 1927; Ashbourne Victoria Cottage Hospital Annual Report 1928. Patient payments in 1927 are £348, and in 1928 £369 – a drop of roughly £200.
[210] Wirksworth Cottage Hospital Annual Report 1925; Wirksworth Cottage Hospital Annual Report 1926.

workers their hospital privileges, which would account for the jump in patient payments alongside steady annual subscriptions. Furthermore, they had a rich plethora of organised fundraising events to augment their finances.

Turning east, to Newark, we see yet another different story. Their hospital garnered a large portion of its income from a 'Workmen's Voluntary Levy' – in essence a Saturday Fund by another name. It experienced few ill-effects from the hardships of 1926, reporting a drop of 'only £4, 17s, 5d, less than the previous year. In a year of great industrial difficulty', it reported, 'the result is highly creditable'.[211] Newark and its surrounding district were not densely populated. Its largest industry was metalworking, but which did not constitute a high enough proportion of the population to present a serious problem to the hospital during the strike. It, too, adopted the entertainments fundraising model of larger hospitals, mainly started in 1926 to counter any potential loss of invoice from other sources: a hospital ball, five hospital dances, sales of allotment produce, carol singing, three whist drives, and a garden fete.[212] The £423 from entertainments alone was a large cash increase on the previous year, though not unheard of for the hospital.[213]

In just the first eight years after the end of hostilities, the nation had seen unprecedented social and economic upheaval. Working families were poorer, the government was broke, and by all accounts this was just the beginning of a slow and painful recovery. The voluntary hospitals did not fare as badly as other groups. The London hospitals aside, where the deficits were monumental and near insurmountable, the voluntary hospitals in the provinces managed to bounce back from difficult years of post-war hardship.[214] The Cave Committee recommendations were almost solely tailored to the benefit of London. Thus, the voluntary hospitals in Derbyshire and Nottinghamshire received little help from this governmental push to bail-out the hospitals, and instead surged ahead with their own efforts (or, in the case of Nottingham, received it from larger charitable sources). It has to be said that the voluntary hospitals, after being funded throughout the war for the services they provided for war wounded, recovered from the administrative stagnation of the war years quite well, but were confounded chiefly by the rising running costs. Incomes were largely stable, but expenditure increased rapidly. However, in spite of the tumultuous few years of rising costs, the situation levelled off, and by the mid-1920s they were starting to expand physically, with new wards

[211] Newark Town & District Hospital and Dispensary Annual Report 1926.
[212] Newark Town & District Hospital and Dispensary Annual Report 1926.
[213] The hospital previously raised £447 from Entertainments in 1924, with a peak of £827 in 1921. It again reached £461 in 1929, but never surpassed that level again after that.
[214] John Mohan and Martin Gorsky, *Don't look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics and Association of Chartered Accountants: London, 2001). pp.40-43.; Abel-Smith, *The Hospitals 1800-1948*, p.309.

and new fundraising endeavours. But once again the impact of exterior economic forces meant that the hospitals were having to respond to crisis. The 1926 General Strike impacted the hospitals of the Derbyshire and Nottinghamshire coalfield significantly, where tens of thousands of men were employed in strike industries. 1926 shaped how the hospitals moved forward, the larger institutions continuing their maintenance of diverse finances, and the smaller institutions re-evaluating how they garnered their funds from occupationally homogenous areas.

These years after the Great War chiefly serve to show that in spite of the fierce independence of the voluntary hospitals, they were unable to remain independent from the external world. Were they able to sustain themselves just on large philanthropic donations, as they had done in the previous century, then they would have been far less affected. But having already expanded their services, as well as their social remit, they had already embedded themselves within the fortunes of the local economy far more than they had in 1914. While large benefactions remained important, and regular donations and annual subscriptions significant, every day they were having to turn more and more to the working man on the street for his subscription, contribution, his time, and his penny donation. Events such as the Derby Hospital Day, and the gradual expansion of the Saturday funds meant that there was a new mutualist way emerging from the hospital volunteers in the two counties. Hospital Days were an effective way of not only fundraising, but evangelising the cause of the hospital, and provided and avenue for local people to offer extra support to the services they themselves benefited from. The hospitals expanded, and now the citizenry had expectations of the voluntary hospitals that could not be reversed. It was the first time that the hospitals had really seen themselves potentially overreach, taking on more services than they could fund. However, as a system, they managed to prevail, fighting off calls for nationalisation or even bigger government funding, instead managing to provide their own solutions. They were set on the path of mutualism, having left behind the traditional incomes, and successfully fended off suggestions of increased government involvement in acute medicine.

The strikes of 1926 proved tumultuous for some hospitals, and for others merely an inconvenience. Hospitals planted in areas that were dependent on mining and heavy industry as their chief employers suffered more than their counterparts that dwelled in either more industrially diverse areas, or areas where mining and heavy industry were simply not prevalent like around Newark and up in the Derbyshire Dales and Peaks. This proves that hospitals were tied to industrial conditions, and furthermore, so were their mutualist schemes. Whether called Saturday Funds, Workmen's Collections, or Work's Subscriptions, there was a marked drop in 'contributions' in the affected areas in 1926. A sustained reduction of mutualist income over this period, at a time when hospitals had quickly become dependent upon them, would have been all but fatal. Luckily, this was not the case,

as more and more individuals entered into social contracts with the hospitals by contributing directly. If these advancements had not developed, the hospitals would never have been able to offer their services to an increased body of patients. The next few years to come were no easier for the ordinary citizen. The economic situation, already bad in the UK, was about to intensify with the 1929 financial crash. The hospitals had a new set of challenges as they started to grow their mutualist schemes and start to expand their repertoire of large-scale fundraising events against the backdrop of a sluggish economy.

Chapter 4: 1929-1933 Resurgence and Consolidation.

> *'In times of accident earning power ceases, whilst expenses increase, and it is a source of comfort to a worker to know that he is, during the days of health, made provision for Hospital treatment at such a time'* Worksop Victoria Hospital, 1930.[1]

The 'Great Slump' following the 1929 economic crash presented a long-term problem for the voluntary hospitals. Unlike the short-term economic and social storms that they had to weather during and after the war, and the 1926 industrial turmoil, the depression meant a sustained downturn in the industries that fed funds into the hospitals. The landscape of the voluntary hospitals, like that of Britain as a whole, was far more complicated than those such as Titmuss and Abel-Smith implied; they were tied intrinsically to the social, economic, and cultural landscape of their communities; their agency was tied to the potential of their community. General income growth for the voluntary hospitals through the 1920s had increased, with the diversifying of new incomes and the decline in precedence of the traditional donations and annual subscriptions.[2] This pattern continued into the broader economic slump of the late nineteen-twenties and early nineteen-thirties. Gorsky, Mohan, & Powell found that a high number of hospital nationally were in deficit by 1929, but that significant deficits were mostly concentrated down in the specialist, teaching, and large general hospitals in London.[3] If the hospitals were to remain buoyant, they had to avoid chronic deficits and encourage broader engagement from their communities.

We know from the flashpoint of 1926 that the hospitals were tied to the economic fortunes of their communities and the broader British economy. From this, one might assume that against a backdrop of prolonged economic strife, that the voluntary hospitals would stagnate or struggle to raise extra income. However, necessity proved to be the mother of invention – or at least innovation. Saturday funds, for example, were becoming increasingly important to hospitals because they spread the risk by enfranchising a far larger population than the old-fashioned subscriptions allowed. This pattern of consciously diversifying was something that had its origins in the pre-war world, but the rationale for innovation was confirmed by the post-war crisis and the social and economic troubles surrounding 1926. It was fuelled, too, by the growing demand for hospital services, part of which was tied to the expansion of contributory schemes. The increased popularity of contribution funds as a form of quasi-health insurance brought its own incremental costs. There were hopes during the 1920s of a decent national recovery after the instabilities and anxieties following the First World War. Instead, Britain entered what Derek Aldcroft labelled a 'decade of instability'.[4] The resources

[1] Worksop Victoria Hospital Annual Report 1930.
[2] John Mohan and Martin Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001) pp.41-42.
[3] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review*, LV:3 (2002) p.539.
[4] Derek Aldcroft, *The British economy between the wars* (Philip Allan: Oxford, 1983) p.1.

of voluntary hospitals, particularly, were tied to the strength or weakness of their local economies.[5] This chapter charts the progress of the Derbyshire and Nottinghamshire voluntary hospitals in an era otherwise defined by 'slump' and hardship.

The elections held in May 1929 brought a second minority Labour government. It signalled a dissatisfaction with the 'wait and see' policies of the Baldwin Conservatives.[6] Unfortunately, the consequences of the Wall Street Crash on 24-29 October 1929 in the US meant that this hope of recovery and stability was dashed, as economic downturn spread throughout the western world.[7] Between 1929 and 1933 the key 'staple' industries suffered major economic setbacks: shipbuilding and steel output halved by 1930 and essentially ground to a halt by 1932; cotton exports halved between 1929 and 1931, and coal, the least affected, saw production fall by a fifth between 1929 and 1933.[8] These were key industries and their decline meant mass unemployment and subsequent crises of poverty throughout the industrialised North, Midlands, Scotland, and South Wales. Macdonald's government was largely blamed for the slump by the popular press. There was press opposition, also, to the benefits afforded to those out of work.[9] By December 1930, there were 2.5 million unemployed workers in Britain, having a monumental impact on poverty levels up and down the country, and concentrated especially in certain areas.[10] At a time when they were starting to recover from the war and its subsequent crises, there was little more that the voluntary hospitals wanted than to gain greater financial stability and preserve their independence. Their fierce independence, like that of many voluntary organisations, precluded them from banding together in any meaningful way; the county Voluntary Hospitals Committees, discussed in the previous chapter, show just how much difficulty the government had in encouraging hospitals to even communicate with each other, let alone cooperate.[11] They dealt with the government – both national and local – on their own terms. At this time few were seriously talking of nationalising the hospital system other than the Labour Party, and then only on the margins.[12] What hospitals feared really was a government that became more proactive in funding the voluntary hospitals, and thus squeezing out their voluntary incomes as well as potentially having government authorities dictate their responsibilities to them.

The introduction of the Local Government Act in 1929, by Neville Chamberlain as Minister of Health (before his loss of the position in the June election), raised new fears that the government was inching closer and closer to actively intervening in hospital services by advancing the public health remit and promoting the cause of local

[5] John Mohan, *Planning, markets and hospitals* (Routledge: London, 2002), p.31.
[6] Robert Blake, *The Conservative Party from Peel to Churchill* (Eyre & Spottiswoode: London, 1970) p.216.
[7] Barry Eichengreen, *Hall of Mirrors The Great Depression, The Great Recession, and the Uses – and Misuses – of History* (Oxford University Press: Oxford, 2015) pp.105-110.
[8] John Stevenson, *British Society 1914-1945*, (Penguin Books Ltd: London, 1984).
[9] Robert Skidelsky, *Politicians and the Slump. The Labour Government of 1929-1931* (Penguin Books Ltd: Harmondsworth, 1970) p.260., p.267.
[10] Taylor, *English History*, p.284.
[11] J E Stone, *Hospital Organization and Management (Including Planning and Construction*) (Faber & Gwyer Ltd: London, 1927) pp.198-200.; Steven Fielding, Peter Thompson, Nick Tiratsoo, *"England Arise" The Labour Party and Popular Politics in 1940s Britain* (Manchester University Press: Manchester, 1995) p.127.
[12] John Stevenson, *British Society 1914-1945* (Penguin Books Ltd: 1984, London); Abel Smith, *Hospitals*, pp.286-289.; http://www.labour-party.org.uk/manifestos/1929/1929-labour-manifesto.shtml.

authority run health services, including hospitals.[13] However, Chamberlain himself was a localist, and was certain that local services – not national – were the way forward for local authorities and thus local voluntary services too.[14] What the 1929 Act founded, in granting local authorities control over the existing Poor Law infirmaries, was a new 'competitor' in the public arena, for which patients might opt for instead of their traditional voluntary institutions.[15] Yet if the nation had voted to the left, its affection for the voluntary system at this time was unwavering, even in intensely Labourite areas such as Sheffield and Leeds.[16] Neither Derbyshire or Nottinghamshire suffered to the same degree as the 'Distressed Areas' of the north, Wales, or Scotland where the old basic, and export-oriented, industries were concentrated. The two counties were industrially diverse, where Nottingham and Derby sat as epicentres of industrial movement, while the hinterlands were occupied with mining, quarrying, and ironworking, and so it did not suffer the fate of somewhere like the Carmarthenshire coalfields, where unemployment was at roughly 27.5% through the 1930s and industry was more homogenous.[17] On the surface, the Midlands fared better than the rest of the UK; it was the second least unemployed region by 1932 at 22.5%.[18] As the Manager of Nottingham's Employment Exchange was later to note: 'Nottingham in pre-slump days was definitely regarded as a prosperous city'.[19] This is not to say, however, that there were not sectors strongly affected by structural unemployment. In Nottingham, unemployment rose rapidly from 9,100 in June 1929 (or some 8.5% of its insured population) to peak at 21, 500 (18.5%) in August 1931.[20] Particularly badly hit was the city lace and textile industry. Coal, too, was heavily affected, even though the local pits in Nottinghamshire and Derbyshire were some of the most efficient in the country. Overall, in 1931 male unemployment within the census data Derby had 14.5% unemployment, and Nottingham had 13.7%, whereas surprisingly the coal-dominated North East Derbyshire around Chesterfield was only at 11.5% unemployment among males.[21] Although rough estimates, it illustrates that within each county there were significant variations in terms of industrial distress. On the other hand, from the hospitals perspective, it meant that where one industry might dip, the shortfall

[13] Martin Gorsky, John Mohan, 'London's Voluntary Hospitals in the Interwar Period: Growth, Transformation or Crisis?', *Nonprofit and Voluntary Sector Quarterly*, 30:2 (2001) p.263.
[14] Bernard Harris, 'Government and Charity in the Distressed Mining Areas of England and Wales, 1928-30', in Jonathan Barry and Colin Jones (eds.), *Medicine and Charity before the Welfare State* (Routledge: London, 1991) p.210.
[15] Martin Gorsky, John Mohan, 'London's Voluntary Hospitals in the Interwar Period: Growth, Transformation or Crisis?', *Nonprofit and Voluntary Sector Quarterly*, 30:2 (2001) p.263.
[16] Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010) p.375., pp.381-382.
[17] Bernard Harris, 'Government and Charity in the Distressed Mining Areas of England and Wales, 1928-30', in Jonathan Barry and Colin Jones (eds.), *Medicine and Charity before the Welfare State* (Routledge: London, 1991) p.208.
[18] John Stevenson, Chris Cook, *The Slump Society and Politics During the* Depression (Quartet Books Ltd: London, 1979) p.286.
[19] F. Hampton, 'A Brief Survey of Nottingham Employment', July 1936, Nottingham Central Library.
[20] F. Hampton, 'A Brief Survey of Nottingham Employment', July 1936, Nottingham Central Library.
[21] Derby: http://www.visionofbritain.org.uk/unit/10109700/rate/CENSUS_MALE_UNEM; Nottingham: http://www.visionofbritain.org.uk/unit/10001389/rate/CENSUS_MALE_UNEM [accessed 07/06/2018]; North Derbyshire: http://www.visionofbritain.org.uk/unit/10084775/rate/CENSUS_MALE_UNEM [accessed 07/06/2018]; 'South Derbyshire' region (not including Derby itself) was the low, at 8%: http://www.visionofbritain.org.uk/unit/10217702/rate/CENSUS_MALE_UNEM [accessed 07/06/2018].

could be made up by the myriad other industries. By diversifying incomes, unemployment might become less of a problem for the voluntary hospitals.

Unemployment and its effects on the hospital incomes will be discussed in greater detail in the next chapter, looking at the entirety of the 1930s decade and its changing employment levels. But the years 1929-1932 saw the most intense levels of unemployment for the nation, and the voluntary hospitals were directly affected, and warrants study in the context of the crisis. Hospitals were linked to their communities, and relied on the money either from donations, or increasingly from regular 'contributions', to survive. Workers out of work were mostly unable contribute, unless they were in receipt of unemployment benefit. However, unemployment is not the only factor one has to consider when looking at hospital communities in Derbyshire and Nottinghamshire. As Colin Griffin highlights, 'underemployment' was just as debilitating to the East Midlands communities as unemployment was to the communities of the 'Distressed Areas'.[22] This was the long-held practice in the East Midlands coalfields that instead of laying off workers in lean times, they would slash the hours that the miners worked and thus the amount companies had to pay them. This became most acute later in the 1920s and into the 1930s. By way of comparison, the average number of days worked per week in Derbyshire during the Great War was 5.69 and in Nottinghamshire 5.44.[23] This had dropped by 1921 to 4.67 and 4.42 days respectively, which when incorporating wage cuts, meant that the miners in the two counties were seriously under strain.[24] By 1931, these days had dropped again, to 3.8 days per week in Derbyshire, and 4.11 days per week in Nottinghamshire. Invariably, as coal prices reduced, so did the wages of the miners, and the inland coalmining districts further suffered from the cheaper-produced coal of the coastal export districts, which were paying their workers less.[25] Griffin asserts that the miners of the East Midlands may have suffered even more acutely as those in the areas in the UK with much higher unemployment rates (wages on short-time working dropping below both unemployment benefit and Public Assistance relief pay) , but their situation went unreported because they were not 'unemployed'.[26] If the national average unemployment peaked in 1932 at 22.5%, then Derbyshire and Nottinghamshire going into the 1930s were well below that.[27] Chesterfield County Borough's unemployment was more than its rural district, and the same was for Mansfield Urban District compared to its rural district, as well as Worksop and its rural district.[28]

---

[22] Colin P Griffin, "Three Days Down the Pit and Three Days Play": Underemployment in the East Midlands Coalfields between the Wars, *International Review of Social History*, 38 (1993) p.322.
[23] Griffin, 'Three Days Down the Pit', p.324.
[24] Griffin, 'Three Days Down the Pit', p.324.
[25] J E Williams, *The Derbyshire Miners* (George Allen & Unwin: London, 1962). Pp.354-356.; Griffin, 'Three Days Down the Pit', p.326.
[26] Griffin, 'Three Days Down the Pit', p.329., p.331., p.334.
[27] 'England', http://www.visionofbritain.org.uk/unit/10217702/rate/CENSUS_MALE_UNEM [accessed 07/06/2018]
[28] Chesterfield town: http://www.visionofbritain.org.uk/unit/10027603/rate/CENSUS_MALE_UNEM [accessed 07/06/2018].; Chesterfield Rural District: http://www.visionofbritain.org.uk/unit/10167152/rate/CENSUS_MALE_UNEM [accessed 07/06/2018].; Mansfield: http://www.visionofbritain.org.uk/unit/10026817/rate/CENSUS_MALE_UNEM [accessed 07/06/2018].; Worksop: http://www.visionofbritain.org.uk/unit/10026842/rate/CENSUS_MALE_UNEM

These coalmining communities had the strongest need for healthcare. Mining was a dangerous industry, with not just accidental injury, but long-term ill health stemming from the conditions worked.[29] These were the communities that potentially had the most difficulty contributing towards the hospitals, and thus securing treatment. In the late 1920s and well into the 1930s, the mining industry, a major employer in north Nottinghamshire and north and eastern Derbyshire hit a nadir as coal prices and profits fell. When prices fell, so did mineworkers' wages, both by the hour and by hours worked.[30] Fewer hours worked meant an inadequate wage to provide for families, yet staggered employment also meant they were unable to draw unemployment benefits.[31] The Staveley Company (one of the many mining companies who were in the Chesterfield Hospital districts), in an act of compassion, decided to have miners work one week in two, so it 'would allow the men to obtain unemployment pay for the week they were not at work'.[32] Yet, the downturn in economic activity after 1929 was not as intense as that following 1920, and by international standards Britain experienced a relatively mild recession and escaped the severe financial crisis that hit other countries (such as the USA, and Germany).[33] In Nottingham, for example, the rapid expansion of companies such as Boots, Player's Cigarettes, and Raleigh, cushioned the impact of recession.[34] These were industries more reliant on domestic markets than on overseas. Areas, however, that lacked a balanced economy, and more significantly were dependent on the nineteenth-century export orientated industries, fared badly.[35] Such diversity of experience can be found in Nottinghamshire and Derbyshire. The large towns and cities remained buoyant, largely unaffected by mass unemployment because they had mixed economies. By contrast, the smaller towns and industrial villages were badly affected by unemployment and underemployment because of their dependence on coal and steel manufacture.

Hospital Finances

Even in the key cities, the impact of economic dislocation was felt. The Derbyshire Infirmary, by September 1929, was already feeling the strain. It stated that the resources of the hospital were 'taxed', and that furthermore the 'work has made heavy claims on the time of the [staff]…the physical and mental strain must have been very great'.[36] In- and out-patients numbers had increased significantly in the previous year, a trend that had started with the Great War and only continued into the 1930s.[37] There was, after 1930, a decline in its Saturday fund income. It was managing to grow its services (like enlarging the outpatient reception area) in

---

[accessed 07/06/2018].; Worksop Rural District: http://www.visionofbritain.org.uk/unit/10108998/rate/CENSUS_MALE_UNEM [accessed 07/06/2018]..

[29] Ben Curtis, Steven Thompson, '"This is the Country of Premature Old Men" Ageing and Aged Miners in the South Wales Coalfield, C. 1880-1947', *Cultural and Social History*, 12:4 (2015) pp.591-593.

[30] Williams, *Derbyshire Miners*, p.734.

[31] Williams, *Derbyshire Miners,* p.735.

[32] Williams, *Derbyshire Miners,* p.735.

[33] Aldcroft, *British Economy,* 44-5.

[34] Stanley Chapman, 'Economy, Industry and Employment', in John Beckett (ed), *A Centenary history of Nottingham* (Manchester University Press: Manchester, 1997), 480-512.

[35] For example, John Stevenson and Chris Cook, *The Slump: Society and Politics during the Depression* (London, 1977).; Derek Aldcroft, *The Inter-War Economy: Britain,* 191901939 (London, 1970).

[36] Derbyshire Royal Infirmary Annual Report 1929.

[37] Derbyshire Royal Infirmary Annual Report 1929.

line with the increases in the patients coming through their doors, but was finding that the its was often operating at the limits. As the table shows, income was stable, actually reaching peaks in 1929-1930 for both total ordinary income, and for the Saturday fund and annual subscriptions, and then a drop-off.

Table 4.1: Derbyshire Infirmary Key Incomes, 1927-1933

Year	Total Ordinary Income	Annual Subscriptions	Donations	Saturday Fund	Sunday Fund
1927	46421	5915	1514	16800	2088
1928	48497	6216	1395	18000	1963
1929	49776	6228	1564	19600	2159
1930	51012	6112	1658	19751	2039
1931	47833	6026	1649	17688	1847
1932	47594	5877	1547	17641	1789
1933	47272	5726	1702	17836	1752

The Saturday fund income, between 1929 and 1933, reduced by roughly £2,000. Clearly there was some change occurring, after successful years increases after 1926, only to see a real crash between 1930 and 1931. Unemployment was having some impact on the communities outside of Derby that were contributing to the Infirmary's Saturday fund. This at a time when patient numbers were increasing. Just to give an indication of the steady but definite growth of patient numbers, the following table offers some figures with regards in- and out-patients, with most notably the increase in outpatient attendances. The decline in Sunday fund donations is also noticeable, falling by £400 and more by 1933, from its 1926 levels, married generally to the falling off in church attendance and its charitable activities.[38] Both middle- and working-class fundraising foci shifted elsewhere. The Infirmary was pleased with the results of the Hospital Day, which saw an increase of £315 over the record of £3,145 in 1928; the flags and copper collection raised £594 and £590 respectively, an increase over 1928.[39] Though these were minor elements in the larger fabric of the hospital finances, they were an effective stimulation that both granted the boon of extra cash and a confirmation that their community was growing and continuing to support them even after such a prolonged period of difficulty.

Table 4.2: Derbyshire Infirmary Key Patient Figures, 1927-1933.

Derbyshire Infirmary Patients	1927	1929	1931	1933
Total patients admitted (inc. inpatients, outpatients, and casualties)	29509	31616	31933	33477
Total inpatients	5693	6364	6734	6364
Total outpatient attendances	149462	159832	177725	189911

[38] J. Morris, *Religion and Urban Change: Croydon, 1840-1914* (Woodbridge, 1992), pp. 128-46; S.J.D Green, *Religion in the Age of Decline: Organisation and Experience in Industrial Yorkshire, 1870-1920* (Cambridge, 1996), pp. 351-79.

[39] 'Derby Day for Hospital. Flag Sales Exceed Last Years. Mayoress Grateful', *Derby Daily Telegraph*, 13 July 1929.; 'Tons of Money – Almost', *Derby Daily Telegraph*, 10 July 1929.;

Table 4.2 shows that in all categories, especially in the outpatient department, swelled considerably in just a few short years. Overall, there was a decline in total income matched with an increase in patient numbers, which presented a challenge to the Infirmary, which had managed to weather the storm of 1926 with little difficulty, only to see the economic slump whittle away its key financial income, resulting in deficits of some thousands of pounds – as much as £4,000 in 1931, £3,000 in 1932, and £1,200 in 1933.[40]

In Nottingham, the 'depression in the coal trade' meant that the board of management viewed contributions as lacklustre.[41] However, William Player (Chair of the board) noted there did not need to be too much concern about the current slump, because incomes were coming from different industries, some unaffected by the economic downturn.[42] Player's optimism was well placed. Annual subscriptions, for example, which arguably provided a good indicator of how the community valued the work of charity, jumped from £11,583 up to £14,119 between 1929 and 1932. Later into the 1930s, this pattern was to change again. But at this time, the annual subscriptions were seeing growth. The Nottingham General's subscriptions averaged around 20% of its total income, both before and after the Great War. Chesterfield's subscription income also remained constant and stable. By contrast, Derbyshire Infirmary saw decline, with subscriptions sitting at 12.5% of total income in 1929, down to 12% in 1930, only experiencing slight recovery at 14% in 1933.

Table 4.3: Derbyshire Infirmary, Nottingham General, Chesterfield Hospital Annual Subscriptions as a percentage of total income, 1927-1933.

Year	Derby Annual Subscription	% of total	Nottingham Annual Subscription	% of total	Chesterfield Annual Subscription	% of total
1927	5915	12.7	11415	20.6	4839	18.6
1928	6216	12.8	11880	20.6	4203	17.2
1929	6228	12.5	11583	19.7	4600	18.7
1930	6112	12.0	11456	18.8	5122	18.7
1931	6026	12.6	11388	19.1	4714	18.3
1932	5877	12.3	14119	25.6	4844	19.0
1933	5726	12.1	10938	19.6	4871	19.1

Hayes and Doyle argued that hospitals that managed to preserve their traditional voluntary income (subscriptions, donations, etc) like Nottingham General were more likely to be those institutions with generally healthy finances, while those who turned away from traditional income were found to be in financial trouble.[43] The Derbyshire Infirmary also had lower proportional incomes from Sunday collections and general donations than Nottingham as well, meaning that across the board the Infirmary was doing a poor job of preserving its

[40] Derbyshire Royal Infirmary Annual Report 1931.; Derbyshire Royal Infirmary Annual Report 1932.; Derbyshire Royal Infirmary Annual Report 1933.
[41] Nottingham General Hospital Saturday Committee Minutes 2 December 1929.
[42] Nottingham General Hospital Saturday Committee Minutes 28 March 1929, 'Report of the Hospital Saturday Committee to the Monthly Board of the General Hospital'.
[43] Hayes, Doyle, 'Eggs, rags and whist drives', p.723.

traditional incomes. This was reflected in its overall financial health, which witnessed a slew of deficits from 1931 to 1933.[44]

Several of the smaller institutions found a similar problem of annual subscription decline. Newark saw a quite drastic decline in the prevalence of the annual subscriptions, as it pushed for its 'Penny-in-the-Pound' scheme quite soon after the war.[45] Newark was one of the earliest adopters of such a scheme, and made efforts to 'expand' the hospital's cover by side-lining the annual subscriptions in favour of the new scheme. Mansfield hospital, by contrast, actively encouraged people to subscribe alongside their mineworker and colliery company subscription schemes; in many ways in this period(before it brought in a more universalist contributory scheme) it viewed the annual subscriptions as part of the broader extension of acquiring hospital services.[46] Worksop remained, as it always had, largely dependent on other sources of charitable income.

Table 4.4: Newark, Mansfield, Worksop, Wirksworth, and Ashbourne annual subscriptions as a percentage of total income, 1927-33.

	Newark		Mansfield		Worksop		Wirksworth		Ashbourne	
Year	A/S	% of total	A/S	% of total	A/S	% of total	A/S	% of total	A/S	% of total
1927	781	15.1	892	15.7	-	-	207	17.2	206	21.3
1928	751	13.6	955	18.9	557	8.4	227	27.1	201	19.4
1929	706	11.6	1020	16.2	527	7.1	222	16.4	195	18.6
1930	754	11.3	975	16.8	525	7.5	230	16.2	206	21.8
1931	695	11.1	1111	15.5	603	8.7	227	-	186	20.0
1932	628	9.8	898	15.2	567	7.9	202	14.2	181	18.0
1933	658	6.2	981	14.5	551	6.5	198	13.0	186	19.7

Wirksworth and Ashbourne cottage hospitals lacked income from mutualist funds. But as Table 4.4 above shows, they were no more reliant on subscription income at this point than their larger counterparts; in fact, even less so. As a proportion of income, annual subscriptions saw a more considerable decline in the smaller hospitals. The economic troubles of the 1920s and 1930s did not see a second mass fall in annual subscription significance (%) that was seen at the end of the Great War. But with this discussion of 'significance; it should be made clear it did not mean that the actual pounds and shillings coming into the hospitals via annual subscriptions was declining. As already mentioned earlier in the case of the Nottingham General, there was a modest growth in real terms in the annual subscriptions which remained competitive with inflation and maintained the overall proportion of the total income. Gorsky, Mohan, and Willis point out that the shift away

[44] Derbyshire Royal Infirmary Annual Report 1928-9.; Derbyshire Royal Infirmary Annual report 1930-1.
[45] Newark and District Hospital Annual Report 1920.
[46] Mansfield and District Hospital Annual Report 1931.

from subscriber tickets (referral of a patient) was tied up not only with the sluggish performance of the subscription schemes to keep up with demands of the hospital's account books, but also that the tickets no longer covered the cost of the patients, and could not reasonably be adjusted.[47] For example, Derbyshire Infirmary and Nottingham General, where a subscribers 'ticket' was given for each Guinea subscribed, average inpatient costs in 1931 were £6 and £8 respectively, or nearly six-times the amount of a subscription for an individual ticket. Outpatient costs for the same year at the Derbyshire Infirmary were 9 shillings, falling at under half of a subscriber ticket. It is clear that on a one-to-one basis, the individual 'ticket' subscriptions would not cover the cost of an inpatient. However, the hospitals never set subscriptions at a one-to-one. There was always the implicit anticipation that the hospital would receive payments from more people that were ever admitted in the year. Thus, subscription income is best viewed, in this period especially, as simply one additional form of financial income with a mix of other sources. It can further be seen that the subscription schemes were simply not diverse or streamlined enough to continue to grow. There were a number of degrees of separation within the subscription scheme for those waged workers paying into hospital cover. The traditional form of payment from wage packets to employer, and then the employer paying into the hospital, and then the hospital issuing tickets back to the employer was long-winded and loaded with the baggage of charity and deference.

Mutualist Funds

Saturday funds came to be, in the view of both contemporaries and historians, the golden goose of voluntary hospitals, that needed the correct encouragement to lay the golden eggs.[48] Even in difficult times, for example during the General Strike, they remained a relatively stable form of hospital income. Yet they were also linked to wider economic and social changes if only because the majority were initially workplace-based. When they morphed into contributory schemes, the relationship of patient-hospital rather than patient-workplace-hospital was consolidated. But the Saturday Funds were more than just a transitional chimera from work-based collections on pay-day to the quasi insurance-based contributory schemes. Their rise in prominence spanned the interwar period, and indeed in many cases, occurred before the Great War. Most morphed into contributory schemes just before or at the start of the Second World War. In that period, they came to mean far more than just a network of cash collection by the hospital. Many of them gained an independent identity from their mother institutions, and became a social group wherein committee members and contributors organised gatherings, competitions, and trips out.

The Saturday funds were labour intensive, and engaged an army of volunteers to recruit, collect, and organise. This meant that the hospitals had an organised team of volunteers that it could potentially call upon to aid the hospital in other areas. Derbyshire Royal Infirmary and the Nottingham General Saturday funds were two of the older of their kind. Founded in the 19th Century as small volunteer efforts, they rose to be an archetypal

[47] Martin Gorsky, John Mohan, Tim Willis*, Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.31.
[48] John Mohan and Martin Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001). p.42.; J E Stone, *Hospital Organization and Management (Including Planning and Construction),* (Faber & Gwyer Ltd: London, 1927). p.46.

hospital funds by the 1930s. The Saturday Funds were managed by a small group of members elected to their position by the broader mass of contributors to the fund; 'representatives, duly elected, as hereinafter prescribed, of workpeople, firms and other bodies which contribute thereto, who shall constitute the General Committee'.[49] A significant amount of work was required to organise and lead the fund, and it was organised along similar lines as the respective hospital with official leadership roles: chair, secretary, executive committee, etc. In Derby, as elsewhere, most members of the Saturday Fund were employees of their respective companies, but the members of the executive committee were frequently businessmen, who had extra time and extra money to finance the administration of the Fund. Usually they served on various other volunteer committees within their companies and within their local community. But this was certainly not always the case. One exception to this rule at the Derbyshire Infirmary Saturday Fund was Mr J H Cox, representative for Butterley Company workers in 1927, whom also served as a member of the Derbyshire Miner's Association, was Chairman of the Denby Hall Miner's Lodge, was a member of the Miner's Executive Council, and was also a member of the Butterley Company's Allocation Welfare Committee.[50] Mr Cox was a miner, and serial volunteer. Mr W E Say was similar – he was a representative of the L.M.S. Railway Engine Drivers and Firemen, where he was also Secretary to the Works Hospital Fund, and later Chairman.[51] It is important to iterate that these men, whether workers or managers, were leading members of local communities. They lived and worked in the two counties, and as such, had a significant vested interest in securing an effective Saturday Fund for themselves and their fellow community members. Without such interested parties from outside of the hospitals institutions themselves, the successes of the mass schemes would have been far less significant.

Figure 4.1: Derbyshire Infirmary Saturday Committee Representatives, 1923-4.

INFIRMARY SATURDAY COMMITTEE REPRESENTATIVES ON THE INFIRMARY BOARD, 1923-4.[52]

In Nottingham, working-class and lower-middle-class members of the executive were always in the clear majority: men like Guy Taylor, a railway collector, who represented the clerks at Midlands Railways; John

[49] *Rules of the Derbyshire Royal Infirmary Saturday Fund*, 1931.
[50] Derbyshire Royal Infirmary Hospital Saturday Fund Souvenir Booklet 1927.
[51] Derbyshire Royal Infirmary Hospital Saturday Fund Souvenir Booklet 1927.
[52] Derbyshire Royal Infirmary Hospital Saturday Committee Souvenir Booklet, 1924., p.85.

Tomlinson, a twist hand in the local lace industry; or Julia Day, who was a welfare supervisor at Boots.[53] These volunteers were the backbone of these Saturday Funds, in driving forward recruitment and in managing the minutiae of the fund itself. The Derbyshire Infirmary's Saturday fund went to lengths to try and impart a certain image of itself to the wider interested public. It released souvenir booklets to evangelise its message, as well as to publicise and commemorate the efforts of the more senior members of the committee. These were similar to annual reports, and funded by local advertising on their pages, as well as by donations from the senior members of the Saturday fund (often local businessman).[54] It is a clear and explicit record of the actions and determination of the Saturday fund committee members to make the fund a success and grow its remit. Mr A. Greatorex was a key leader in the fund. He was a local businessman, a governor of the institution, a member of the Hospital Board of Management, and a member of the Printers' Managers and Overseers Association which meant he was able to print and distribute the fund booklets.[55] He was the 'Advertisement Contractor' for the fund, and as such, managed to get publicity printed and distributed without having to charge the fund itself for them.[56] He was elected to the Saturday Committee executive in 1925, and was elected as Vice-President from 1928. He also published the humorous magazine 'The Ram-Page', which was sold in aid of the local hospitals in association with Derby Hospital Day.[57] His connections in business and advertising meant the hospital was able to rely on him to engage locally with the commercial sector. Organisation was key, and Saturday funds required lots of organising.

By the early 1930s, the meaning and function of the Saturday fund had all but changed from its original form. Emphasis had moved away from the yearly payments on 'Hospital Saturday' and towards weekly or monthly payments (dependent on salaried or waged workers) collected at source from workplaces, often deducted directly from the workers' wages or salaries. It was a key distinction from the annual subscriptions, which required the payment of a guinea up front, once a year – something that no workers could afford, and had required either falling upon the charity of a subscriber, or had to band together. Significant effort had been put into recruiting workers to enrol in such schemes during the 1920s, with officials holding hustings with employees at their place of work to bolster recruitment. This had been very successful. Yet, as already noted, success could be hindered by economic circumstance. By 1929, the contributions to the Nottingham General Saturday Fund from the collieries in the outlying districts, though contributing as much as £5,330 that year, were stagnating; a concern elicited by William Player himself, when in a speech in 1929 he encouraged contributors not to think the hospital's income was assured.[58] He argued that the 'position of the voluntary hospitals in the future will be more firmly established' as a result of the efforts of such organised funds.

---

[53] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', *Midland History*, 37:1 (2012) p.90.
[54] Most pages in the booklets contain advertisements from local businesses and organisations – in fact, the booklets would be half their size if they did not contain such a quantity. See Appendix A for examples.
[55] DRI Saturday Committee Souvenir Booklet, 1927.
[56] DRI Saturday Committee Souvenir Booklet, 1927.
[57] Derbyshire Royal Infirmary Saturday Committee Souvenir Booklet, 1928.
[58] 'City Hospital Support. The Saturday Fund Thousands. Mr W G Player. A Warm Speech Of Appreciation', *Nottingham Journal,* 2 December 1929.

Economic uncertainty meant that the Nottingham General Saturday fund committee had to constantly innovate to reach a wider audience through, for example, the local media.[59] It was a success, drawing in contributions from 'new firms' around the city, as well as extra fundraising efforts by friends at the Notts County and Nottingham Forest Football Clubs, and the Mechanics Institute Amateur Operatic Society which amounted to £758.[60] As a result, the hospital had a very successful year in 1929. Although the committee was successful in spreading the hospital cause within Nottinghamshire civil society, it must not be forgotten that at its heart the Saturday fund was a quasi-health-insurance fund, giving nominal coverage to participants.[61] Beveridge and Wells found that for most workers that were members of such a scheme, the democratic and ethical aspect of the funds was of no great interest; attendance at fund management meetings were low.[62] Instead, the aims for the individual fund members was pragmatic: being in the scheme brought peace of mind to the individual and their family. In this sense, notions of belonging to a broader hospital community were secondary, but the overt public image of the Saturday fund as garnering interest from all workers in the community meant that self-interest coalesced with a sense of community-interest.

Gorsky, Mohan and Willis point out that between 1926-36 some hospitals were receiving over 60% of their income from mass contribution on a regular basis.[63] It would suggest that balance was required – all efforts should not be put into the mass schemes, because without the smaller elements of the income, the mass schemes were not able to (nor were they meant to) support the hospitals on their own. For example, Sheffield Infirmary and Sheffield Royal both benefited significantly from one of the biggest and most efficient contribution schemes in the country, yet, as Hayes and Doyle have shown, both ran chronic deficits because of the decline in income from other sources.[64] By 1928 Chesterfield Hospital had managed to clear its cumulative deficit and repay the loans incurred building its new ear, nose and throat department which opened in early 1928.[65] Success here, however, depended on the moneys raised by the carnival and other fundraising committees which made special efforts in the last few years to try and raise lump sums that would ensure the hospital was able to clear its substantial debts.[66] The 'Shilling Fund' was especially successful, where volunteers managed to collect over £1,900 by selling 36,000 individual tickets for the prize draws.[67] An anonymous donor, who had already gifted £1,000 for the endowment of a bed in 1926, offered up a further £3,000 for general

[59] 'More For Hospital? Nottingham Saturday Fund Forecast', *Nottingham Journal,* 24 November 1927.
[60] 'Hospital Finance. New Firms Counter-balance Miners' Lower Contributions', *Nottingham Journal,* 29 November 1929.
[61] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.117, pp.149-51.
[62] William Henry Beveridge, A F Wells, *The evidence for voluntary action: being memoranda by organisations and individuals and other material relevant to voluntary action*, (George Allen and Unwin: London, 1949) p.18, pp.76-77., pp.80-86.
[63] Gorsky, Mohan, Willis, *Mutualism and health care* (Manchester University Press: Manchester, 2006) pp.60-61.
[64] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) pp.717-719.
[65] Chesterfield and North Derbyshire Royal Hospital Annual Report 1928.; Chesterfield and North Derbyshire Royal Hospital Annual Report 1929.
[66] Chesterfield and North Derbyshire Royal Hospital Annual Report 1928.
[67] 'Chesterfield Hospital. Success of Shilling Fund.', *Derbyshire Times and Chesterfield Herald,* 3 March 1928.

purposes.[68] So, Chesterfield's financial stability in this period was a result of conscious efforts and unexpected windfall, and not necessarily from its burgeoning mutualist scheme.

Mansfield District General Hospital, Chesterfield's junior neighbour to the east in Nottinghamshire, struck a better balance. It had very close associations with the local collieries and colliery workers, encompassing large swathes of northern Nottinghamshire within its geographical remit. As far back as 1903, the hospital adopted the Chesterfield model of splitting the hospital's catchment into regions, and set up a network of working men's delegates to boost financial income and their connection to their outlying areas.[69] By 1927-8, a zenith was reached, with 14 colliery companies and 26 colliery locations' workmen contributing to the scheme.[70] The Mansfield and District Saturday Fund, which was absent of colliers and seemingly for all other professions, gave £1,876, with employees from banks, printers, trades, quarries, textile mills, and the town corporation.[71]

Table 4.5: Mansfield Colliery, Colliery Workers, and Saturday Fund incomes, 1927-33.

Year	Colliery Company Subscriptions	No. of Colliery Companies	Colliery Workman's Subscriptions	No. of Colliery Workman's Locations	Hospital Saturday Fund/Worker's Subscriptions	Total Ordinary Income
1927	1632	14	8616	25	1524	13458
1928	2177	11	7729	26	1876	13304
1929	1552	7	7440	24	1973	12671
1930	2045	8	7461	23	1885	13072
1931	1567	8	6724	24	1924	12181
1932	1644	9	6725	23	1464	11797
1933	1496	9	6332	25	2378	11881

The number of colliery companies reduces, but without an accompanying reduction in income from that category. This is likely as a result of the amalgamations under the 1930s Coal Mines Acts, wherein there were 58 large mergers between colliery companies in Britain between 1926 and 1936, involving workforces of 376,460 men.[72] It was a change in the fabric of the mining landscape, and it meant that it was easier for the hospital to get subscriptions and contributions from owners and workers alike, because fewer colliery companies had to be targeted for acquiring a subscription, and with the companies now connected, it was easier to evangelise the hospitals' cause across a larger workforce. The subscriptions from Colliery workmen was previously stable (apart from 1926), but declined some ten per cent following 1929, and throughout the 1930s never approach those highs of the years immediately preceding the crash, once again revealing the strain that the 'Slump' put on the finances of contributors to the hospital. In 1931, the Hospital Saturday Fund changed its name to the 'Worker's Subscriptions', still collected via the workplace, but focussed on a broader

[68] 'Chesterfield Hospital. Success of Shilling Fund.', *Derbyshire Times and Chesterfield Herald,* 3 March 1928.
[69] 'Mansfield and District Hospital Following Chesterfield's Example', *Derbyshire Times and Chesterfield Herald*, 21 November 1903.
[70] Mansfield District Hospital Annual Report 1926.
[71] Mansfield District Hospital Annual Report 1926.
[72] Trevor Boyns, 'Strategic Repsonses to Foreign Competition: The British Coal Industry and the 1930 Coal Mines Act, *Business History*, 32:3 (1990) pp.133-136.

spectrum of employees, in an attempt to refresh the roster of firms associated with the hospital. While it worked to increase the income from non-colliers marginally (by roughly £100), it did not take the big enough step to ensure the hospital was free from deficits.

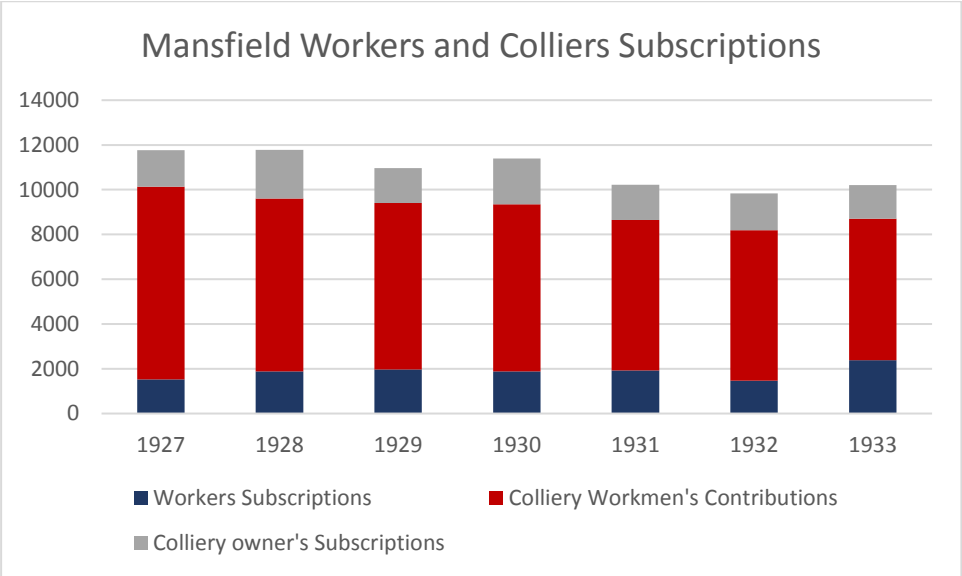
By 1931, Mansfield hospital had run a deficit on the maintenance account for three years straight, a concern for which the board of management had no ready answer, and in fact were considering the closure of a ward to try and reign expenditures in. They had already exercised economies, reduced expenditure on provisions (mostly thanks to the reduction in food prices) and still they found the income unable to match up with the total expenditure. By 1932, the general workers subscriptions had dropped by £460 on the previous year. Luckily this was ameliorated by a very successful carnival effort in 1931; and an endowment of £5,000 handed to the hospital for the furnishing of its wards and facilities by the Miners' Welfare Committee. It was an uncommon example of a large working-class-led philanthropic donation, which succeeded in bringing the finances to balance that year and allowing the expansion of much needed facilities like the X-Ray Department, that would have otherwise not been possible. As a percentage of total income, the colliery worker's subscriptions fell from 64% in 1927 down to 53% in 1933. Subsequently, while colliery company subscriptions remain static as a proportion of total hospital income, the Saturday Fund grew steadily. Taken together, the income from colliery owners and the two workers subscriptions accounted for some 89% of the hospital's total income in 1928, the year before depression struck, and still 86% in 1933.

Table 4.6: Mansfield Hospital Colliery and Worker Subscription Percentages 1927-33.

Year	Colliery Company Subscriptions	Colliery Worker Subscriptions	Saturday Fund	Total Percentage
1927	12.1	64	11.3	87.4
1928	16.4	58.1	14.1	88.6
1929	12.2	58.7	15.6	86.5
1930	15.6	57.1	14.4	87.1
1931	12.9	55.2	15.8	83.9
1932	13.9	57	12.4	83.3
1933	12.6	53.3	20	85.9

So what do these patterns say? It would appear that the Colliery Company and Colliery Worker's Subscriptions do not remain competitive, and although they still bring in the lion's share of cash, they are not on a steady increase like the Worker's Subscriptions. This graph shows how the Hospital Saturday Fund roughly equals the supplementary donations of the colliery companies, and to what extent the donations from the colliery workers themselves dwarfs the other two incomes.

Graph 4.1: Mansfield Hospital Colliery and Saturday Funds 1927-33.



Graph 4.1 Indicates the state of trade had a significant impact on hospital income from these sources, and particularly from pit worker subscriptions, even though it still brought in the majority of the cash. General worker subscriptions, by contrast, rose steadily in the 1930s. The colliery companies were 'passive' in their subscriptions, in that they did not proactively increase – or likewise decrease - their donations as the other funds fluctuated. Attempts to tie the colliery owner's subscriptions to a certain percentage of colliery employee contributions largely failed. This combination of static donations and shrinking mutualist incomes posed significant problems for Mansfield Hospital which saw it run consistent annual deficits on its maintenance account through the early to mid-1930s. It illustrates how important it became for the hospitals to diversify their income and reach ever more potential donors. Unemployment, as well as the physically limited amount of men available to subscribe within the local mining industry, may account for the lack of growth from that particular income. Were the Saturday fund not reformed in 1931 to broaden the definitions of those who could pay in to the scheme, the hospital may have experienced a sluggish decade relying on just the colliery worker's subscriptions.[73]

Separate statistics are given about the number of accidents and operations that were treated from the Collieries over the year.[74] Table 4.7 indicates the number and proportions of patients that came from the Collieries.

[73] Mansfield and District Hospital Annual Report 1931.
[74] Mansfield District Hospital Annual Report(s) Passim

Table 4.7: Mansfield Hospital Patient Cases, 1925-1935

Year	Accidents	Days in Hospital due to Accidents	Medical and Operations	Days in Hospital due to Medical and Operations	Dependent admissions	Miners and miners' dependents as a % of total patients
1925	241	4469	247	4575	551	65.8
1930	314	5863	388	5598	610	54
1935	356	5785	360	6064	421	52

The Hospital was dealing with more and more patients going into the 1930s. 1930 saw a peak of the amount of time inpatients spent in the hospital, as well as the amount of admissions of dependents. Miners fall from being 65% of patients to 52%; in line with the marginal increases in workers subscriptions and the hospitals' drive to recruit more individual contributors. However, patient payments remain low, only peaking at £360 in 1933, and its calendar of single fundraising events was still quite sparse.[75] The total income from single fundraising events for 1931 was only £510.[76] It indicates that the hospital's efforts at evangelising the mass schemes to the broader community, and not just the miners that made up the single largest employer, was working successfully. However, what was clear was that the hospital was still focussed on providing its services for the working classes, rather than opening up the avenue (as some other medium- and small-sized hospitals did) of larger numbers of paying patients, who were usually from the middle classes.

As observed in the last chapter, Worksop Hospital and Newark Hospital were two similar sized hospitals, overseeing similar sized but very different communities.[77] Worksop was surrounded by many coalmining communities, sitting equidistant from Mansfield and Sheffield, whereas Newark, which was a medium sized urban centre, was surrounded by the Nottinghamshire and Lincolnshire farmlands. Both had quite similar problems, relating to their own endeavours into mass subscription/contribution schemes. By 1928, concerns were raised in Worksop over the hospital's ability to sustain its services. They stated that: 'the trade depression, of which was made last year, has still hovered over the district, making the work of raising the necessary funds increasingly difficult'.[78] Rising expenditure and difficulties with income, as well as the erection of an expensive war memorial, meant a debt of £1,064 was owing at the bank.[79] When the whole annual income for the hospital was only £3,589, it was a significant debt to hold. Furthermore, the hospital was in desperate need of extensions – more beds were required not only to keep pace with the demands of the ever increasing body of patients, but also comply to the recommendations of the General Nursing Council requiring that one third of beds be set specifically for medical cases (as opposed to surgical).[80] Without this, it was at risk

[75] Mansfield and District Hospital Annual Report 1933.
[76] Mansfield and District Hospital Annual Report 1931.
[77] *Marketing Survey 1938,* p.382. Worksop Town Population: 27,800, Newark Town and Rural District Population: 29,556.
[78] Worksop Victoria Memorial Hospital Annual Report 1928.
[79] Worksop Victoria Memorial Hospital Annual Report 1928.
[80] Worksop Victoria Memorial Hospital Annual Report 1928.

of not being able to train nurses adequately or in a nationally recognised fashion. Hope was tagged onto its burgeoning Penny-in-the-Pound Scheme, which in spite of the 'distress in industry' had managed to increase income. However, after this point, the hospital struggled to maintain any growth in the Penny Scheme until 1933. From 1929 to 1932, the scheme only manages to accumulate some £2,300 per annum, far from the high hopes they had that the scheme might save the hospital from the struggles it was experiencing.[81] The reason for this is two-fold. First, that unemployment around Worksop was relatively high, a state that remained the same throughout the 1930s.[82] Secondly, they failed to adequately advertise and evangelise the penny-in-the-pound scheme until 1933, wherein it started to utilise its modest army of volunteers to organise a carnival, which among other things, advertised the existence of the scheme.[83] Prior to that, the hospital had relied on word-of-mouth.

Newark started the new year in 1928 with the completion of alterations begun in mid-1927. Its wards were expanded, and it built a new waiting hall, dispensary, casualty theatre, X-ray room, and ultraviolet and radiant heat facilities.[84] As welcome as this expansion in facilities was, there seemed to be pangs of regret at the cost of over £4,500, which was far more than they originally envisaged. This had to be covered by the sale of invested capital at prices 'much below' the original cost because, unlike other hospitals, it failed to launch a special buildings appeal; or to organise enough large-scale fundraising efforts, as well as the fact that they had incorrectly budgeted for the cost of alterations.[85] The lack of a tradition of community fundraising meant that they lost a large section of their capital investment, but the liquidation of assets at least meant they avoided a heavy overdraft and subsequent debts at the bank. All told, they were in a favourable position, with a newly extended and renovated hospital, free of debt, even if their capital assets were diminised. Newark's 'Workmen's Voluntary Levy' – a contributory workplace subscription similar to Chesterfield's Working Men's Subscription – was also lacklustre. From 1929 to 1932 income from the Levy dropped by £300, and only started to rise significantly again in 1934.[86] Newark's unemployment rate in town and rural district was only about 5%. Lower than most areas in Nottinghamshire, including Nottingham itself.[87] The difficulty lay more in the disparate nature of local industry, and in the lack of payment-scheme recruitment in the farming community. In many ways, Newark's district was not well suited to a mass scheme, because administering to the far-removed workplaces was very labour intensive and each individual workplace did not yield very high contributions – quite unlike the collieries or workshops that might employ fifty or more men. Annual

[81] Worksop Victoria Memorial Hospital Annual Report 1929; Worksop Victoria Memorial Hospital Annual Report 1930; Worksop Victoria Memorial Hospital Annual Report 1932; Worksop Victoria Memorial Hospital Annual Report 1933.
[82] *Marketing Survey 1938*, p.382.
[83] Worksop Victoria Memorial Hospital Annual Report 1933.
[84] Newark and District Hospital Annual Report 1928.
[85] Newark and District Hospital Annual Report 1928
[86] Newark and District Hospital Annual Report 1929; Newark and District Hospital Annual Report 1930; Newark and District Hospital Annual Report 1931; Newark and District Hospital Annual Report 1932; Newark and District Hospital Annual Report 1933; Newark and District Hospital Annual Report 1934.
[87] *Marketing Survey 1938*, p.382.

subscription levels were also weak, though they were higher in Newark than Worksop, which only managed to sustain a couple of hundred pounds per annum[88]

Disruption in income streams caused by industrial dislocation and distress was also very evident in Chesterfield, which had a large hinterland of heavy industries, but was varied enough to allow for regional decline. Where one region occupied with a struggling industry might bring in a lower income in one year, other regions were able to compensate this loss. For example, if one charts the progress of Pilsley & Tibshelf, the district most dominated by mining, there is a decline in subscriptions from 1927 to 1934 of roughly £400. Conversely, Sheepbridge which had not just mining but ironworks and potteries, as well as a plethora of other, smaller firms subscribing, actually increased its income by roughly £400 over this period. Chesterfield district was particularly successful, growing its working men's subscriptions by roughly £1,000 from 1927-1934. The regional system really helps to show how the impact of industrial downturn or stagnation (i.e. mining) affected the hospital finances. The scheme's ultimate strength was diversity; that although the mineworkers were at the heart and soul of the Chesterfield Hospital, the fact that they had so many other different industries and firms subscribing meant that their scheme was able to grow even in a time of economic slump. It confirms Hayes and Doyle's assertion that diversification was the root of success for the hospitals, though not just by diversifying over different types of income (traditional versus mutualist) but diversifying within mutualist schemes.

Carnivals and Community in straitened times

As John Stevenson rightly notes, the 'most obvious feature of leisure activity between the war was its growth', and commercialised and standardised leisure activity became the norm within a society whose thirst for leisure only increased.[89] The interwar period was also the high-water mark of popularist charitable fund-raising activities: whist drives, bazaars, galas, rag days and other public displays and activities.[90] So how did such activities fair in times of economic distress? In times of hardship, the hospitals and their organising volunteers had to make the hospitals sites of hope, vibrancy, and activity, so as to attract people to the cause. The Derby Hospital Day continued to expand, becoming ever more creative and vibrant. There were nineteen classes alone for the fancy dress competition parade, and 'Zulus', 'Dutchmen', 'merry pierrots', and 'Arabian Knights' were among the group entrants, illustrating a proclivity for 'exotic' (racial) depictions.[91] The parade contained more than a dozen entry categories: 'artistic vehicles, comic vehicles, artistic cycles, comic cycles, hand propelled vehicles (including prams), men's artistic walking costume, mens comic walking costume, women's artistic walking costume, women's comic walking costume, couples artistic walking costume, couples comic

[88] Worksop Victoria Hospital Annual Report 1932.
[89] Stevenson, *British Society 1914-45*, p.401.
[90] Hayes and Doyle, 'Eggs, rags and whist drives', p.714., p.724.
[91] 'Derby En Fete. Carnival Day as Thank Offering for King's Recovery. Invading Crowds', *Derbyshire Advertiser and Journal*, 12 July 1929.

walking costume, each of which had individual, group, and juvenile prizes'.[92] Even in these difficult times, the voluntary spirit was kept alive by the social aspect of hospital fundraising. In a throwback to pre-war times, a large bazaar was held to help finance the construction of the new nurses home at the Derbyshire Infirmary, attended by the High Sheriff of Derbyshire and the Marchioness of Hartington.[93] 1929 showed a record income of £3,145, all but £54 (reserved for expenses) of which was passed on to the hospital and associated charities.[94] 1931 set another record, with £3,110 donated to the Hospital Day Committee.[95] This signifies the robustness of community fundraising even at times of significant economic uncertainty, at a time when other modes of hospital income were struggling to grow and some fell into decline. Thus the landscape of large-scale hospital fundraising was not as dour and downtrodden as the wider economic situation might suggest. At one level, it was much easier for people to throw a penny in a collection bucket on hospital day than it was to set up a subscription or enter into a weekly contribution, especially when the employment situation was so unstable for so many. Yet it also demonstrates a community attachment to, and an identification with, the hospital cause. Perhaps, too, people just wanted a little fun.

Worksop Hospital similarly saw a spike in donations and from entertainments between 1929 and 1930, doubling the 1928 figures.[96] Other more passive activities had mixed success. Cash donations were strong, but donations in kind struggled. In Worksop, Box collections saw a small increase, but donations to the hospital's Pound Day fell, a trend which continued into the 1930s.[97] Pound Day was, in many ways, not an activity suited to times of economic hardship. Where previously even the poorer people might have donated some bits of food or linen, they were now far less able to do this. This was at a time when Worksop's other voluntary efforts were growing steadily, including their working men's subscription scheme, which took a significant jump in 1929 of £515.[98] However, the rise in cash donations was mirrored in the large institutions. Nottingham General saw an increase of £1,232 in general donations from 1928 to 1930, an increase that sustained until 1935 when the total shot up another £1,600 on its previous year.[99] Derbyshire Infirmary's increases were smaller, climbing from £763 in 1928, to £978 in 1931 and a high of £1,057 in 1933.[100] Box collections for Derbyshire Infirmary remained stable, with small increases and decreases of ten and twenty pounds a year.[101] But overall, donations achieved a temporary high through the tough period. Derby's Special Appeal (in aid of specific building works

[92] 'Derby En Fete. Carnival Day as Thank Offering for King's Recovery. Invading Crowds', *Derbyshire Advertiser and Journal*, 12 July 1929.
[93] Derbyshire Royal Infirmary Annual Report 1930.
[94] 'A Wonderful Year. Reported by Derby Hospital Day Committee. Record Sum Raised.', *Derbyshire Advertiser and Journal*, 29 March 1929.; 'Decrease in Funds. Derby Hospital Day Sports Committee Report.', *Derbyshire Advertiser and Journal*, 23 May 1930.
[95] 'Derby Hospital Day. £3,110 Allocated By Committee.', *Derby Daily Telegraph*, 31 January 1931.
[96] Worksop Victoria Hospital Annual Reports 1928-1930. Donations: 1928 £102, 1929 £201, 1930 £188. Entertainments: 1928 £22, 1929 £51, 1930 £43.
[97] Worksop Victoria Hospital Annual Reports 1928-1936. Boxes: 1928 £20, 1929 £30, 1930 £28. Pound Day: 1928 £32, 1929 £28, 1930 £27.
[98] Worksop Victoria Hospital Annual Reports 1928-1932.
[99] Nottingham General Annual Reports 1928-1936.
[100] Derbyshire Royal Infirmary Annual Reports 1928-1933.
[101] Derbyshire Royal Infirmary Annual Report 1927-1933.

or equipping wards) took a minor reduction of £250 in 1929, but then gained a further £629 in 1930, and managed to maintain increases well into the nineteen-thirties.[102] The aforementioned bazaar in Derby raised £1,234, really quite a small amount considering that eight years previously a bazaar in Nottingham, for the similar purpose of furnishing a nurses home, managed to raise £6,835[103]

The women collectors from the Mayoress of Derby Ladies' Committee had success in 1929, when they made extra efforts with their collections by going around different businesses, most notably the city's newspaper offices and other printing firms, as well as conducting extra collections at the hospital's whist drives, and the Hospital Day.[104] It was at its most successful in the 1920s, and introduced the organisation of Whist and Bridge Drives throughout the year to supplement funds.[105] They raised £147 in 1929, when usually they raised just under £100. This was a small total when compared to other fundraising events, but the volunteers in the committee were doing what they could to 'relieve the institution of financial embarrassment', and in doing so became a physical presence of the hospital out in the community.[106] Although this form of canvass was derided by the Mayor on the occasion of the first Hospital Day, it nonetheless was very effective during the 1920s and early 1930s at linking people to the hospital on a permanent level, rather than just once a year when the collectors came around.[107] It was strenuous work, and many elderly women had to retire from the committee when they found they were no longer physically able to participate.[108] Hospital supporters, even in times when they had less money for themselves and their families, were still putting their hands in their pockets and offering up money.

Captain Stone's 1927 review of hospital administration took a generally unenthusiastic view of the broader strokes of hospital fundraising via carnivals and entertainments, because he saw them as fleeting and unreliable. Stone was an experienced hospital administrator, and a renowned expert on hospitals in his own time, having been chief accountant at St Thomas's Hospital in London and secretary of the Birmingham Hospitals Centre.[109] Like many of his contemporaries and historians such as Du Plat Taylor, Coleridge, & Abraham and Titmuss, he saw the dwarfing of the 'traditional' incomes as reason enough to discount them.[110] However, he himself points out that donations, fetes, bazaars, carnivals, parades, appeals, street collections, and all other forms of active 'spasmodic' fundraising 'augmented' the incomes of the hospitals, without ever

[102] Derbyshire Royal Infirmary Annual Report 1929, 1930, 1926. 1926 showed quite a large increase in this fund at £544, which was not matched until 1930.
[103] Derbyshire Royal Infirmary Annual Report 1930; Nottingham General Hospital Annual Report 1922.
[104] Mayoress of Derby's Ladies Committee Minutes 15 April 1929.
[105] Mayoress of Derby Ladies Committee Minutes, October 1928. This seems to the be the first time that a Whist Drive is recorded – for the Nurses' Home Extension. Every year subsequent, there are small amounts of cash raised for the hospital via Whist Drives.
[106] Mayoress of Derby Ladies Committee Minutes, May 1924
[107] '£5,000 Day. Big Appeal for Derby Hospitals. New Scheme Founded.', *Derby Daily Telegraph*, 4 September 1920.
[108] Mayoress of Derby Ladies Committee Minutes, November 1934.
[109] F K Prochaska, *Philanthropy and the Hospitals of London The King's Fund 1897-1900* (Clarendon Press: Oxford, 1992) p.143.
[110] Major Du-Plat-Taylor, John Coleridge, Dr J J Abraham, *Cottage Hospitals,* (Ernest Benn Limited: London, 1930) p.12., pp.19-22.

providing 'real' sustenance for the hospitals.[111] Stone failed to see that augmentation of incomes was just as vital in keeping the hospitals afloat. PEP were equally sceptical, asserting that hospitals 'have to waste much time and energy' on appeals and fundraising, a statement which ignored the intrinsic link that these activities had to the very nature of the voluntary hospitals.[112] Without this augmentation the hospitals would have struggled considerably – in fact, places like Chesterfield, that neglected fundraising, did struggle. Even proponents of smaller hospitals, caught up with the new vogue of mutualism, were encouraging the development or inclusion of a contributory scheme so as to make obsolete the need for lacklustre subscriptions and unreliable fundraisers.[113] It is fortunate that the hospitals themselves were not so ready to abandon their traditional incomes. Without this 'augmentation', the hospitals (especially those like Chesterfield and Mansfield who were existing quite close to the line) would have been in debt far more than they were. Indeed, the whole financial landscape of the voluntary hospital system around Nottinghamshire and Derbyshire would be far less picturesque. Without these smaller slivers of income, the contributory and Saturday funds would not have been able to carry hospitals just on their own. Again, these events were an opportunity for the local people to cement their relationship with their hospital, solidifying the common bonds that joined a hospital to its community.

At a time of acute economic uncertainty and disruption, and of widespread social hardship, the hospitals were able to maintain their incomes with only minimal fluctuations or reductions. Luckily, costs did not increase at the rate they did during the Great War or the economic crisis of the early 1920s, although cost per patient and per bed did continue to rise. There were some fluctuations in such things as fundraising, entertainments, and other more staple elements such as subscriptions and Saturday funds, but there was a more stable trend upwards. Nottingham General, already forging ahead with its Saturday Fund at the beginning of the 1920s, had consolidating its scheme while maintaining its other traditional incomes. Most other hospitals in the two counties, however, started to turn to the security and broad appeal of the mass schemes, although Derbyshire Infirmary did so without seeing the need to preserve the 'augmentative' but old-fashioned annual subscriptions. Chesterfield Hospital was still failing to see that it could not rely solely on its working men's subscriptions for stable finances; it needed supplementing if it was to avoid the chronic deficits of the early 1920s. Mansfield Hospital, though it managed to bounce back from the crash in income in 1926, also did not seem to learn this lesson, instead desperately trying to regain what it felt was a previously secure footing with the miner's subscriptions. It was a silver bullet fallacy, which goaded hospitals into following a singular, seemingly ideal, target, but which actually meant they were on less secure financial footing.

It must be remembered, however, that the impact of the depression fell unequally. Areas around Chesterfield and Mansfield felt the economic downturn far more than the towns themselves, and as a result the voluntary hospitals were at risk of being dragged down by the poor coal trade and the underemployment and unemployment tied up with this. However, by spreading the risk throughout their communities, and tapping

[111] Stone, *Hospital Organisation and Management,* p.202.
[112] Hayes, Doyle, 'Eggs, Rags, and Whist Drives', p.74.
[113] Du Plat Taylor, Coleridge, Abraham, *Cottage Hospitals,* pp.23-25.

into a more varied field of occupations rather than just mineworkers, the hospitals in the north of the counties were able to remain at least fairly buoyant and avoid slipping into serious, overwhelming debt. Aside from the noticeable economic and social disparities apparent even in a relatively confined area such as Nottinghamshire and Derbyshire, there were noticeable differences, too, in the resilience or otherwise of different types of fundraising activity. It appears that charitable donations in a time of hardship increased, even when direct payments from workplaces were sluggish. Large-scale fundraising events were just as popular, providing distraction for ordinary people in an otherwise dour time. Overall, while this was a difficult period for the nation, the voluntary hospitals fared well, considering the potential obstacles to success. They were able to modestly grow, both physically and financially, and in the few incomes that were affected by the downturn in the economy, the damage was not so extreme as to cause deep problems.

Chapter 5: 1933-1939 – 'Be Wise – Contributise!'. Unemployment, entitlement, and organisation in the voluntary hospitals

Gorsky, Mohan, and Willis have countered Titmuss and Abel-Smith's claims that the voluntary hospital services were poorly run, poorly funded, and behaved poorly, asserting that there is ample evidence to suggest a vital and growing economy around the voluntary hospitals that cannot be discounted. The majority of evidence for these arguments is rooted in the 'Devil's Decade' – the 1930s. It was a decade of privation, hunger strikes, the Jarrow Crusade, a scandalous abdication, and pitched battles between communist and fascist parties. However, in spite of these events, there were far fewer strikes than in the previous decade, and was a shift away from the immediate economic flashpoints of the 1920s.[1] Indeed, for many in parts of the country, the 1930s marked the beginnings of what would later be labelled a consumer society: a 'New England' of 'giant cinemas and dance-halls and cafes, bungalows with tiny garages, cocktail bars, Woolworths, motor-coaches, wireless, hiking, factory girls looking like actresses'.[2] For some, especially in the south and parts of the midlands, the 1930s marked the beginning of the 'dawn of affluence', noticeably removed from the miseries of industrial depression and mass unemployment.[3] This was the 'age of the dream palace', with new forms of mass entertainment and cultural consumption, all of which potentially impacted on the ways in which hospitals might likely use to fund their activities.[4]

As Webster notes when reviewing the Medical Officer of Health returns to the Ministry of Health on infant death rates, whilst the national average death rate was slowly declining, there were still significant regional variations within England and Wales.[5] Stevenson and Cook, though more optimistic than Webster over the degree to which the 1930s was defined by grinding poverty, were nonetheless cognisant of the struggles of the poorer population. Citing Seebohm Rowntree's studies of York, they note too that certain groups were more likely to experience extreme poverty: the unemployed, the elderly, and the chronically sick.[6] As they indicated, these groups were often in a

[1] John Stevenson, *British Society 1914-1945*, (Penguin Books Ltd: London, 1984). P.197.
[2] J B Priestley, *English Journey* (Heinemann: London, 1934). p.401.
[3] Stevenson, John, Cook, Chris, *The Slump Society and Politics During the* Depression (Quartet Books Ltd: London, 1979). pp.8-30.
[4] Jeffrey Richards, *The Age of the Dream Palace: Cinema and Society in Britain 1930-1939* (Routledge and Kegan Paul: London, 1984). pp.7-15.
[5] Charles Webster, 'Healthy or Hungry Thirties?', *History Workshop Journal,* 13 (1982) pp.117-118.
[6] John Stevenson and Chris Cook, *Britain in the Depression Society and Politics 1929-1939* (Longman: London, 1994) p.43., pp.45-50.

state of poverty that allowed no spare money for paying into unions or sick clubs, and likely could not afford hospital schemes either.[7]

As discussed in previous chapters, what defined the coal industry in Derbyshire and Nottinghamshire just as much as wholesale unemployment was chronic 'underemployment'. Colin Griffin's study found that the average number of days per week that coal was wound in North Derbyshire and Nottinghamshire by 1933 was roughly two days less than that in 1923.[8] This obviously impacted the pay packets that the mineworkers brought home, and Griffin argues that this in some circumstances caused acute poverty in households, often at times worse than those conditions felt in the 'Distressed Areas' that received so much more attention from contemporary commentators and subsequent historians.[9] The unemployment rates for Derbyshire and Nottinghamshire after 1933 sit at, or just below, the national average, but these figures don't capture accurately the true social problem. There was great disparity throughout the two counties, and while mineworking was as much a staple industry for Nottinghamshire and Derbyshire as it was for the nation, there were many other industries that the people of the two counties were occupied in by the mid-1930s. The two counties had very similar employment demographics: Of the top five employers, Derbyshire had (in order) mining, metals and machining, commerce and finance, transport and communication, and textiles. Nottinghamshire was the same, save for the fact that its commerce and finance sector was larger than its metals and machining.[10] For female employment, in both counties the largest employers were textiles, personal service, and finance and commerce, though Nottinghamshire employed far more women in clothing, and food, drink, and tobacco manufacture.[11] Questions will be asked as to the extent that unemployment in certain areas affected the hospitals that dealt with those areas, and how growing forms of mutualist payment schemes were potentially hampered by their members being out of work.

The historical focus on hospitals has lain with this period primarily because many hospitals by this time had established some form of mutualist-type fund, refining their schemes and gaining larger percentages of their income from mutualist funds. The 1930s broadly saw the different hospitals start to operate in similar ways, and administrate along standardised lines. Gorsky, Mohan, and

[7] Stevenson and Cook, *Britain in the Depression*, p.41.
[8] Colin P Griffin, "Three Days Down the Pit and Three Days Play": Underemployment in the East Midlands Coalfields between the Wars, *International Review of Social History*, 38 (1993) pp.324.
[9] Griffin, "Three Days Down the Pit and Three Days Play" p.329.
[10] 'Industrial Order (1931) by Sex', Vision of Britain, http://www.visionofbritain.org.uk/unit/10061428/cube/IND_ORDER_1931_SEX; http://www.visionofbritain.org.uk/unit/10025035/cube/IND_ORDER_1931_SEX.
[11] 'Industrial Order (1931) by Sex', Vision of Britain, http://www.visionofbritain.org.uk/unit/10061428/cube/IND_ORDER_1931_SEX; http://www.visionofbritain.org.uk/unit/10025035/cube/IND_ORDER_1931_SEX.

Powell point out that the 1930s were not a time of crisis for the hospitals, but of growing levels of stability afforded by steadily growing income and new relationships between patient and hospital.[12] As a result, the 1930s were a microcosm of near-stability the likes of which the nation had not seen since before the Great War. Only at the end of the decade, it is suggested, did the problem of hospital finances, and then primarily London teaching hospital funding, become a potentially major issue.[13]

This is not to suggest that all were satisfied with the voluntary system. The Socialist Medical Association in 1936, dissatisfied with the duplication of services and lack of communication between institutions and the sectors, called for a 'complete, unified and co-ordinated service'; in essence a centralised national service.[14] The SMA, just like the national Labour Party and many observers on the left, had been calling for more coordinated planning for years, wanting to create a planned and rationalised system of hospitals with less control sitting in the hands of the individual hospital management committees.[15] It left saw the independence of the hospitals as a barrier to progress which only fostered waste and factionalism. Yet local Labour Parties were often more optimistic about their voluntary hospital services. Sheffield's Trades and Labour Council was nominally in favour of municipalisation but saw great benefit in the democratising effect of the penny-in-the-pound scheme that was developed and refined in the 1930s.[16] Through the decade the Labour dominated city council oversaw excellent cooperation between the voluntary and municipal sector. It appears that where the voluntary hospitals were open to cooperation and co-ordination, the left was happy to encourage voluntarism. There was little pressure from councillors – either Labour or Conservative - in Derbyshire and Nottinghamshire for hospitals to rationalise or cooperate. For example, there was little-to-no communication between the Derbyshire Royal Infirmary and the municipal City Hospital (established before 1929 as a purpose-built hospital). The only instance of real cooperation was in the Chesterfield Venereal Diseases clinic, where the Corporation paid Chesterfield Hospital to provide the VD services that the local authority would otherwise have to provide with their own institution (that did not yet exist). It was a one-off effort of expediency on the part of the Corporation, however, rather than the beginning of a pattern of integration.

[12] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review*, 3, (2002) p.535., p.553.
[13] Gorsky, Mohan, Powell, 'The financial health of voluntary hospitals', pp.537-538.
[14] John Stewart, *The Battle for Health. A political history of the Socialist Medical Association, 1930-51* (Ashgate: Aldershot, 1999) p.51.
[15] Stewart, *Battle for Health*, p.51.
[16] Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010) p.383.

This was not an untypical state of affairs for the voluntary and municipal sectors. Different counties had different levels of municipal health coverage, and Powell found that where there was a dearth in one sector, the other sector would likely compensate, the balance usually sitting with the voluntary hospitals for acute medical and surgical services, while local authority held the rest.[17] Gorsky and Mohan point out that in 1938 the voluntary hospitals held only 33% of the nation's hospital beds, the rest sitting in Public Assistance Committee (formerly Poor Law) institutions (20%), isolation hospitals, and municipal general hospitals (the two combined 47%).[18] Coordination between the municipal services and the voluntary services remained low, and only started to converge in certain areas such as Birmingham, Oxford, Liverpool, and Manchester in the early 1930s.[19] However, this only occurred as far as the appetite that local authorities had for expansion – the voluntary hospitals themselves were rarely the instigators of cooperation.[20] Having accumulated the Public Assistance Committee institutions, some local authorities felt little or no need to coordinate with the voluntary services, believing that the services provided by the old Poor Law were adequate and did not need expansion.[21] Indeed, roughly only one half of local authorities chose to appropriate their Poor Law institutions, which further handicapped attempts to rationalise and unify.[22]

Sheffield, which initiated early attempts to meld together public and voluntary provision, was also in the forefront of coordinating a centralised system of patient's payments, which were distributed equitably among the respective institutions. By the end of the decade, Chesterfield hospital was in intense consultation with the Sheffield hospitals committee in trying to establish its own contributory scheme. The schemes typified Gorsky, Mohan, and Willis' identification of the 'shift in entitlement' towards a democratisation of access to hospital services, which, as Cherry notes, offered an increasingly '"non-deferential" approach to hospital provision'.[23] Hayes also found this to be the case with Nottingham, Leeds, and Leicester, each of which had well established Saturday

[17] Martin Powell, 'Hospital Provision before the National Health Service: A Geographical Study of the 1945 Hospital Surveys', *The Society for the Social History of Medicine*, (1992) pp.498-9.
[18] Martin Gorsky, John Mohan, 'Uses of Yearbooks: The Voluntary Hospitals Database', *Social History of Medicine*, 24:2 (2011) p.479.
[19] John Mohan, *Planning, markets and hospitals* (Routledge: London, 2002). P.53.; John V Pickstone, *Medicine and Industrial Society: A history of hospital development in Manchester and its Region, 1752-1946*, (Manchester University Press: Manchester, 1985). pp.272-292.
[20] George Campbell Gosling, '"Open the Other Eye": Payment, Civic Duty and Hospital Contributory Schemes in Bristol, c.1927-1948', *Medical History*, 54 (2010) pp.478-480., p.487.
[21] Julia Neville, 'Explaining Local Authority Choices on Public Hospital Provision in the 1930s: A Public Policy Hypothesis', *Medical History*, 56 (2012) pp.57-58.
[22] Alysa Levene, Martin Powell, and John Stewart, 'Patterns of Municipal Health Expenditure in Interwar England and Wales', *Bulletin of History of Medicine,* 78 (2004), 645.
[23] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006) p.25.; Steven Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *The Society for the Social History of Medicine*, 5:3, (1992) p.467.

funds and a progressive attitude towards funding reform, melding together patient payment with other income streams.[24] Indeed, most of the hospitals were finding their own path onto the mutualist track.

Contemporary leftist commentators such as Allen Hutt identified a shift in general public attitudes towards mutualism, after such a protracted period of difficulty wherein conventional capitalism had not prevented economic disaster and widespread poverty among the working populace.[25] Yet, friendly societies, having had a real heyday before the Great War declined into the 1930s as state provision gradually increased.[26] And as previously noted many people subscribing to friendly societies and their ilk were did so not out of 'fellowship', but simply a necessary desire for good insurance outside of the private sector, where the large commercial providers such as the Prudential were viewed negatively.[27] This was also true of other voluntary organisations, including Saturday funds and hospital contributory schemes.[28] The trades unions were bankrupted from the excessive strike payouts of the 1920s, and were struggling to rationalise their efforts since the government took the step in 1927 of introducing the Trade Disputes and Trade Unions Act, which curbed the ability of the unions to coordinate and galvanize their members.[29] The hospitals remained a pillar of hope in terms of being able to continue to build better systems for ordinary people. The shift in entitlement was also a growth in empowerment. The pennies that an ordinary worker once paid into the workplace hospital subscription were now new entitlements in a direct social (if necessarily legally-binding) contract with the hospital which ownership offered a greater guarantee of admittance if a worker needed medical care. The old 'Sick and Accident' Funds, like those of the Butterley Company, were usually formed under the auspices of the company itself, where the company dictated the terms under which the workman would subscribe (amount, length of subscription before benefit could be drawn), how and when they would be admitted to a hospital (usually at the decision of the foreman, or even the company managers), and how long they were

[24] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013). p.717.
[25] Allen Hutt, The Post-War History of the Working Class, (Victor Gollancz Ltd: London, 1937). p.57.; pp.75-76.
[26] Peter Grant, 'Voluntarism and the impact of the First World War', Matthew Hilton and James McKay, *The Ages of Voluntarism How we got to the Big Society,* (Oxford University Press: Oxford, 2011) p.28.
[27] Steven Fielding, Peter Thompson, Nick Tiratsoo, *"England Arise" The Labour Party and Popular Politics in 1940s Britain* (Manchester University Press: Manchester, 1995) p.127.
[28] Lord Beveridge and A F Wells (eds.) *The Evidence for Voluntary Action* (George Allen and Unwin Ltd: London 1949) pp.74-83.
[29] H A Millis, 'The British Trade Disputes and Trade Unions Act, 1927', *Journal of Political Economy*, 36:3 (Jun 1928) pp.305-6.

entitled to be excused from work and in receipt of sick pay.[30] Now contributory schemes moved away from relying only on workplaces for organisation (though many workers still paid-in to the hospitals via their workplace) and instead shifted the responsibility onto the worker. It meant that individuals were able to decide where to contribute to (rather than just contributing where their workplace contributed to) as long as they had the money to do so. For example, the new Chesterfield contributory scheme emerged, Post Offices in and around Chesterfield utilised as payment-depots, so that all members of the general public were able to sign up for hospital contributions. The only proviso, generally, was that individuals had to earn below the income cap, normally set at the upper end of a skilled wage. This was in contrast to the earlier system, where access was through a ticket via a subscriber, or having to be employed by a company that had decided to organise contributions en-masse.

Mike Savage identifies a 'defensive working-class consciousness', during this period, tied to a 'practical' community-based politics geared towards reducing their material insecurity, which had a strong mutualist component, rather than organising for ideological or moral reasons; essentially that workers were pursuant to a way to procure the things that they needed (better wages, living conditions, healthcare, provisions).[31] Hospital provision, and Saturday funds, despite their workplace based origins, were key components, like friendly societies and the cooperative movements, of a self-help that negated the need for conflict.[32] Indeed, it brought different communities together, increasingly outside of relationships defined by deference and complicity. In fact, class definitions of activity amongst the hospital communities do not easily apply. Rather than 'militant' versus 'deferential', it is more 'active' versus 'passive' that best categorise hospital communities: those that volunteer and innovate, and those that simply use the services available. But even this more nuanced dichotomy does not quite give an accurate picture of what the contributory schemes meant. Although Beveridge and Wells showed that many members of payment schemes and the like were 'passive' insofar as they did not attend meetings or become involved in fundraising, they were still more 'active' in terms of the positive opinions that they held of their local hospitals.[33] The contributory schemes, in a certain sense, made all contributors active participants in hospital

[30] *The Butterley Company, Limited, Butterley Iron Works Near Alfreton Amended Rules & Regulations to be observed by the Surgeons, Foremen, and Others in the Management of the Workmen's Sick and Accident Fund* (S Rowbottom and Son: Alfreton, 1891)
[31] Michael Savage, *The Dynamics of Workng-class Politics The Labour Movement in Preston, 1880-1940* (Cambridge University Press: Cambridge, 1988). pp.1-19.
[32] Eric Hopkins, *Working Class Self-Help in nineteenth Century England* (UCL Press: London, 1995). p.3., pp.53-62.; Eric Hopkins, *A Social History of the English Working Classes 1815-1945* (Hodder & Stoughton: London, 1979) pp.247-8.
[33] Nick Hayes, 'Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948', *English Historical Review*, CXXVII:526 (2012) pp.630-632.

voluntarism, because they enfranchised them into a system that they had a direct hand in, instead of paying into indirect funds or suing for subscriber tickets.

The traditional post-NHS narrative of the voluntary hospitals in the 1930s established by Titmuss and solidified by Abel Smith condemned the voluntary system, perceiving it as inefficient, unsympathetic, and 'morally bankrupt'. Titmuss argued that the initial drive of the Emergency Medical Scheme at the start of the Second World War was 'inevitably' stalled because of the 'confusion and delay' inherent within this existing system. Klein similarly argues that he pre-NHS system was 'irrational', and Eckstein asserted that the chaos of the voluntary system was only highlighted by the conditions of the war.[34] It is certainly that voluntary hospitals were fiercely independent and frequently railed against all attempts at moves towards rationalisation, let alone central organisation, proposed by local authorities, the Socialist Medical Association, the Labour Party, and the Nuffield Provincial Hospitals Trust.[35]

The unique and incredibly strong connections built up between hospitals and their communities has already been noted. It was not a connection that foundered during the 1930s. Indeed, generally Gorsky, Mohan, and Powell found that there was far more financial stability within hospitals than Titmuss and Abel Smith had assumed, and although deficits and debts were a regular occurrence in many hospitals (which was enough for Titmuss to condemn them), these were not necessarily representative of the success or failure of the hospitals both within the voluntary system and as independent healthcare institutions.[36] Theirs is a broad view of the hospitals across the nation, reviewing the voluntary hospital finances comparatively. Many voluntary hospitals operated consecutive years without entering into deficits. In fact, Titmuss' suggestions only apply to a few London hospitals. Most hospitals, by contrast, matched rising overdrafts with rising assets, to which might be added the success of contributory schemes.[37] It is worth noting, too, that fluctuations of surpluses and deficits had existed for years in the voluntary system; it was the nature of the beast in many ways, and not necessarily indicative of a bankrupt or inefficient system. Institutions like the

[34] Titmuss, *Problems of Social Policy*, p.58.; Rudolf Klein, *The Politics of the National Health Service* (Longman: London, 1983). p.3.; Harry Eckstein, *The English Health Service* (Harvard University Press: Cambridge, 1958). pp.86-8.
[35] John Mohan, pp.66-67.; John E Pater, *The Making of the National Health Service*, (King Edward's Hospital Fund for London: London, 1981). P.13.
[36] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', Economic History Review, *Economic History Review*, 3, (2002) pp.535-537.; Titmuss, *Problems of Social Policy,* pp.66-67.
[37] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review*, 3, (2002) pp.533-5, p.537., pp.539-541.; John Mohan and Martin Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001) pp.46-50.

hospitals were looking to innovate new, more stable forms of income that were mutually appealing to both themselves and their prospective patients.

Contributory Schemes

Contributory schemes have frequently been presented as the saviours of the voluntary hospital system, without whom the system would have collapsed. Yet, they were not created in an air of consensus. Many hospital volunteers that were sceptical about the move over from Saturday funds to contributory schemes. Debate over the transfer in Nottingham had rumbled along for almost a decade, and while it did establish a contributory scheme in 1939, it was not without some reluctance from certain members of the old Saturday Fund Executive and board of management of the hospital. R G Hogarth, surgeon, former president of the British Medical Association, and president of the General Hospital was greatly in favour of a contributory scheme, but garnered such resistance from the volunteers of the boards of management that he felt compelled to resign in November 1936.[38] Progress was only truly made two years later, when the wider body of Saturday Fund delegates were exposed to the benefits of a contributory scheme. A consultative meeting in 1938 with Mr Harper, governor and secretary of the Royal Hospital Wolverhampton, and a packed hall of Saturday fund delegates illustrated the advantages of a contributory scheme, and the positive impact it could have on hospital finances.[39] Harper asserted that Wolverhampton struggled with huge deficits until they converted over to a contributory scheme, and that their workpeople's income all but doubled in just the first couple of years of the new scheme.[40] However, he also pointed out, after questioning from the audience of delegates, that the annual hospital carnival had been 'discontinued' since the contributory scheme in Wolverhampton had come into effect – a negative side-effect of the different attitude towards hospital voluntarism.[41] Contributory schemes were seen as a big leap into the unknown for a lot of more traditional-minded hospital volunteers, because they removed the organising power of the workplaces and placed the onus upon individuals. While the benefits were evident in the finances, the transformation it could have on the voluntary hospitals could be huge, and were already occurring in places like Wolverhampton, where the coming of a contributory scheme heralded an instantaneous boost to the finances as the scheme enfranchised more workers

[38] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', *Midland History*, 37:1 (2012) p.99.; Alfred Teeboon, 'The Nottingham and Nottinghamshire Hospital Satruday Fund, 1873-1948', *Transactions of the Thoroton Society*, Vol LXXXIV, (1980) p.71.
[39] Alfred Teeboon, 'The Nottingham and Nottinghamshire Hospital Saturday Fund, 1873-1948', *Transactions of the Thoroton Society*, Vol LXXXIV, (1980) p.71.
[40] 'Contributory Scheme Advocated for Nottingham Hospitals. Crowded Meeting of Saturday Delegates. Wolverhampton Official on "Only Successful Method".' *Nottingham Journal*, 31 October 1938.
[41] 'Contributory Scheme Advocated for Nottingham Hospitals. Crowded Meeting of Saturday Delegates. Wolverhampton Official on "Only Successful Method".' *Nottingham Journal*, 31 October 1938.

than the former Saturday fund. But the 1930s saw a large increase in the number of patients attending the hospitals in Nottinghamshire and Derbyshire, an era when the 'hospital habit' started to become entrenched in civil society, and the utilisation of hospitals went hand-in-hand with growing enfranchisement of workers via Saturday and contributory funds.[42] Essentially, demand was increasing, and had to be met with adequate resources. The following two tables (Table 5.1 and Table 5.2) show at quick glance how the numbers of patients in the Nottinghamshire and Derbyshire voluntary hospitals increased throughout the 1930s.

Table 5.1: Total new in-patients. Nottingham, Derby, Chesterfield, Mansfield, 1928-39.

New In-patients	Nottingham General	Derbyshire Infirmary	Chesterfield Hospital	Mansfield Hospital
1928	6098	5670	2949	1916
1929	6458	6078	2798	2368
1930	6631	6370	2786	2409
1931	6540	6441	2623	2286
1932	6303	6566	2710	2589
1933	6873	6364	2748	2800
1934	7288	6684	3016	2819
1935	7185	6561	3053	2459
1936	7608	6434	3399	2318
1937	7800	6569	3571	2756
1938	8764	6504	4060	3054
1939	9311	6877	4169	3141
Total % growth 1928-38	44	15	38	59

[42] Abel-Smith, *The Hospitals*, p.402.; Gorsky, Mohan, Powell, 'The financial health of voluntary hospitals', pp.554-555.

Table 5.2: Total new out-patients 1928-39. Nottingham, Derby, Chesterfield.[43]

New Out-patients	Nottingham General	Derbyshire Infirmary	Chesterfield Hospital
1928	37834	12095	14119
1929	41452	25538	12658
1930	43190	27188	13932
1931	45019	25492	13958
1932	46707	26174	14070
1933	47643	27113	13993
1934	48384	28373	14469
1935	53527	28589	14466
1936	59144	29595	15725
1937	65195	30583	18078
1938	72092	31138	20186
1939	71634	30220	20273
Total % growth 1928-38	89	150	44

The more 'universalist' structure of the contributory schemes meant that they could drown out other forms of hospital voluntarism. It was almost reminiscent of the anti-nationalisation arguments that Viscount Cave's inquiry found; that to have such large amounts of regular income coming to the hospitals would stifle voluntary innovation and create a disinterested hospital community. This was at heart the product of the changing nature of the relationship between hospital and community, as there developed as expectation of treatment by the contributors, and a removal of the charitable stigma associated with the older hospital finance systems like annual subscriptions.[44]

Nottingham General started work on founding its contributory scheme in 1937, citing the need to keep income competitive against the rapidly expanding expenditure, as well as the desperate need to construct an additional women's ward.[45] The following November, the delegates voted in favour of inaugurating a contributory scheme (after numerous examples of beneficial schemes, especially Wolverhampton, were presented to the committee), and its income by May 1939 (the next year), after just six month of opening up the contributory scheme, showed an increase of £2,034 over the previous Saturday fund income in May 1938.[46] Interest in such a scheme had been introduced as early as 1931, when forward thinking volunteers saw the need for a scheme of contributions rather than donations, but the arguments grew protracted as many were resistant to the potential

[43] No accurate out-patient data recorded by Mansfield Hospital
[44] Hayes, '"Our Hospitals"', pp.87-88.
[45] Nottingham General Hospital Annual Report 1938.
[46] 'Saturday Fund's £2,034 Increase. Great Success of New Contributory Scheme.' *Nottingham Journal,* 16 May 1938.

downsides of a universalist scheme, namely the erosion of the voluntary charitable ethic.[47] However, by 1937 and 1938, attitudes had changed, as had financial circumstances. It was seen, now that the Saturday fund was well-established and well-tested, that they would be able expand its remit: 'by extending the scope of the Hospital Saturday Organisation to include not only employees of the large firms, but employees of the smaller firms and shopkeepers – in fact, all firms who do not contribute to the Saturday Fund'.[48]

Chesterfield was also planning its scheme at the same time as Nottingham, but had a far more protracted planning experience. As early as June 1936 the hospital was discussing income limits and terms of service for a contributory scheme.[49] By 1937, its first rules were published, and the agents for the collection of contribution were already taking money for the scheme.[50] Far more protracted planning went into Chesterfield's shift over to a contributory scheme than in Nottingham. While there was little controversy over the move itself, there was hesitation in opening up the scheme before the hospital had everything in place to facilitate payments. In 1936 a committee was formed to consider key factors that a scheme required.[51] At this early stage, logistics were a key concern. The population centres around Chesterfield were disparate; until this point, the Workmen's Subscription Scheme had relied on hospital committees of workmen that would filter their workplace payments to the hospital. However, with the contributory scheme, they needed to find a way to allow those workers in areas without hospital committees to make payments. The solution (as previously alluded to), proposed in the June 1936 meeting, was to approach the postmasters of the various village and town post offices around North Derbyshire to ask if they would facilitate payments by as-yet unassociated contributors.[52] It was decided in September 1936 that a system of stamp cards should be developed for all contributors, so that those within hospital committees and those who were paying into post offices had the same paperwork and certificates.[53] An advertisement was to be taken out in the *Derbyshire Times*, detailing how workers could contribute and where to do so.[54] An upper income limit for membership was initially set at £300, but enquiries at local companies revealed that numbers of prospective and existing subscribers earned more than this, so the committee decided that they would allow admission to the scheme on an ad-hoc basis. It also encouraged those on higher incomes to contribute their full share annually in advance, rather

[47] 'Contributory Schemes for Hospitals. Ensuring Adequate Finances. Lack of Beds. Sir Robert Bolam in Nottingham', *Nottingham Journal,* 29 April 1931.
[48] Nottingham General Hospital Annual Report 1938.
[49] Chesterfield and North Derbyshire Royal Hospital Sub-Committee Re Contributory Scheme, 30th June 1936.
[50] *The Chesterfield and North Derbyshire Royal Hospital Contributory Scheme,* 1st October 1944.
[51] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, June 1936.
[52] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, June 1936.
[53] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, September 1936.
[54] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, September 1936.

than weekly.[55] In this respect, it meant that the scheme usually had a 'soft' cap on its income limit. Others, such as Mansfield and Nottingham, enforced their income cap more strictly, restricting: '…eligibility…to those whose incomes did not exceed £300 a year and to those eligible for medical benefit under National Health Insurance'.[56] The Chesterfield committee actively sought a homogenous contributory bloc consisting of north Derbyshire and also north Nottinghamshire. In 1937, Mansfield appointed a sub-committee to discuss forming such reciprocal arrangements. [57] This was in advance of becoming a bona fide contributory scheme which finally occurred late in 1939.[58] Similarly to Chesterfield, it had to make the leap straight from a broad subscription scheme to contributory scheme, having never developed a Saturday fund.

Parallel to all these schemes, a Midlands hospitals reciprocal scheme being established, which Mansfield and Chesterfield had joined. Already signed up to the scheme were hospitals from Wakefield, Grantham, Leicester, Manchester and Salford, Newark, Nottingham (Children's, Ear, Nose, and Throat, and Women's), Nuneaton, Pontypool, and Sheffield.[59] Not members, however, were the Nottingham General and Derbyshire Infirmary. By this time, Chesterfield and Mansfield had come to an arrangement about the boundaries of their districts, as well as the level of their responsibilities over patients from those respective districts.[60] But they had yet to enter into such arrangements with the general hospitals in Derby and Nottingham.[61] Chief among the reasons for this was because of the different cost of treating inpatients between the Chesterfield Hospital and the Derbyshire Infirmary and Nottingham General. The Derbyshire Infirmary flatly refused to enter into a reciprocal relationship with Chesterfield in June 1937, stating that it would not be an equitable arrangement.[62] More likely it was that they already had their own designs on founding their own system – the Derbyshire Hospitals Contributory Association (DHCA).

The DHCA was an ambitious county-wide scheme devised essentially by the Saturday committee of the Derbyshire Royal Infirmary. In late 1938, the Derbyshire Infirmary board consulted with other

[55] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, December 1936.; Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, June 1937.
[56] 'Mansfield Hospital Development. New Contributory Scheme Proposed: Additional Wards.', *Nottingham Journal*, 16 May 1938.
[57] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, July 1936.
[58] 'Mansfield Hospital Development. New Contributory Scheme Proposed: Additional Wards.', *Nottingham Journal*, 16 May 1938.
[59] 'Midlands Hospitals Big Link-Up. Mansfield to Join Reciprocal Scheme.', *Nottingham Journal,* 1 December 1938.
[60] 'Midlands Hospitals Big Link-Up. Mansfield to Join Reciprocal Scheme.', *Nottingham Journal,* 1 December 1938.
[61] 'Midlands Hospitals Big Link-Up. Mansfield to Join Reciprocal Scheme.', *Nottingham Journal,* 1 December 1938.
[62] Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, June 1937.

hospitals throughout the county to establish a county-wide scheme involving as many hospitals as possible.[63] The board of the Derbyshire Infirmary was becoming concerned at the increasing demand on the Infirmary beyond the physical capacity of its premises. A county-wide scheme would mean that patients would go to other, more local hospitals instead of flocking to the Infirmary. The Derbyshire Infirmary drafted up articles of association for a contributory scheme in February 1938.[64] In April they decided to redraft their articles of association on the same lines as the Norfolk and Norwich Hospitals Contributory Fund.[65] It seems unusual that the hospital would look to Norfolk, rather than Sheffield (its closest neighbour with a well-publicised scheme), for its inspiration. But this rationale lay in the fact that the Sheffield Hospitals scheme was only city-wide, whereas the scheme headed by the Norwich hospital was county-wide.[66] Norwich had notably established a contributory scheme as early as 1919, creating a county-wide Norfolk Hospital Contributors Association by the early 1930s.[67]As such, the Infirmary was keen to see how a county-wide scheme, encompassing many different types and sizes of hospitals, would operate. Furthermore, the contributory schemes in many town hospitals in Norfolk had been present since the mid-1920s, meaning they were among the oldest bona-fide contributory schemes in the country.[68] In June 1938, after some discussion amongst its Board of Management and General Purposes Committee, the Derbyshire Infirmary decided to call a meeting with the other voluntary hospitals of the county, many of the leading employers and top county and city officials.[69] Also present were the Saturday Committee, honorary medical staff, and the Derby County and Borough Panel Committee. T W Place, Honorary Secretary of the British Hospitals Contributory Schemes Association, was also consulted.[70]

Bridgen argues that the middle classes, not catered for by the various schemes of the voluntary hospitals, were essentially the drivers for universal contributory systems.[71] This argument seems

[63] 'Increasing Demands. Need for Better Accommodation. Contributory Scheme.', *Derby Daily Telegraph,* 17 November 1938.
[64] Derbyshire Royal Infirmary General Purposes Committee Minutes 24 January 1938; Derbyshire Royal Infirmary General Purposes Committee Minutes 7 February 1938
[65] Derbyshire Royal Infirmary General Purposes Committee Minutes 11 April 1938.
[66] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives', p.717.; Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010). p.375., p.383.; 'Norwich Hospitals Contributory Scheme Diss and District Fund', *Diss Express*, 9 March 1934.; 'Hospital Contributory Fund', *Diss Express,* 17 January 1936.; 'Topics of the Week. Our Hospital.', *Yarmouth Independent,* 18 April 1936.
[67] Steven Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *The Society for the Social History of Medicine*, 5:3, (1992) p.467.
[68] Steven Cherry, 'Change and Continuity in The Cottage Hospitals c.1859-1948: The Experience in East Anglia', *Medical History,* 36:27 (1992) p.282.
[69] Derbyshire Royal Infirmary General Purposes Committee Minutes 21 June 1938.
[70] Derbyshire Royal Infirmary Annual Report 1937-8.
[71] Paul Bridgen, 'Voluntary Failure, the Middle Classes, and the Nationalisation of the British Voluntary Hospitals, 1900-1946', Bernard Harris, Paul Bridgen (eds.) *Charity and mutual aid in Europe and North America since 1800* (Routledge: London, 2007) p.215

fundamentally flawed when the income caps are correlated to general income levels of the population.. The 1938 Marketing Survey split private families into four classes: 'A', 'B', 'C', and 'D', wherein class 'A' were the highest earners at £500 per annum or more, 'B' at £250-500, 'C' at £125-250, and 'D' at £125 or below.[72] Essentially these categories correlate to Upper and Upper Middle (A), Middle-Middle (B), Lower-Middle (C), and Working Class (D) incomes, though the work refrains from defining them as such. It can be seen that the income caps that were loosely enforced around the contributory schemes (the hospitals treated the cap as a porous barrier, not taking into account wartime pay bonuses or overtime payments for contributors) correlated with contemporary parameters of income for the working population of Britain.

In spite of the fact that the Infirmary viewed itself as a traditional charity-motivated institution (its nickname amongst volunteers being 'The Charity'), it had failed to cultivate its traditional income.[73] The step over to a contributory scheme, far more so than the existent Saturday fund, only confirmed this trend. Moreover, the executive committee of the Saturday fund, whom one might assume to be the key instigators and organisers of the new contributory scheme, were actually not involved in its foundation, although its existing capital was transferred to the new scheme.[74] The Derby Daily Telegraph, alongside the Chamber of Commerce, went to great pains to explain to the public about the new scheme, illustrating its advantages and where people could contribute.[75] However, it also confirmed that membership costs would be higher than that of the Saturday fund: 'None of us likes to pay more for any article or service than we have been accustomed to paying in the past, but this feeling disappears when we are satisfied that there is just reason for the increased charges and that we are getting full value for our money'.[76] As the Derby Daily Telegraph noted in January of that year, ''people are becoming more hospital-minded than ever before', and it was now a vital consideration in ordinary people's lives to acquire healthcare for themselves and their families.[77] It took a short period of transition for working class contributors to be fully convinced that the price increase was both worth it, and provided the same service (and more) that the Saturday Fund had.

[72] *1938 Marketing Survey p.2.*
[73] G Herbert Strutt, *Letter to Edmund Forster (Secretary of Derbyshire Royal Infirmary)*, 30 December 1907.; Derbyshire Royal Infirmary Annual Report 1915-16.; Derbyshire Royal Infirmary Annual Report 1916-17.;
[74] The Derbyshire Royal Infirmary Saturday Fund Year Book 1939.
[75] 'All This For 3d Per Week. Hospital Scheme Worth While', *Derby Daily Telegraph*, 24 February 1939.
[76] All This For 3d Per Week. Hospital Scheme Worth While', *Derby Daily Telegraph*, 24 February 1939.
[77] 'Future of the Derby Hospitals. Effect of the New Contributory Scheme', *Derby Daily Telegraph,* 3 January 1939.

The scheme came into effect on 1st January 1939 and as mentioned necessitated an increase from the previous weekly payment via the Saturday fund of 2d. per week to 3d. per week. According to Mr C W Murray, president of the new scheme, it added extra value to the contributor, because it allowed treatment free-of-charge at any of the hospitals that were members of the scheme, while only strengthening the bonds between those hospitals and their contributors.[78] Further, 'It is hoped that in addition to the hospital treatment they will be able to offer such auxiliary services as convalescence treatment, district nursing, general dispensary, and ambulance service', suggesting that the scheme eventually had ambitions of becoming a full health service for the county.[79] But whatever its future plans, the scheme itself was commendably ambitious considering the previous lack of cooperation between the voluntary hospitals. Branches were officially established in the smaller hospitals around the county, with Ripley Hospital particularly supportive of the new scheme. The small hospital was by this time in a fragile financial condition, having running deficits for a number of years because costs had risen yet income had fallen because of local unemployment levels, and so was welcoming of anything that meant it could bolster its incomes.[80] The new scheme, with its centralised funding, would act as a financial prop to the institution.[81]

The scheme was masterminded by the leading lights of the Saturday fund, which itself carried on until the contributory scheme was fully established.[82] The former chair of the Saturday executive, Mr M E Cholerton, resigned his post to become chair of the newly founded DHCA in 1939.[83] As a mark of its ambition, it hired an accountant, Mr H E Sturdy, who had been the accountant for the Birmingham Hospitals Contributory Association for six years, where he had managed to oversee large increases in income.[84] It is difficult to review the initial success of the scheme, because it had only been in existence nine months before war broke out. But the organisers were enthusiastic, seeing a large influx of new contributors even just in the first few months.[85] The next chapter shall review the condition of the Derbyshire contributory scheme in greater detail, but suffice to say that that the new initiative brought a large boost in income that other similar hospitals experienced when they opened up their schemes. From 1939 to 1940, the income of the contributory scheme and remaining Saturday fund increased from £20,394 to £34,922, meaning an increase of £14,528 or

[78] 'All This For 3d. Per Week. Hospital Scheme Worth While.', *Derby Daily Telegraph*, 24 February 1939.
[79] 'All This For 3d. Per Week. Hospital Scheme Worth While.', *Derby Daily Telegraph*, 24 February 1939.
[80] 'Hospital Work. Derbyshire Contributory Association. Ripley Officers and Collectors.', *Ripley and Heanor News and Ilkeston Division Free Press*, Friday 03 March 1939; 'Ripley Hospital.', *Ripley and Heanor News and Ilkeston Division Free Press*, 21 October 1938.;
[81] 'Future of the Derby Hospitals. Effect of New Contributory Scheme.', *Derby Daily Telegraph*, 3 January 1939
[82] 'Mr M E Cholerton. Infirmary Saturday Fund Secretary Resigns.', *Derby Daily Telegraph*, 3 January 1939.
[83] 'Mr M E Cholerton. Infirmary Saturday Fund Secretary Resigns.', *Derby Daily Telegraph*, 3 January 1939.
[84] 'Rush to Join Scheme. Weekly Payments for Hospitals.', *Derby Daily Telegraph*, 21 January 1939.
[85] 'Rush to Join Scheme. Weekly Payments for Hospitals.', *Derby Daily Telegraph*, 21 January 1939.

71%.[86] It allowed for the compartmentalising of efforts, such as how the Saturday fund continued to operate, but just dealt with the Derby hospitals, including the women's and children's hospitals, as well as the local authority-owned City Hospital, which had negotiated to become part of the scheme.[87] Although the Saturday fund was now small, it managed to sustain its income in subsequent years with this new focus.

In Chesterfield, that the new arrangements brought in significant extra income came as no small measure of relief to the members of the Chesterfield board of management: '[the] Board…feel that for ordinary maintenance purposes the financial affairs of the Hospital are now on a sound basis'.[88] Income from the scheme boomed, helped by the improved rates of employment in the town and district.[89] The jump from the 1936 'Workmen's Subscriptions' to the 1937 'Employee's Contributory Scheme' gave an increase in income of some 40% from £17,812 to £25,209. Thereafter, growth in income slowed, settling at some £26,000 annually. After this point, however, there is no significant continual growth of the scheme. For the next three years at least, the amount never increases more than £400 more than in 1937. On balance, the decision to switch to a contributory scheme gave an immediate injection to the hospital, but was no guarantee of continued financial growth.

The contributory scheme in Mansfield was established in 1938. The old colliery company and colliery workers and other worker's subscription schemes were amalgamated into the 'contributory' process, eliminating distinctions between professions that previously been the basis of the payment schemes for Mansfield. Although not drastically different at the point of service, it meant that the elimination of the 'Recommendation System', and the perceived universality of the contributory scheme, might give the impression that the hospital was in less need of its supplementary fundraisers. It was a common concern, at Mansfield Hospital and others, that any newly comprehensive scheme would dishearten volunteers and diminish traditional fundraising activity, and so the hospital board addressed its most active volunteers; the carnival committee:

> The Board sincerely hopes that Carnival Committees will continue to organise these events, and proposes to recognise in a permanent and lasting way amounts handed over to the General Funds by the naming of Beds in the wards of the Hospital for each £1,000

[86] 1939 including Sept-Dec 1938.
[87] Derbyshire Royal Infirmary Annual Report 1939-1940.; 'Increasing Demands. Need for Better Accommodation. Contributory Scheme.', *Derby Daily Telegraph,* 17 November 1938.
[88] Chesterfield and North Derbyshire Royal Hospital Annual Report, 1937.
[89] Chesterfield and North Derbyshire Royal Hospital Annual Report, 1937

> subscribed, or £500 in the case of a Cot. A Bed or Cot so endowed may be named in accordance with the wishes of the Carnival Committee.[90]

This was vital, the Board argued, because the hospital still needed extra income to 'to treat free of all charge the necessitous poor, unemployed, old age pensioners, etc., etc.', that is, those for whom the hospital, and other voluntary hospitals, were originally founded.[91] But more importantly, it tries to get across the important work that 'General Funds' does, and that active members of the community are still required, even in conjunction with the Contributory Scheme. They conclude with the compassionate statement:

> The income derived from Carnivals is indeed valuable and cannot afford to be lost, and the Board in the name of those who unfortunately cannot subscribe anything towards their treatment because of their circumstances, appeals to the public spirited organizers of Carnivals to continue their efforts in support of the Hospital.[92]

Similar promises had been made in Nottingham when it introduced its contributory scheme. From now on, the President of the Saturday Fund in Nottingham argued, 'people who could afford to pay, if they were not in the scheme, would be asked to do so', although 'nobody would be refused admission because of an inability to pay'.[93]

[90] Mansfield District Hospital Annual Report 1938
[91] Mansfield District Hospital Annual Report 1938.
[92] Mansfield District Hospital Annual Report 1938.
[93] 'Nottingham General Hospital', *Nottingham Guardian,* 28 November 1938.

Figure 5.1: 'Well covered, sir!', Mansfield General Hospital, 1939.

Mansfield and District General Hospital Contributory Scheme.

HOSPITAL CONTRIBUTORY SCHEME

WELL COVERED, SIR!

With acknowledgments and thanks to "Strube," of "The Daily Express."

1.—THE OBJECTS OF THE SCHEME.

The purpose of the Contributory Scheme is :—

(a) To enable workpeople generally—that is, all those who are entitled to treatment in Hospital should the need arise—to take their part in the support of the Hospital by means of moderate and regular contributions paid weekly or otherwise as may be convenient.

(b) To secure thereby freedom from charges when treatment is obtained.

2.—RATES OF CONTRIBUTION.

Minimum Rates.

Males and Females over 16 years of age 2d. per week.
Juveniles under 16 years of age ... ... 1d. per week.

3.—HOW YOU MAY JOIN THE SCHEME.

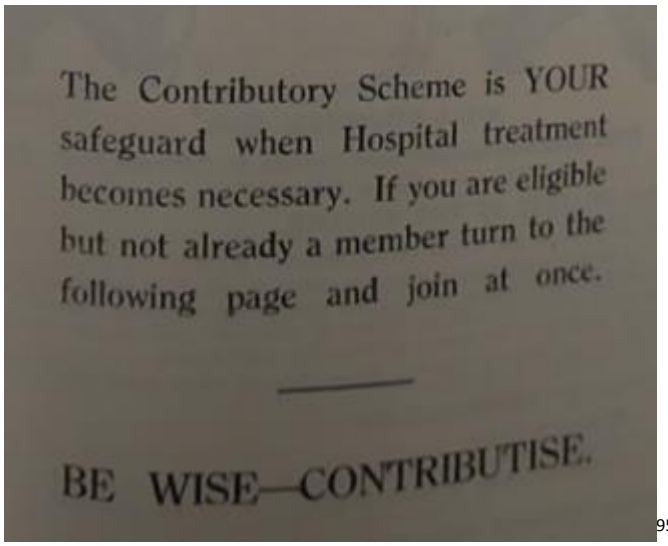
(1) If you are employed by a firm where there are several other employees you should fill in **Form "A"** (page 95), and hand same to your employer, requesting him to deduct your Hospital Contributions from your wages each week.

92

[94]1939.

[94] Mansfield District General Hospital Annual Report 1939.

Figure 5.2 Be Wise: Contributise!', Mansfield General Hospital, 1939



[95]1939.

Did the introduction of the contributory schemes, like Mansfield General feared, result in a reduction in other forms of income? Clearly there was a perception that the contributory schemes, as well as being a more effective way of accumulating income, were also a philosophical step towards a different sort of voluntary system, wherein the contributory schemes provided the hospitals with an ability to offer more universal coverage. This was most evident in the Derbyshire-wide scheme, where coverage was not confined to just one or a handful of hospitals, but as many hospitals and auxiliary services throughout the county. This universalist view had been discussed since the 1920s, when debates around Saturday funds schemes revolved around the idea that they needed to be of a scale (and income limit) that provided universal income to the hospitals they were associated with, while also offering patients universal affordability.[96] However, in effect the contributory schemes were borne of far more practical desires to increase the incomes of the hospitals to keep them on a competitive footing with the increasing expenditures and growing inflation rates, and they were attractive to prospective patients in the community because they offered cheap hospital cover. Costs had increased in no small part due to the massive increase in the number of voluntary hospital beds across the nation from 37,027 in 1921 to 58,007 in 1938.[97] From the perspective of the hospitals, the shift over to the contributory schemes was largely to garner a financial injection, typified by the keen statement made by the Derbyshire Infirmary: 'there is every prospect of the finances of the Infirmary benefitting to a considerable extent'.[98] First and foremost,

[95] Mansfield District General Hospital Annual Report 1939.
[96] F C B Gittings, 'Contributory Schemes for Hospitals', *British Medical Journal*, 17 December 1927, p.1166.; L S Luckham, 'Hospital Contributory Schemes', *British Medical Journal,* 31 December 1927, p.1245.
[97] Robert Pinker, *English Hospital Statistics 1861-1938*, (Heinemann: London, 1964). p.61.
[98] Derbyshire Royal Infirmary Annual Report 1938-9.

the hospitals had to secure solid incomes in order to continue their work, and so ultimately the shift to contributory schemes from Saturday funds was financial. The financial lure finally overrode the ideological misgiving many within the Nottingham General hospital had about a contributory scheme. The overarching faith to the voluntary system was only a narrative that was wheeled out when the system itself was under some manner of threat, for instance back during the Hospitals Crisis of the early 1920s, and the coming concerns over the founding of the NHS.

Unemployment

The previous chapter touched upon the impact of unemployment beginning during the intense years of the 'Slump'. However, unemployment continued to be a burden shouldered by much of the nation right until the Second World War. As such, this section shall review unemployment from 1932 through the rest of the decade, to give a clearer and more comprehensive picture of the issue of unemployment on hospitals. It transfixed scholars then and now with its wide reaching and deeply damaging effects on society. In 1926, hospitals situated in areas that were dominated by strike industries (chiefly mining) were disproportionately affected, with incomes from workers' funds dropping drastically in Mansfield and Chesterfield. However, climbing into the 1930s, unemployment was becoming a permanent fixture of a number of industries, and many more thousands of men were finding themselves out of work for more than a year at a time.[99] It was not a flash in the pan, or an outlying circumstance that could be counted on to disappear shortly (as much as the government initially believed it would).[100] It was a chronic problem for the nation, and far more acute in certain areas than others. Another pattern within unemployment figures for mining locales was seasonal unemployment. Unemployment levels for somewhere like Heanor, which had most of its working men occupied in coalmining, were actually relatively low in winter, but drastically increased in summer months as the demand for coal (in warmer weather) plummeted.[101] Colliery owners tried to encourage stocking up of coal throughout the warmer months, in an effort to reduce the amount to which they lost their market, but this was ineffective: customers both big and small bought their coal as-and-when they needed it, meaning a cyclical rise and fall in demand over the year.[102]

---

[99] Alan Deacon, 'Systems of Interwar Unemployment Relief', Sean Glynn and Alan Booth (eds.) *The Road to Full Employment (*Allen & Unwin: London, 1987) p.36.

[100] Deacon, 'Systems of Interwar Unemployment Relief', pp.33-4.

[101] GB Historical GIS / University of Portsmouth, Heanor through time | Historical Statistics on Work and Poverty for the Urban Labour Market | Rate: Claimant Count Unemployment, *A Vision of Britain through Time*. URL: http://www.visionofbritain.org.uk/unit/12836478/rate/CLAIMANT_COUNT [Date accessed: 14th January 2020].

[102] Colin P Griffin, '"Three Days Down the Pit and Three Days Play": Underemployment in the East Midlands Coalfields between the Wars', *International Review of Social History*, 38 (1993) p.326.

The question has to be asked, therefore, as to what extent unemployment in Derbyshire and Nottinghamshire affected the incomes of the voluntary hospitals. There was a link, ever growing, between the hospitals and the working prosperity of their communities. The Saturday and workers' funds relied on working people paying into the schemes; without work, funds from those channels would be strictly limited. The Table 5.3 shows the unemployment figures for a number of key towns in the two counties, as well as the county averages, and the national average unemployment rate for England, using data from *A Vision of Britain*.

Table 5.3: Unemployment Rates for England, Derbyshire, and Nottinghamshire, 1928-1938.

Location	1928	1930	1932	1934	1936	1938
England Average	9%	11%	20%	14%	14%	11%
Nottinghamshire Average	5%	10%	20%	15%	15%	10%
Nottingham	7%	10%	15%	14%	14%	10%
Mansfield	23%	17%	45%	20%	13%	23%
Newark	4%	6%	24%	11%	10%	4%
Worksop	8%	18%	25%	15%	21%	19%
Derbyshire Average	6%	10%	25%	15%	12%	10%
Derby	4%	6%	16%	8%	6%	5%
Chesterfield	29%	17%	38%	23%	19%	13%
Ilkeston	25%	10%	21%	12%	10%	13%
Ripley	10%	10%	29%	17%	15%	23%
Ashbourne	5%	18%	31%	24%	21%	13%

The most obvious point to take from these two tables are that the county towns had generally lower unemployment both than the county averages and the national average at the height of the downturn, and subsequently, because of their greater economic diversity. By contrast, unemployment in Chesterfield and Mansfield, the two key coal towns of the two counties, remained high even after recovery. It might be expected, therefore, that hospital income here witnessed a much sharper drop in income than the far more cosmopolitan hospitals in Derby and Nottingham. The growth of total incomes, and the growth of the workers' and Saturday funds was affected by the rates of unemployment in the respective towns. The following tables show the total ordinary income and total Saturday/workers' funds income for Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, Mansfield Hospital, and Worksop Hospital, as well as the unemployment rates in their respective towns, and also the percentage growth rate of each fund in relation to the previous data point. Shown in green are years of positive growth, while in red are years where the income actually shrank.

Table 5.4: Saturday and worker's funds income versus unemployment, Derbyshire and Nottinghamshire 1928-1938.

Saturday and Workers' Funds	1928	1930	1932	1934	1936	1938
Nottingham General	24545	26177	24952	25604	27593	30443
% unemployed	7	10	15	14	14	10
% growth of income		6.6	-4.7	2.6	7.8	10.3
Derbyshire Infirmary	18000	19751	17641	18865	21415	23161
% unemployed	4	6	16	8	6	5
% growth of income		9.7	-10.7	6.9	13.5	8.2
Chesterfield Hospital	13909	15250	15096	15018	17812	25521
% unemployed	29	17	38	23	19	13
% growth of income		9.6	-1.0	-0.5	18.6	43.3
Mansfield District	11782	11391	9833	11209	11444	13215
% unemployed	23	17	45	20	13	23
% growth of income		-3.3	-13.7	14.0	2.1	15.5
Newark Hospital	1894	1775	1565	1911	2219	No data
% unemployed	4	6	24	11	10	4
% growth of income		-6.3	-11.8	22.1	16.1	No data
Worksop Victoria	3785	4140	4254	5166	5750	6093
% unemployed	8	18	25	15	21	19
% growth of income		9.4	2.8	21.4	11.3	6.0

Table 5.5: Total ordinary income versus unemployment, Derbyshire and Nottinghamshire 1928-1938.

Total Ordinary Incomes	1928	1930	1932	1934	1936	1938
Nottingham General	57674	60806	55075	60469	66400	71816
% unemployed	7	10	15	14	14	10
% growth of income		5.4	-9.4	9.8	9.8	8.2
Derbyshire Infirmary	48497	51012	47594	49842	51437	56452
% unemployed	4	6	16	8	6	5
% growth of income		5.2	-6.7	4.7	3.2	9.7
Chesterfield Hospital	24374	27364	25559	27207	29631	41287
% unemployed	29	17	38	23	19	13
% growth of income		12.3	-6.6	6.4	8.9	39.3
Mansfield District	16545	17940	16718	17647	20245	24645
% unemployed	23	17	45	20	13	23
% growth of income		8.4	-6.8	5.6	14.7	21.7
Newark Hospital	5426	6279	5975	6234	6562	No Data
% unemployed	4	6	24	11	10	4
% growth of income		15.7	-4.8	4.3	5.3	No Data
Worksop Victoria	6561	6924	7149	8275	9223	11346
% unemployed	8	18	25	15	21	19
% growth of income		5.5	3.2	15.8	11.5	23.0

As shown, the peak year for unemployment, nationally as well as locally, was 1932. However, even after this point, unemployment remained high throughout most of Derbyshire and Nottinghamshire. It has to be remembered that while the majority of their patients and funds came from their immediate urban environs, they were county institutions as well. So, while Derby and Nottingham themselves did not have high unemployment, they were receiving patients and funds from areas that did. Ripley, Heanor, and Ilkeston were towns which all had their own hospitals, but many workers also gave payments to the Derbyshire Infirmary and Nottingham General, in case they needed treatment that their smaller local hospitals could not provide. These 'feeder' towns, as they might be called, had very high rates of unemployment, and even the towns that were not occupied almost solely with mining, like Long Eaton and Alfreton, had relatively high levels of unemployment that sat above national average.[103] Places like Eastwood, Sutton-in-Ashfield, Kirkby-in-Ashfield, Ripley, Heanor, Bolsover, Clay Cross, Belper, Hucknall, and Mansfield Woodhouse were places that had high unemployment due to their occupational domination by the mining industry.

Worksop was an unusual case. It was an area dominated by mining, had high unemployment in the town and district, and yet managed to retain growth within both its Penny-in-the-Pound Scheme and across its total income. They managed to sustain payments into the scheme that relied most heavily on miners. The reason for this is not clear until you observe the occupational data of Worksop's citizens, the strategies that the hospital board and volunteers employed, and further consider what exactly unemployment meant for people paying into the hospitals. Of the 16,907 working citizens in Worksop's urban and rural districts, 7,285 men were occupied in mining.[104] That means that nearly half of the active workers in Worksop's rural and urban district were in an industry that had high levels of unemployment. The nearest comparable town was Mansfield, which had a working population of 21,726, with 6498 occupied in mining.[105] It was a far smaller proportion of their total

[103] GB Historical GIS / University of Portsmouth, Long Eaton UD through time | Industry Statistics | Persons of Working Age by Sex and 1931 Occupational Order, *A Vision of Britain through Time*. URL: http://www.visionofbritain.org.uk/unit/10003052/cube/OCC_ORD1931 [Date accessed: 14th January 2020].

[104] GB Historical GIS / University of Portsmouth, Worksop through time | Historical Statistics on Work and Poverty for the Urban Labour Market | Rate: Claimant Count Unemployment, *A Vision of Britain through Time*. URL: http://www.visionofbritain.org.uk/unit/12832436/rate/CLAIMANT_COUNT [Date accessed: 14th January 2020].

[105] GB Historical GIS / University of Portsmouth, Mansfield through time | Historical Statistics on Work and Poverty for the Urban Labour Market | Rate: Claimant Count Unemployment, *A Vision of Britain through Time*.

number in mining, and yet in Mansfield Hospital they experienced the fall in income that most other hospitals had experienced. However, there were still 9,622 workers in Worksop's district that were potential contributors to the scheme. The hospital board had designs on universal membership among their community, rather than just trying to capture a slice of the community like other hospitals (specifically, a focus on workplace subscription). In 1931 they laid out their intentions, stating that, 'an active canvass is being conducted, with a view to bringing all the workers into the scheme', utilising such events as the hospital bazaar (being conducted to help raise funds to clear the debt on the building fund) as platforms to sign individuals up to the scheme.[106] It was an early example of a contributory scheme. The Penny-in-the-Pound scheme facilitated a wide subscriber base, focussed on the individual rather than the workplace, and enforced no explicit upper limit on income.

They focussed on individual contributors as well as the large employers throughout the town and district. Initially they saw a reduced income in the fund but argued that 'the reduction would have been greater but for the fact that an increased number of individual members has been obtained'.[107] Their strategy was to try to beat out the decline of incomes from the mines by active encouragement of other (non-mining) workers to join the scheme. It proved successful by 1932, staving off the losses that were so acutely felt by other hospitals. In this short period from 1928-1932, they managed to sign up more than a dozen new firms' employees, as well as an increase in contributions from employees of firms that were already members, and more again that were not contributing via a workplace. It was not to say that these increases meant solvency. In 1932 the hospital had a deficit of £374 on the maintenance account, despite growing its Penny-in-the-Pound income from the previous year by £254. It managed to increase its income from £6561 in 1928, up to £7149 in 1932, and further reaching £11,346 by 1938 – almost doubling their total income in just a decade. As for the Penny-in-the-Pound scheme itself, as unemployment reduced in 1933-4, the income of the scheme jumped by roughly £1,000, from £4,254 in 1932 to £5,166 in 1934. They had managed to grow their income far beyond the rate of expenditure, such that in 1934 they had a £714 surplus, which they put straight into the 'extending and modernising' of the X-Ray department.[108]

URL: http://www.visionofbritain.org.uk/unit/12832783/rate/CLAIMANT_COUNT [Date accessed: 13th January 2020].

[106] Worksop Victoria Hospital Annual Report 1931.
[107] Worksop Victoria Hospital Annual Report 1930.
[108] 'Worksop Victoria Hospital. X-ray Department To Be Extended', *Nottingham Evening Post*, 28 March 1934.

However, high unemployment did not necessarily equate a level of poverty that prevented paying into the hospital schemes. To be totally unemployed meant the ability to draw on unemployment benefits, a system which by this time had been expanded by successive governments in the previous decades.[109] While these benefits were regarded as 'generous' by the standards of the day, and in comparison to the benefits available to unemployed citizens in the US and Germany, they did not equate to the wages of an individual in full-time work.[110] There were circumstances where a family only living off of unemployment benefits were in extreme poverty, but for the most part the unemployed and their families were able to 'get by' with very limited spare funds.[111] But there was potential for spare funds that could be paid into the hospitals. The Penny-in-the-Pound scheme in Worksop had already developed the idea of individual contribution, rather than just focussing on firms (that were potentially out of work). Worksop's approach, therefore, was multi-pronged. They had contributions from firms, contributions from individuals, and were able to secure contributions from unemployed individuals too. Furthermore, their Penny-in-the-Pound scheme did not, unlike other contemporary and later schemes, have an income cap.[112] This meant that they were able to appeal not just to the working classes, but also to the middle-classes, a group that might have otherwise found themselves excluded from other schemes that had hard income-caps.[113]

Subscriptions

By the 1930s, subscriptions were most definitely the junior partner to the Saturday funds. They had been reduced from a key source of income and vital link to communities, down to essentially a formalised form of regular charitable donation from individuals and groups. Diverse though the subscribers were, the meaning of subscriptions had essentially changed to the extent that they were never able to regain the relevance and prominence they once had. It is tempting to place this in the context of alleged decline in elite volunteering and civil engagement, and the withdrawal of middle-class support for urban institutions.[114] This, however, would be misleading. Subscriptions still had

[109] Deacon, 'Systems of Interwar Unemployment Relief', p.33., pp.36-7.
[110] Whiteside, 'The Social Consequences of Interwar Unemployment', pp.17-23.
[111] John Stevenson and Chris Cook, *Britain in the Depression Society and Politics 1929-1939* (Longman: London, 1994) pp.43-47.; Deacon, 'Systems of Interwar Unemployment Relief', p.41.
[112] 'Hospital Ban On Roller Skaters. Rink Accidents Not Covered By 1d. in the £ Scheme. Worksop Board's Decision', *Nottingham Evening Post*, 4 April 1930.
[113] Paul Bridgen, 'Voluntary Failure, the Middle Classes, and the Nationalisation of the British Voluntary Hospitals, 1900-1946', Bernard Harris, Paul Bridgen (eds.) *Charity and mutual aid in Europe and North America since 1800* (Routledge: London, 2007) p.219.
[114] Bill Rubinstein, 'Britain's elites in the inter-war period, 1918-39', in Alan J Kidd and David Nicholls (eds.), *The Making of the British Middle Class?* (Sutton: 1998). p.198; John Garrard, 'Urban elites, 1850-1914: the rule and decline of a new squireachy?', *Albion,* 27 (1995). pp.583-621.; David Reeder and Richard Rodger, 'Industrialisation and the city economy', in Martin Daunton (ed.), *Cambridge Urban History*, (Cambridge University Press: Cambridge, 2000). p.585.

relevance as an important, yet smaller, part of the financial mix of income in provincial voluntary hospitals.[115] There was no slow death of subscription income in the 1930s, and indeed there is a strong case to be made that where such income types remained buoyant, the hospitals concerned flourished, whereas if it was squeezed out by pre-payment hospital finances, the hospitals suffered deficits and resultant debt.[116] Many hospitals, therefore, were still intent on keeping their annual subscriptions healthy. Not all attempts were successful. It is clear that the existence of contributor funds had the capacity to negate aspects of charitable giving. For example, the sincere but ultimately limited efforts made by the Mayoress of Derby Ladies' Committee, which in the mid-nineteen twenties was raising upwards of two hundred pounds in both donations and in new subscriptions was, by the mid-nineteen thirties, raising only half that amount. By 1939, its income had all but petered out, so that the Committee was wound up in 1941. It explicitly cited that the introduction of the contributory scheme that 'had also rendered it more difficult to obtain supplementary contributions'.[117] It indicated the generally lacklustre reception to old-fashioned door-knocking fundraising.

As shown in previous chapters, annual subscriptions had changed significantly across the decades. They started the 20th Century as the key focus and largest income group for hospitals, but by the 1930s were a much smaller part of a larger network of funding. A basic comparison looking between 1900 and 1935, subscription income increases with inflation, and the number of individual subscribers increases, but never grows enough to increase its proportion after the Great War.[118] By the 1930s, the Derbyshire Infirmary saw significant increases in larger subscriptions – 366% increase on subscriptions over £20, and a 533% increase on subscriptions over £50. In the first two decades of the twentieth century, the only 'large' subscribers to the hospital were the Midland Railway Company, and the Dukes of Devonshire and Portland. By 1935, many larger businesses and organisations were subscribing £50 and more to the hospital, including the Midland Drapery Company, the Duke of Devonshire's Chatsworth estates, the Derby Corporation, and largest of all, the Butterley Company.[119]

[115] Gorsky, Mohan, Powell, 'Financial Health', p.549.
[116] Hayes and Doyle, 'Eggs, rags, and whist drives', pp.720-725.
[117] Mayors of Derby Ladies Committee Minutes, July 1941
[118] Derbyshire Royal Infirmary Annual Report, 1900; Derbyshire Royal Infirmary Annual Report, 1935. Annual subscriber lists extend by a significant amount.
[119] Derbyshire Royal Infirmary Annual Reports 1929-30 to 1934-1935.

Table 5.6: Annual Subscription Income and Percentages of Total Income, for various hospitals, 1930-39.

Year		1930	1935	1939
Derby	Ann. Subscriptions	6112	7464	5872
	% of total	12	15	8
Nottingham	Ann. Subscriptions	11456	11053	11816
	% of total	12	15	14
Chesterfield	Ann. Subscriptions	5122	5080	6596
	% of total	19	18	16
Newark	Ann. Subscriptions	754	630	647
	% of total	11	10	11
Mansfield	Ann. Subscriptions	975	1270	1452
	% of total	17	16	13
Worksop	Ann. Subscriptions	525	533	-
	% of total	8	6	-
Wirksworth	Ann. Subscriptions	222	200	196
	% of total	16	13	12
Ashbourne	Ann. Subscriptions	206	162	158
	% of total	22	15	9

Those hospitals whose subscription incomes that sat on or below 10% were also more susceptible to deficits, particularly Worksop and Mansfield, which despite having successful mutualist style schemes, found themselves hundreds of pounds in the red. It is relevant to look retrospectively at the course of the previous decades, and how the hospitals arrived at the 1930s with the subscription income proportions they had, and how the importance of subscriptions, both to the hospitals and the subscribers themselves, changed over the years. Examples from the Derbyshire Infirmary and Nottingham General indicate that while total proportions of annual subscriptions declined, the number of larger subscriptions increased, and the big firms that previously subscribed, still subscribed. Table 5.7 and 5.8 indicate how, despite annual subscriptions shrinking as a proportion of total income, companies were making much larger donations than previous years, and the numbers of subscriptions over £50 reached a pinnacle in the mid-1930s.

Table 5.7: Derbyshire Royal Infirmary Large Subscriptions, 1900-1935.

Derby. Royal Infirm.	Subscriptions £10+	Subscriptions £20+	Subscriptions £50+	Highest Subscriber
1900	41	9	3	Midlands Railways Co., £210, plus £100 'donation'
1905	58	10	2	Midlands Railways Co., £210, plus £100 'donation'
1910	66	15	3	Midlands Railways Co., £315
1915	72	19	2	Midlands Railways Co., £315
1920	76	19	3	Midlands Railways Co., £315
1925	90	35	10	Butterley Co., £715
1930	81	30	13	Butterley Co., £679
1935	79	33	16	Butterley Co., £471

Table 5.8: Nottingham General Hospital Large Subscriptions, 1900-1935.

Nott. Gen. Hospital	Subscriptions £10+	Subscriptions £20+	Subscriptions £50+	Highest Subscribers
1900	37	12	1	Duke of Portland, £50; Midland Railways, £42
1905	38	13	1	Duke of Portland, £50; Midland Railways, £42
1910	40	13	2	Nottingham Corporation £58, Duke of Portland £50, Midlands Railway £42
1915	41	14	2	Nottingham Corporation £58, Duke of Portland £50, Midlands Railway £42
1920	131	41	14	John Player Co., £500
1925	155	64	36	Butterley Company, £537, John Player, £500
1930	169	73	36	Butterley Company £590, John Player £500
1935	175	69	39	John Player Co., £500, Butterley Co, £490

Two elements stand out from these tables. Firstly, that there are a greater number of larger subscriptions as the decades progressed, especially in Nottingham in the 1930s. Secondly, that large industrial firms like Midlands Railways and the Butterley Company increased their share of subscriptions over the years, the Butterley Company remaining especially prevalent, matched only by the individual subscription from John Player (Player's cigarettes). So, while the subscriptions decreased as a proportion of income, it was not as a result of a lack of interest from subscribers themselves. It was not so much a narrative of decline, but of being overtaken by other forms of income. People coming to pay into the hospital for the first time were more likely to enter into the Saturday/contributory schemes rather than enter into the annual subscription scheme. As the decades progressed, the Derbyshire Infirmary and Nottingham General hospitals drastically diverged in terms of the income from annual subscriptions. In real terms, Derby had let its subscriptions slip during the Great War, and by the 1930s they had only just recovered their pre-war figures. The Nottingham General, on the other hand, experiencing similar decline in the Great War, managed to

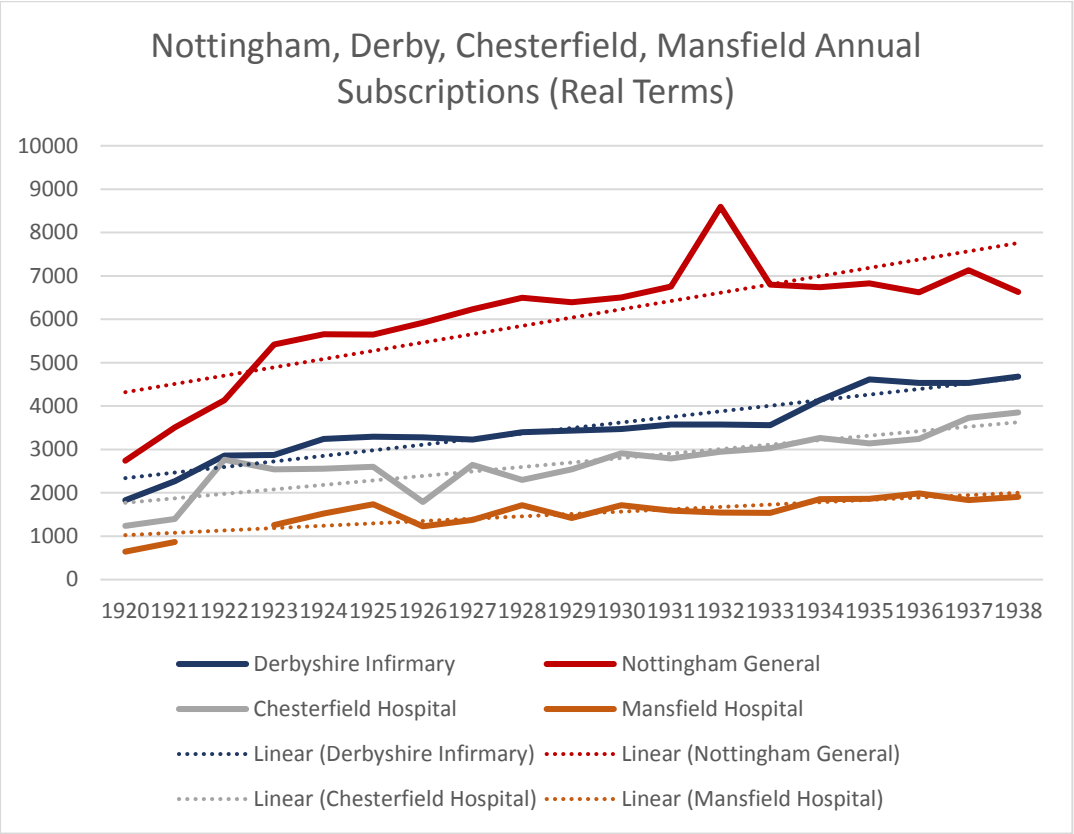
increase its annual subscriptions year on year after the war, so that they were at a stable and much increased level by the 1930s. Unemployment did not adversely affect annual subscriptions; in fact in years of high unemployment, the Derbyshire Infirmary managed a rare spike in its subscription income, something it had not managed to do for a decade.

Generally, the new position of annual subscriptions in the financial hierarchy of the hospital was more a product of the rise in other modes of income. The same old firms were giving more and more money to the annual subscription schemes at Derby and Nottingham, which indicates that although the employees of these large firms were embracing the contributory ideal, employers continued to donate via more traditional methods. However, in 1938 the Derbyshire Infirmary decided to alter the relationship that the subscribers had to the hospital in a more definitive and official way. Their system of 'Recommends' (similar to most other voluntary hospitals), that was associated with admitting patients to hospital via annual subscriptions was reviewed by the management committee and seen to be inefficient on the part of both the hospital and the patient.[120] Instead, it decided to offer 'Subscribers Letters' to sources outside of the annual subscriptions and contributory scheme such as the Sunday collections, carnivals, box collections, whist drives, etc. '"Subscribers' Letters"' were 'available only for persons whose financial position is such that they cannot afford to join the Contributory Association, e.g., old age pensioners, persons with limited means, unemployment, disabled, etc.' Thus, the subscription continued to be important to help cover payment for those in need and who were effectively uninsurable, but the subscribers themselves would not hold the tickets. In this context, it can be seen the last vestiges of the traditional charitable ethic, wherein the fundraising of the community is used directly for the treatment of the disadvantaged who are unable to contribute towards their own care.

Graph 5.1, however, reveals the significant disparity between the key hospitals in this case study. Whilst in real terms all experienced a growth in subscriptions across the interwar years, both rates of growth and the level of contribution varied markedly.

[120] Derbyshire Royal Infirmary Annual Report 1938-9

Graph 5.1: Nottingham, Derby, Chesterfield, Mansfield Annual Subscriptions, 1920-1938.



Derbyshire Infirmary, the second largest hospital in the two counties by far, had comparable levels of growth in annual subscription to Chesterfield Hospital, and its income per bed from this source was significantly smaller.

Table 5.9: Annual subscription per bed, Nottingham, Derby, Chesterfield, Mansfield, 1930-39.

	1930			1935			1939		
	Beds	Annual Subscription income	£ per bed	Beds	Annual Subscription income	£ per bed	Beds	Annual Subscription income	£ per bed
Nottingham General	383	11456	30	386	7464	19	432	11816	27
Derbyshire Royal	347	6112	18	362	11053	31	362	5872	16
Chesterfield Royal	190	5122	27	220	5080	23	295	6596	22
Mansfield Hospital	140	975	7	145	1270	9	181	1452	8

However, annual subscription was not the only thing that the Infirmary was not doing as well as other institutions. Income from investments, though by 1930 bringing in £4,494 and £5,481 by 1938, were roughly half the income for Nottingham: £5,873 by 1930, and £11,680 by 1938. Further again,

general donations to the Infirmary were smaller by proportion, just £1,658 in 1930 compared to Nottingham's £5,766, and even Chesterfield's £1,531. It was not just a matter of the Nottingham General performing exceptionally well; the Derbyshire Infirmary was operating schemes that were more comparable to hospitals half its size. By failing to maintain these income streams, it suffered. It found itself in deficit every single year from 1930 to 1938, its smallest being just £5 in 1934, but its largest being £9,554 in 1936. On two points, the Derbyshire Infirmary fell down. After the Great War, they failed to evangelise their annual subscriptions and failed to invest surpluses in shares. As a result, by the end of the 1930s they had a comparatively low income from both annual subscriptions and investments – on a similar level to that of Chesterfield, a hospital some one hundred beds smaller. To ignore or neglect other forms of income proved very unwise, especially for a hospital as large and far-reaching at the Derbyshire Infirmary. It shows how annual subscriptions were still vital to large voluntary hospitals, and how although the mutualist funds were providing the lion's share of the cash, without the 'augmentations' that Captain Stone talked about, the hospitals would struggle.

Carnivals and community alongside mass contribution

The 1930s saw a real explosion of hospital carnivals, particularly in the scale of events. There were still the garden parties, pound days, fetes and carnivals, that would have been just as familiar to a hospital volunteer in the 1910s as in the 1930s. But what did change was the size and frequency of events. With the increased usage of hospitals, the broadening of the pay-in schemes, and the widespread evangelising of the hospitals through the mutualist ethic, the carnivals became an extension of the 'self-preservation' pragmatism of the voluntary hospital communities. Attending the carnival was not just entertainment and feel-good charity giving, it was an act of supporting one's own healthcare needs. David Cannadine argues that the concept of community was very significant in creating the context for the creation of tradition, and that pageantry and celebration was welcomed gladly as orderly entertainment by local peoples.[121] Hospital carnivals were one key visible manifestation of hospital voluntarism and its connection to its local community. He notes to that such annual events should not be seen as a 'dependent variable' of civic context. The hospital carnivals were organic; they emerged from communities as a unique manifestation. But nor were they independent from their context. There would be no carnivals without the fundraising rationale; no one was going to organise such a large carnival with no material object in mind. They were also ubiquitous, springing up in urban sprawls as readily as small villages. They emerged from the mining and heavy industry communities of the north of the counties like Sheepbridge, or from the rural

[121] Cannadine, 'Transformation of Civic Ritual', p.129., p.120.

areas of the northwest of Derbyshire like Ashbourne and Wirksworth. The earlier events have already been shown in detail; there were Bazaars in Nottingham in 1903, Chesterfield in 1917, and in Buxton in 1928, organised by their respective hospital volunteers. Mansfield Hospital was organising large town-based events from 1902. Matlock Cycling Club was raising money for the hospitals in small but meaningful ways since the 1890s. Ashbourne Hospital, from its outset in 1901-1902, was organising events all over its town and district in an effort to keep up with the new hospital's costs. Derby Hospital Day was created in 1920; and Long Eaton Carnival came about in 1930, and finally Ripley Hospital Carnival in 1932. These fundraising events, big or small, had become part of civic society by the late 1930s, but more particularly were part of the annual calendar of ritual. They were also sure-fire way to raise significant amounts of money.

A concept of community lay at the heart of all such events, albeit that they were organised by representative organising committees, and participation included all classes and social groups. The carnivals were rarely a site of class conflict, and often only in a comical fashion (such as the arrest of the Sheriff of Nottingham on the rag days). They were essentially charitable activities; the pot of money raised was not a contribution but a donation. But the efforts made were essentially of self-help: of a community investing in its own institution. The donations were not for some distant charity or unknown group of strangers, but their own hospital, that they, their friends, and their family used. The Long Eaton Carnival was perhaps the largest single event in the region, with a plethora of attractions and a host of volunteers to make it possible. In 1933, for example, it attracted an audience of some 30,000 attendees from across Nottinghamshire and Derbyshire (Long Eaton sits on the borders of the two counties).[122] It managed to attract carnival goers from all over, tempted in by the offer of cheap recreation and entertainment it provided, which sat outside any higher ideological commitment to voluntarism. Thus there was always an ambiguity about the relationship between events that were intended to fundraise, but could most effectively do so by providing entertainment. The hospital volunteers had to provide something that people were willing to pay for; latent donation that garnered nothing in return other than a warm sense of satisfaction was nowhere near successful, and the stagnation in box collections is testament to that. The event at Long Eaton was unusual because, unlike the other hospital fundraising events, it was not directly associated with one particular hospital, nor was it within the local vicinity of a hospital. Long Eaton by the 1930s became hospital-minded, not just establishing the carnival in the early 30s, but also a special committee to establish a Long Eaton Contributory Fund in the late 30s as well.[123] Compared to the rest of the locales in Derbyshire and Nottinghamshire, it was quite a large town (population in

[122] 'Long Eaton Carnival. Derby Mayor to Open the Proceedings', *Derby Daily Telegraph,* 19 August 1933.
[123] 'Long Eaton Hospital Contributory Scheme', *Long Eaton Advertiser*, 24 February 1939.

1931 was 22,000). Towns much smaller than itself, like Ripley, Heanor, even Newark, all had established hospitals.[124] Instead Long-Eaton decided to put its efforts into payment schemes and fundraising for the two county capitals. When it found that the carnival was not bringing in as much money as it previously was, a contributory scheme was established to secure the shortfall.[125] Most, if not all, other events in aid of the hospitals were organised by hospital volunteers in the towns and cities that the particular hospital was situated in.

The carnival also contributed towards many different charitable causes beyond the major hospitals. By 1936, the Committee was donating its proceeds to Nottingham General Hospital, Nottingham Children's hospital, Nottingham Women's Hospital, Nottingham Eye Infirmary, Nottingham Ear, Nose and Throat Hospital, the Derbyshire Royal Infirmary, Derbyshire Women's Hospital, Derbyshire Children's Hospital, Derby Deaf and Dumb Institution, Buxton Devonshire Hospital, as well as to the Fire brigade, St John Ambulance and Nursing Division, and to the Police Widows and Orphans Fund.[126] Nottingham General took the majority of the money, £800 in 1936, compared to Derby Royal Infirmary's £400. The event spanned a whole week, and included competitions, sports events, fireworks, and large-scale pageantry.

[124] Newark population 1931: 18,000; Ripley population 1931: 13,500. www.visionofbritain.org.uk [accessed 25/01/2020]
[125] *Nottingham General Hospital Monthly Board Minutes,* 4 April 1939.
[126] Long Eaton Carnival Committee Minutes, 1936.

Figure 5.3: 'Long Eaton Hospital Carnival', *West Bridgford Times & Echo*, 7 September 1934

Long Eaton Hospital Carnival

SEPTEMBER 8 to 15 INCLUSIVE

Stupendous Attractions: Originality and Ingenuity!!

A Riot of Spontaneous Fun!

Saturday, September 8, 6.0 p.m.
Crowning of Carnival Queen: Monster Lantern Parade, Carnival Ball.

Sunday, September 9, 10.0 a.m. and 8.0 p.m.
Civic Church Parade: Grand Concerts, Mount Tabor and Central Methodist Churches.

Monday, September 10, 3.0 p.m.
Opening of Trades and Models Exhibition by Sir William Ray (London). Scala Theatre, 6.35 p.m. and 8.50 p.m., Teddy Brown (the world-famous xylophonist) and All-Star Variety Show. 7 p.m., Searchlight Tattoo by Massed Carnival Bands.

Tuesday, September 11, 1.30 p.m.
Gigantic Competitive Fancy Dress Parade: Children's Sports, Special Performance by Clown Bobby and Evelyn: Carnival Band Parade and Contest. Motor Cycle Gymkhana.

Wednesday, September 12, 7.0 p.m.
Carnival Band Contest. Fancy Dress and Lantern Parade.

Thursday, September 13, 10.45 a.m.
Opening of Floral Market: 2.15 p.m., Monster "Rag." Civic Reception to "King Tub." Wedding of "King Tub" to "Princess Leaner." 7 p.m., Wedding Feast of King Tub and Princess Leaner.

Friday, September 14, 7.0 p.m.
Tramps' and Gypsies' Parade and Supper. An ox will be roasted whole! March Past of Tramps' and Gypsies' Bands.

GRAND FINALE

West Park, Saturday, September 15, 2 p.m.

MONSTER SPORTS AND ATHLETIC MEETING OPEN TO ENGLAND

The Wight Rodeo, thrilling horsemanship and trick riding, roping, etc., by professionals: All England Carnival Band Contest (three Cups and £16 in prize money): Horticultural and Cage Bird Shows: Fun Fair, Side Shows and Entertainments.

GRAND FIREWORK DISPLAY: LANTERN PARADE AND

The Biggest Fancy Dress and Decorated Vehicle Parade in the Country

ADMISSION TO WEST PARK : : ADULTS 1/-, CHILDREN 6d.

All the Week Shows: TEDDY BROWN AND ALL-STAR VARIETY SHOW, SCALA THEATRE (Popular Prices). TRADES EXHIBITION, 2.30 p.m. to 9 p.m. See Posters and Handbills for Details.

For Entry Forms for the various events, apply: Gen. Secretary, FIRE STATION, LONG EATON.

CHEAP TRIPS BY L.M.S.

[127]

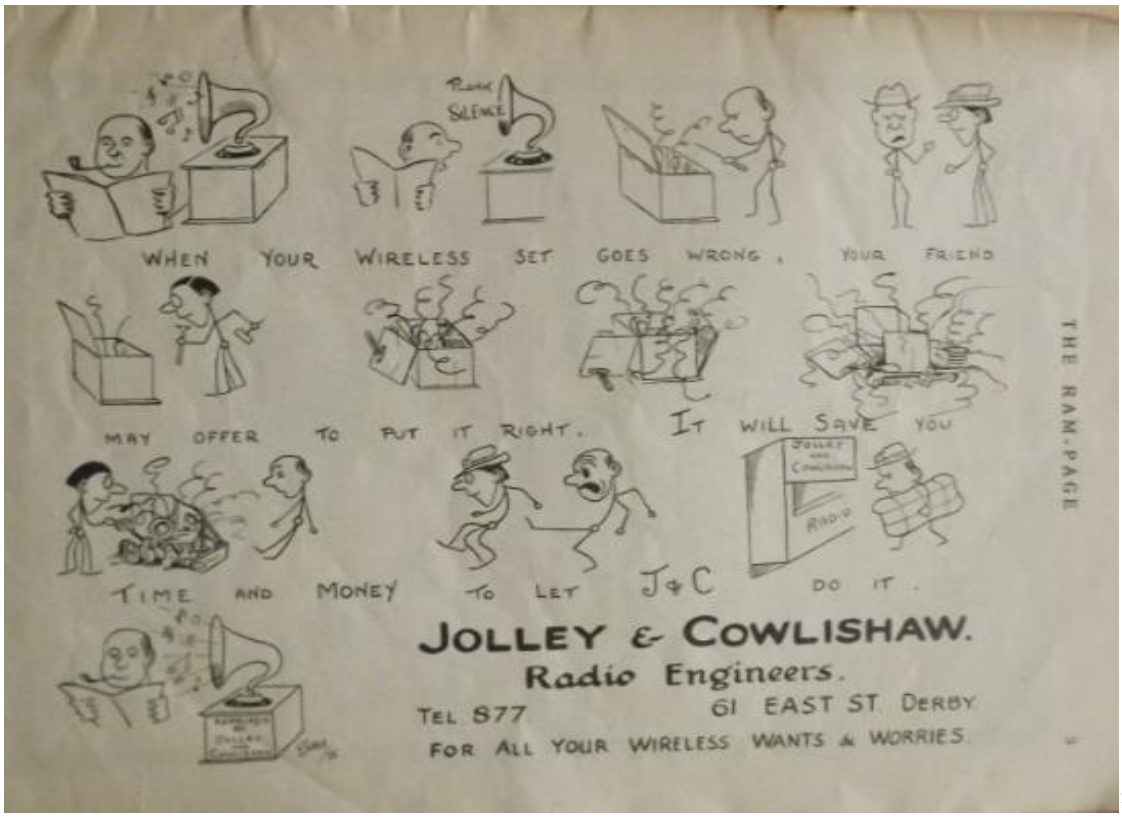
Yet there were issues with hosting such a large event. The costs were incredibly high. It seems that in contrast to small local events where hospital committees were able to ask for performances by volunteers or professionals that donated their time, as well as donated premises, this was not the case for Long Eaton, because it de facto became a professional event. In 1934 it grossed the substantial sum of £3,628, but £1,893 had to be spent on renting the ground, paying the performers, catering, and other general expenses.[128] That left over only £1,735. The next year they took £3,661, spending £2,108, leaving only £1,553.[129] The costs were so high that in 1936 they took steps to rationalise the event, and even considered cancelling some of the attractions. Despite making economies, there was still only £1,411 available for donation that year.[130] It meant that the allocation for Nottingham General Hospital fell from the £800 to £650, and for Derbyshire Royal Infirmary, from £400 to £350. This type of professionally organised event was far more costly than

[127] 'Long Eaton Hospital Carnival', *West Bridgford Times & Echo*, 7 September 1934.
[128] Long Eaton Carnival Committee Minutes, 1934.
[129] Long Eaton Carnival Committee Minutes, 1935.
[130] Long Eaton Carnival Committee Minutes, 1936.

something like the Hospital Day, or the Rag Days in Nottingham. But on balance, the carnival was one of the few examples throughout the hospital calendar that was able to raise such funds.

Despite a comparatively poor performance in maintaining its traditional charitable income, the Derbyshire Infirmary's Hospital Day made significant advances in the 1930s. From its inception after the Great War, it became a Derby institution. By the 1930s it had an accompanying magazine, the 'Ram-Page' (playing on the Derby mascot, the ram) which it published to raise extra funds and add community awareness. The magazine was full of the usual adverts for local and national firms, Midland Drapery taking out a full-colour back-cover advert each year.[131] It carried caricatures of local dignitaries, accounts of local sports matches, and absurd descriptions of Derby's streets and attractions. Even the adverts, like those of Jolley & Cowlishaw Radio Engineers of Derby (see below), had special humorous advertisements drawn up to enter into the spirit of the event.[132]

Figure 5.4: 'Jolley & Cowlishaw', The Ram-Page, 1928.

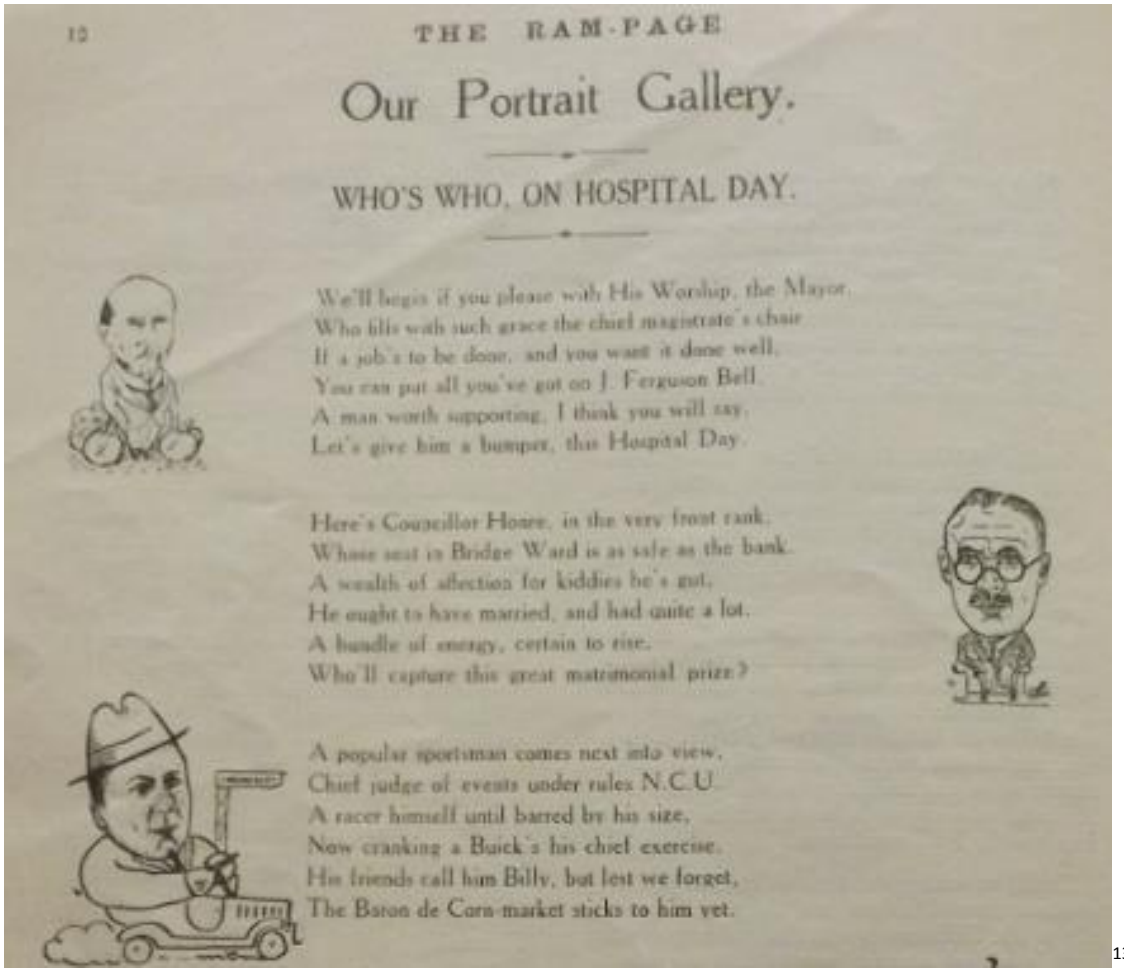


[133]

[131] *The Ram-Page*, 1930
[132] *The Ram-Page,* 1928
[133] *The Ram-Page,* 1928.

The magazine carried satirical poems and cartoons drawn for a 'Who's Who, On Hospital Day' piece, where local figures, like the mayor, town councillors, sportsmen, carnival committee members, and even the chief constable, were gently mocked.[134]

Figure 5.5: 'Our Portait Gallery', *The Ram-Page,* 1929.



12 THE RAM-PAGE

Our Portrait Gallery.

WHO'S WHO, ON HOSPITAL DAY.

We'll begin if you please with His Worship, the Mayor,
Who fills with such grace the chief magistrate's chair
If a job's to be done, and you want it done well,
You can put all you've got on J. Ferguson Bell
A man worth supporting, I think you will say,
Let's give him a bumper, this Hospital Day.

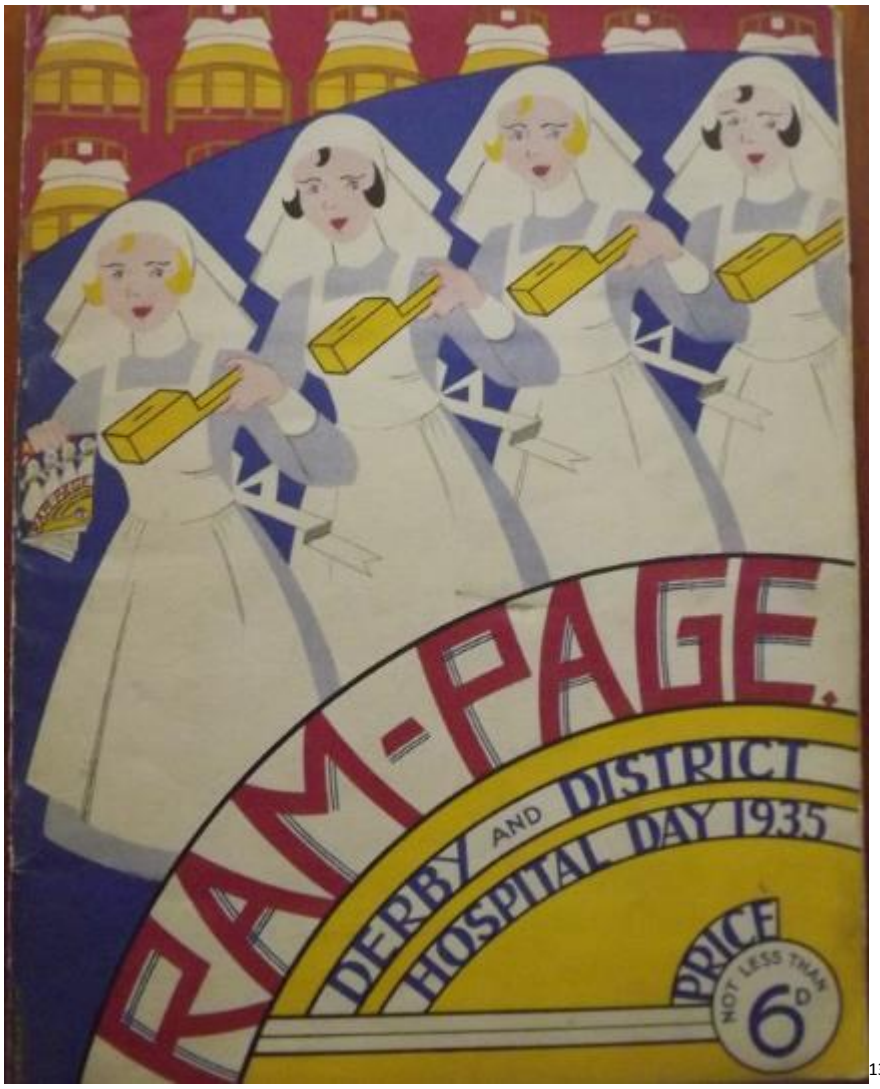
Here's Councillor Howe, in the very front rank,
Whose seat in Bridge Ward is as safe as the bank
A wealth of affection for kiddies he's got,
He ought to have married, and had quite a lot.
A bundle of energy, certain to rise,
Who'll capture this great matrimonial prize?

A popular sportsman comes next into view,
Chief judge of events under rules N.C.U.
A racer himself until barred by his size,
Now cranking a Buick's his chief exercise.
His friends call him Billy, but lest we forget,
The Baron de Corn-market sticks to him yet.

135

[134] *The Ram-Page,* 1929.
[135] *The Ram-Page,* 1929.

Figure 5.6 Front Cover, *The Ram-Page,* 1935.

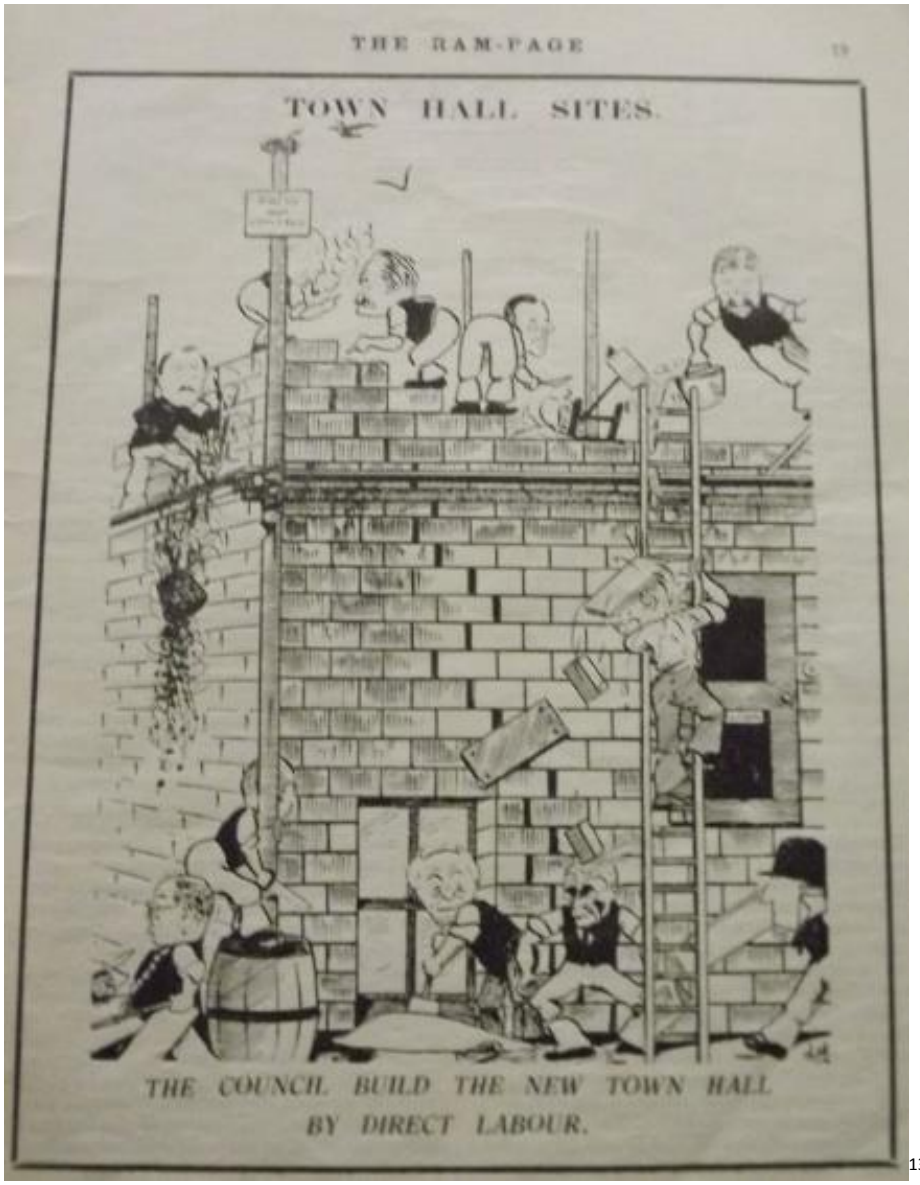


[136]

Such coverage was designed to add a certain approachability to the organisers and contributors to the Derby Hospital Day: a mild, carnivalesque social inversion, offering its audience a roster of human beings, real volunteers, who worked on behalf of the hospital. The magazine also ventured into political satire. The county council was a source of eternal mirth. Direct works contracting, where local councils employed their own labour force rather than engaging local private contractors was politically controversial. This was satirised, for example, by the cartoon named: 'The Council Build The New Town Hall By Direct Labour' shows identifiable members of the council, in striped trousers and white shirts, making a poor job of building the new town hall themselves.[137]

[136] *The Ram-Page,* 1935.
[137] *The Ram-Page,* 1931.

Figure 5.7: 'The Council Build the New Town Hall By Direct Labour', The Ram-Page, 1931.



[138]

It also poked fun at itself. Figure 5.8 shows two hospital volunteers in fancy dress on Hospital Day selling flags, discussing a donation by the sour looking gentlemen behind them: 'He said he'd bought a flag, given to the collection, and got a Ram-Page, so when I asked him for something extra for the Hospital he gave me this medicine bottle!'.[139] Here the satire is directed against the persistence of the hospital charity collectors that would harangue people in the streets asking for donation after donation. It indicates that there was a definite self-awareness around the culture of charitable fundraising by this time, and even its shortcomings. There were various different avenues that volunteers pursued when street-collecting. Some, like Nottingham University students rag week were both incredibly popular and raised significant sums of money annually: in Nottingham's case

[138] *The Ram-Page*, 1931
[139] *The Ram-Page, 1935.*

roughly £1,000 annually across the inter-war period.[140] Yet as the Ram-Page indicated, not all-street based activities were popular with the public. There was 'long-standing antipathy' towards flag days, viewed by many members of the public as little better than begging, tied to a general dislike of the old-fashioned charitable ethos.[141] In fact, so unpopular were the requests for extra donations at events, 'immunity badges' were sold for set prices to attendees, so that they could attend the events without being harassed by box-wielding volunteers.[142] By the 1930s, the public wanted entertainment for their money: raised through admission fees and extra pence spent on food, competitions, and keepsakes. Collection boxes and flag sales were auxiliary to that, and looked upon with less favour.

[140] Hayes, Doyle, 'Eggs, rags and whist drives, p.728.; 'The Pilgrim Fathers Come Back, 1928', *Pathe News,* https://www.britishpathe.com/video/the-pilgrim-fathers-come-back/query/nottingham+university+students [accessed 15/06/2020].
[141] Nick Hayes, 'Did We Really Want a National Health Service? Hospital, Patients and Public Opinions before 1948', *English Historical Review*, CXXVII:526 (2012) pp.642-643.
[142] *The Rip*, 1934.

Figure 5.8: 'He said he'd bought a flag, given to the collection, and got a Ram-Page, so I asked him for something extra for the hospital and he gave me this medicine bottle!', *The Ram-Page,* 1935.

[143]

[143] *The Ram-Page,* 1935.

Figure 5.9: 'Buy an Immunity Badge', *The Rip,* 1934.

[144]

The *Ram-Page* raised hundreds of pounds each year for the Derby Hospital Day.[145] Donors got a 60-70 page illustrated magazine chocked full of stories, poems, cartoons, songs, and advertisements. It was more appealing than a flag, ribbon, or badge, and did far more to evangelise the cause than those traditional, and disposable, tokens. Some criticised the magazine and the Hospital Day generally, arguing that costs were running out of control.[146] The consensus, however, was that in the current day attendees to such events expected a certain standard, and that committees had to spend certain amounts of money to raise larger amounts.[147] It was pointed out too that the Hospital Day net income continued to grow despite the expenditures. It was generally accepted that, in the words of Mr W G Underwood, 'you have to pay something to get something'.[148] Hospital Day donors expected quality entertainment in return for their donations. In fact, if anything, the pageantry grew more lavish, so that the costumes of the 'Carnival Court' became ever-more regal, the retinue more grand and more exuberant. The parades and processions, from the sincere but amateurish attempts of the previous decades, had turned into fantastic displays aimed at not just drawing the attention of the townsfolk, but at actually impressing them with the scale and effort. Thus, in 1936 at Markeaton Park in Derby: 'more than 40,000 people enjoyed a programme of entertainment, scene of jollity in

[144] *The Rip,* 1934.
[145] *The Ram-Page,* 1937.
[146] 'Spending To Attract. This Year's Carnival Arrangements. New Suggestions', *Derby Daily Telegraph,* 7 April 1936.
[147] 'Spending To Attract. This Year's Carnival Arrangements. New Suggestions', *Derby Daily Telegraph,* 7 April 1936.
[148] 'Spending To Attract. This Year's Carnival Arrangements. New Suggestions', *Derby Daily Telegraph,* 7 April 1936.

the streets where gaily dressed collectors wrung every possible penny out of citizens for the hospitals, the colourful procession, and finally the Carnival dance, at the Drill Hall, where 500 people danced until the day closed' – the increased attendance at the dance in no small part to Len Reynolds and his 'Metro Band' providing modern music for the partygoers.[149] New competitions, such as the capture of 'Mr Ram-Page' (a volunteer dressed in a certain way, whose description was broadcast over loudspeaker at the park) for the reward of £5, were well received. That year, over 400 copies of the Ram-Page were sold at Markeaton Park alone.

Figure 5.10: 'Principal Figures in Derby's Carnival Court', *Derby Daily Telegraph,* 1936.

DERBY EVENING TELEGRAPH, MONDAY, JULY 6, 1936.

PRINCIPAL FIGURES IN DERBY'S CARNIVAL COURT

The Carnival Court, civic dignitaries, and officials who took part in the Derby Hospital Carnival on Saturday. In the centre are the Carnival King and Queen, Mr. R. W. Haywood and Miss Dorothy Birch, and on either side are the Mayor and Mayoress of Derby (Alderman and Mrs. J. Clark). Standing on the right are (right to left) Mr. John Hill and Mr. Arthur Taylor, the joint secretaries, and Councillor C. W. Murden, and on the left are two former Mayors of Derby, Alderman A. E. Moult and Alderman H. Slaney.

150

The Hospital Carnival in Ripley arose, according to local press reports, because of the spontaneous desire of many citizens of the town and district to support their hospital.[151] This 'local patriotism' was quickly expanded to encompass a number of institutions in the county. 'What other towns have done well, Ripley can do better' was the claim from the speaker at a meeting held to plan the foundation of the carnival committee.[152] After it was formed, the carnival was planned to the usual winning formula: a parade or procession, a carnival king and queen, and a number of entertainments

[149] '40,000 Merrymakers Join In Carnival Gaiety At Markeaton Park. Unforgettable Scenes On Hospital Day. Hopes That 1935 Total Will Be Exceeded.', *Derby Daily Telegraph*, 6 July 1936.
[150] 'Principal Figures In Derby's Carnival Court', *Derby Daily Telegraph,* 6 July 1936.
[151] 'Ripley Ready To Let Things Rip. Carnival Royalty in Derby To-day', *Derby Daily Telegraph*, 24 August 1932.
[152] 'Ripley Ready To Let Things Rip. Carnival Royalty in Derby To-day', *Derby Daily Telegraph*, 24 August 1932.

and competitions. Its first year managed to raise £971 in profits, the money split between the cottage hospital, the Derbyshire Infirmary, Derbyshire Women's Hospital, Derbyshire Children's Hospital, the Ripley Nurse Fund, and the Ripley After Care Committee.[153] Considering that the much bigger, much more intensely organised, Long Eaton Carnival raised just a few hundred pounds more that Ripley's efforts, it shows that Ripley did an exceptional job of organising its efforts. In 1935, for example, the carnival donated £300 to clear Ripley Hospital's overdraft that had accumulated over the previous months.[154] The carnival, like so many other fundraising efforts across the two counties, added to the financial buoyancy of local hospitals, allowing greater financial freedom. Like Derby Hospital Day, it published a humorous magazine called 'The Rip', which gently mocked Ripley and its people, presented caricatures of local dignitaries, the local council, and the hospital volunteers themselves.

Figure 5.11: 'Ripley Urban Council's Idea of Cheap Public Baths…', *The Rip,* 1935

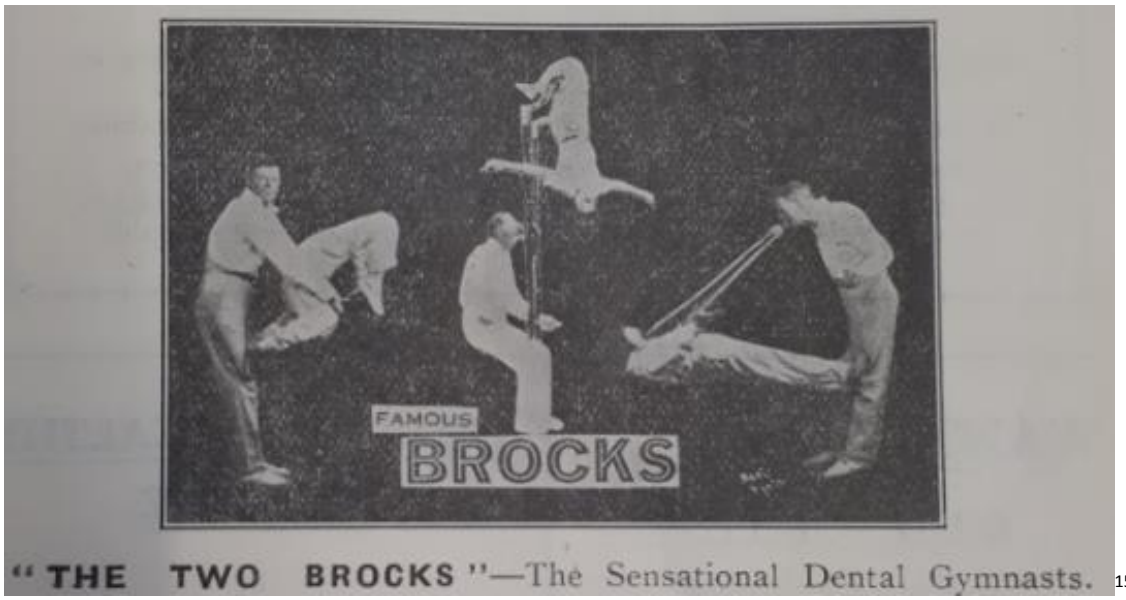
155

Some events were serious, others comical. There was a 'Stocking Competition', 'Blowing up a tube' competition, 'Pillow Fight on a Greasy Pole', 'Mothers and Grandmothers Ankle' competitions that

[153] 'Ripley Carnival Result', *Nottingham Journal*, 5 October 1932.
[154] 'Saved by Carnival Proceeds. Timely Grant of £300 to Ripley Hospital', *Derbyshire Times and Chesterfield Herald,* 8 November 1935.
[155] *The Rip,* 1935

were lined up alongside large boxing and tennis tournaments.[156] In doing so, it retained a light-hearted atmosphere, providing amusing entertainment beyond the normal sports competitions that populated most hospitals since the 1900s. There was a clear delineation between the events that featured local people and volunteers (such as the 'Go-as-you-like Concert – Bring your accordions, harmonicas, combs and paper!' and the Gresham Ladies' Gymnasts' Display team) and those events that were staffed by paid performers. In 1935, for example, there were two circus acts, 'The Czaras' Cossack Gymnasts and 'The Two Brocks – The Sensational Dental Gymnasts'.[157]

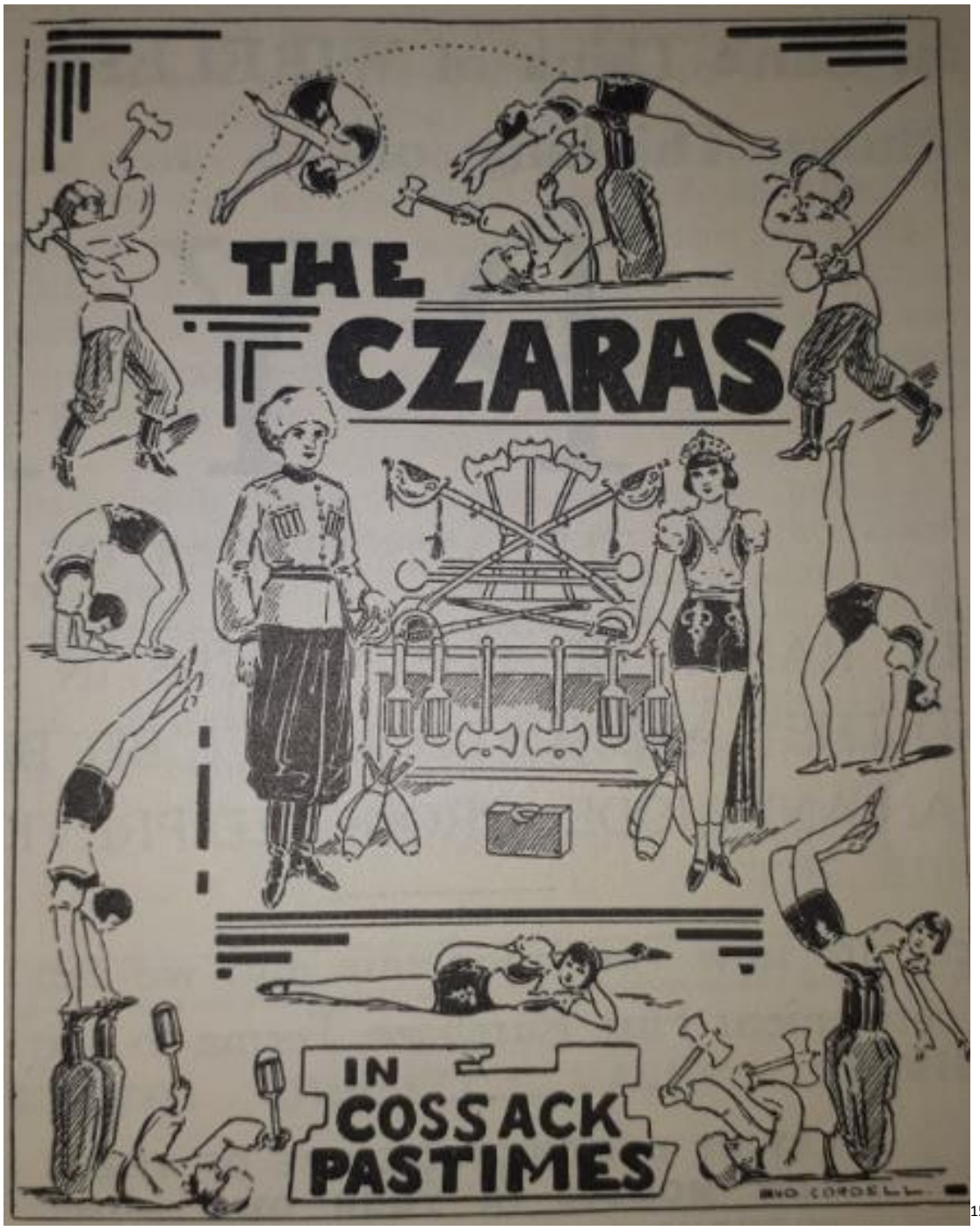
Figure 5.12: 'Famous Brocks', The Rip, 1935



[158]

[156] *The Rip,* 1932.; *The Rip,* 1934.; *The Rip,* 1935.; *The Rip,* 1937.
[157] *The Rip,* 1935.
[158] *The Rip*, 1935.

Figure 5.13: 'The Czaras', The Rip, 1935



[159]

In the evenings there were band concerts, dances, mass whist drives, and in particular a 'Grand Tramps Ball', where a prize was offered for 'Worst Dressed'.[160] It attracted the younger people, keen to socialise, dance, and soak up some music.[161] The Carnival made efforts to try and appeal to all demographics. It also had a 'senior' event competitions for older attendees, including bowls and

[159] *The Rip,* 1935.
[160] *The Rip,* 1932.; *The Rip,* 1937.; *The Rip,* 1938.
[161] Ross McKibbin, *The Ideologies of Class: Social Relations in Britain 1880-1950* (Oxford University Press: Oxford, 1994). p.395.

wicket bowling, as well as 'junior' events for children to participate in.

To make this happen there were a large number of volunteer organisers: a Procession Committee, Dance Committee, Entertainments Committee, Finance Committee, Publicity Committee, Magazine Committee, Grounds and Buildings Committee, and Ladies' Committee, all of which had at least 15 members (though there was some overlap).[162] Similarly, there was a large number of local firms and groups that contributed financially and materially to the carnival. Schools, council departments, churches and chapels, guilds and clubs, bus companies, newspaper offices, even allotment holder's associations, were all among the contributors to the organisation and execution of the carnival. It was a true focal point for cross-class community effort, bringing together businesses and government, worker and employer, to try and fundraise for a good cause. Once again it confounds the dichotomy of 'mutualism vs. charity' that is prevalent among historical debate today. However, after the initial bumper year for the carnival, 'profits' never managed to climb higher than £540. It appears that Ripley Carnival fell victim to the same over-ambitiousness that Long Eaton Carnival did, booking (thus paying) too many acts. The number of professional 'performers' rather than amateur volunteers increased, significantly raising costs. To reiterate, the first year in 1932 brought in £971, but figures for subsequent years were: £350 in 1934, £540 in 1935, £390 in 1936, and £400 in 1937.[163] Organisers became more focussed on providing pageantry than on charitable endeavour. In this respect carnivals, in becoming increasingly professionalised, took on a life force of their own.

Music and dance was a staple of hospital carnival events in the 1930s – much more than the ubiquitous marching bands of the pre-Great War era. Local brass and big bands, be they simply a village prize band, or a local colliery band, or a professional hired jazz band with a band leader, would accompany the parades, set up orchestra as an attraction themselves, or play the music for the evening's dance.[164] At Derby Hospital Day in 1936, the Carnival Bands Contest saw no less than a dozen bands enter, and the winners were the 'Ripley Jubilee Band', the 'Romany Rovers Band' (of Long Eaton), 'The Derby Midshipmen', and the 'Argentinas' (also of Long Eaton).[165] At no event was a band of some description not present. Their attendance meant that the carnivals were a distinct cultural event, typifying not just the culture of hospital fundraising, but the artistic and recreational culture of the working classes of the districts, who were (by greatest numbers) the primary

[162] *The Rip,* 1935.
[163] *The Rip, 1938,* p.7.
[164] 'In aid of Hospital – Cycle Carnival at Whittington Moor.', *Derbyshire Courier*, 20 April 1909, 'Children's Hospital Carnival', *Derby Daily Telegraph,* 18 April 1931.
[165] '40,000 Merrymakers Join In Carnival Gaiety At Markeaton Park. Unforgettable Scenes On Hospital Day. Hopes That 1935 Total Will Be Exceeded.', *Derby Daily Telegraph*, 6 July 1936.

attendees of these events. In the Long Eaton hospital carnival there were also numerous bands, and film reels show each band dressed in a different uniform: mock-military or as 'Spaniards' (Spanish Conquistadors) or other distinctive fancy dress.[166] Clearly the pageantry was not lost on the band members, who marched in ranks behind banners, accompanied by small children at their heels. Such 'dressing up' took these parades out of the local, and gave them an exotic international flavour.[167] As well as decorations advertising the local co-operative society and other businesses, the floats at Long Eaton's carnival were adorned with the British flag, and with ladies and gentlemen wearing formal eveningwear as a signifier of respectability and middle-classness.[168] Yet frequently such displays were parodies of authority, where men were dressed in tailcoats and bathing shorts, a display of subversion towards the traditional modes of class dress. There was also reference to international icons, such as the mock American skyscrapers built on the back of a flatbed truck. Yet there was room for tradition, too. The working and skilled-labouring classes were well represented, with the 'trades' being celebrated, with a float made into a large staircase with 'The Stairway to Prosperity' painted on the side, and 'Bricklayers, painters, Plumbers, Wheelwright & Blacksmiths' adorning each step.[169] Daunton argued that the voluntary hospitals sustained class division and defended class control, and that therefore they were not flexible nor responsive to their communities.[170] Class was most certainly present and obvious in fundraising, but it did not necessitate conflict or social control. Furthermore, hospital fundraisers and many hospitals themselves were far from unresponsive and inflexible when it came to organising new and up-to-date events. These events showed the way in which the hospitals had become ensconced in their communities; true 'people's hospitals' that Pickstone found, encapsulating community spirit within the practical necessities of medical provision.[171] Self-help and mutualism around hospitals and healthcare, Pickstone further argued,

---

[166] 'Long Eaton Hospital Carnival 1934', *Derby on Film*, DRO
[167] 'Long Eaton Hospital Carnival 1934', *Derby on Film*, DRO
[168] Nathan Joseph, *Uniforms and Nonuniforms: Communication Through Clothing* (Greenwood Press Ltd.: Westport, 1986) p.2., pp.65-68.; Roland Barthes, *The Fashion System* (University of California Press: London, 1990) p.115.; Hardy Amies, *The Englishman's Suit* (Quartet Books Ltd.: London, 2009) pp.47-58.
[169] *Derby On Film DVD 0022*, DRO
[170] M J Daunton, 'Payment and Participation: Welfare and State-Formation in Britain 1900-1951', *Past & Present*, 150 (1996) p.207.
[171] John Pickstone, 'Production, Community and Consumption: The Political Economy of Twentieth-Century Medicine', Roger Cooter and John Pickstone (eds.), *Medicine in the twentieth Century* Harwood Academic Publishers: Amsterdam, 2000) pp.6-7.; Anton Zijderveld, *A Theory of Urbanity: The Economic and Civic Culture of Cities* (Transaction Publishers: New Brunswick, 1998) pp.22-3.; Martin Gorsky, John Mohan, Martin Powell, 'British Voluntary Hospitals, 1871-1938: The Geography of Provision and Utilization', *Journal of Historical Geography* 25:4 (1999) p.474.; Hilary Marland, 'Lay and Medical Conceptions of Medical Charity during the Nineteenth Century: The Case of the Huddersfield General Dispensary and Infirmary', Jonathan Barry and Colin Jones (eds.), *Medicine and Charity before the Welfare State* (Routledge: London, 1991) pp.151-5.; Jonathan Reinarz, 'The Funding of Birmingham's Voluntary Hospitals in the Nineteenth Century', in Martin Gorsky and Sally Sheard, *Financing Medicine: The British Experience since 1750*, (Cambridge University Press: Cambridge, 2007) p.44.

was a growing core component of working-class identity.[172] One can see how the hospital carnivals started to take on the imagery of popular culture, as well as local culture.

Not all carnivals were large events using professional entertainers. All over the two counties, smaller towns and villages went to great lengths to hold carnivals. Ashbourne, Wirksworth, Alfreton, Ilkeston, smaller suburbs of larger towns like Chaddesdon in Derby, and even sleepy Whatstandwell had a carnival with over a dozen prizes awarded to fancy dress entrants and competition winners.[173] There were fewer individual events throughout the year – fewer cycling parades, fewer sports days, fewer collections. Instead though they were concentrated over a week of festivities under the larger umbrella of 'carnival'. Worksop town and hospital united to host the 'Worksop Shopping Week and Hospital Carnival', a combined week-long bazaar and carnival both in aid of the hospital but also as an example of civic boosterism: 'We hope to prove to all Visitors that Worksop is the Ideal Place to Live and Shop in'.[174] Even these smaller carnivals often split their proceeds between various hospitals, though most often had a key institution (either their most local one if there was one, or their county institution).

Mansfield's carnival was part of a broader event to raise money under the Mayor's Appeal Fund. In 1932 the carnival day itself included all the usual attractions as well as 'the roasting of a whole bullock'. [175] It raised £500 towards a £2,000 overall target. The bullock roasting was carried out with ceremony, and was an unusual event geared towards attracting the crowds as well as adding novelty to the event as a whole: 'It was estimated that the cooking would occupy six or seven hours before the Mayor…began the sale of sandwiches by cutting the first slice'.[176] Wherever the carnival-organisers could squeeze any form of pomp and ceremony in, they would do. No carnival was held without having at least a carnival king and queen, and more usually with a full retinue of carnival princes, princesses, or ladies-in-waiting, all participating in processions. In 1932 the Ripley Carnival king and queen even had a procession that started in Derby and worked its way via train all the way to Ripley town, where they were met by the 'master of the pageant' (a local councillor) whom escorted them to the 'royal coach', wherein was the 'court jester' and six 'maids of honour' (all local

[172] Pickstone, 'Production, Community and Consumption', pp.6-7.
[173] 'Hospital Carnival. Whatstandwell's Annual Effort', *Ripley and Heanor News and Ilkeston Division Free Press*, 19 August 1932.; 'The Rest of the News', *Nottingham Journal,* 21 July 1930.
[174] 'Worksop Shopping Week and Hospital Carnival', *Sheffield Independent,* 23 September 1933.
[175] 'Mansfield Hospital Carnival. Saturday's Good Beginning. About £500 Collected. To-day's Bullock-Roasting Ceremony', *Nottingham Evening Post,* 30 May 1932.
[176] 'Mansfield Hospital Carnival. Saturday's Good Beginning. About £500 Collected. To-day's Bullock-Roasting Ceremony', *Nottingham Evening Post,* 30 May 1932.

people chosen for the occasion), and the Ripley United Silver Prize Band escorted them to the marketplace where they were duly crowned.[177]

Similarly, the Newark Carnival king and queen began their procession in Nottingham, in an antique stagecoach, bearing a letter from the Lord Mayor of Nottingham to the Mayor of Newark, imparting best wishes and success in the carnival.[178] Chesterfield Carnival king and queen here heralded with two brass bands and their procession culminated with a fireworks display.[179] Carnivals, even the smaller ones, had grown to be much more fantastical than their more amateur forebears, in terms of both events, attractions, and ceremony. As such they had taken on 'civic' proportions, aping formal ceremonies in a light-hearted but simultaneously serious way. And it proved effective. The money accumulated by the carnival events was nothing short of a boon for the hospitals, the attraction of performance that the hospital carnival provided combined well with the altruistic ethos, appealing to the charitable sentiment of the public, but rewarding them with entertainment. The editors of the 'The Rip' put it best when they stated: 'Remember, this is no money-grabbing campaign. Every time you put your hand in your pocket during Carnival Week we intend to give you full value for money'.[180]

The Derbyshire Infirmary had decided to embark on large building works to accommodate the increased number of nursing and domestic staff that the institution had to hire after limitations were put on working hours.[181] It planned out an 'Extension Week', which was an ambitious programme of events, similar to other carnival weeks across the two counties, wherein the hospital used its extensive contacts to try and raise money.

[177] 'Ripley Ready To Let Things Rip. Carnival Royalty in Derby To-Day', *Derby Daily Telegraph,* 24 August 1932.
[178] 'Newark's Week of Carnival. Stage Coach to Start from Nottingham', *Nottingham Journal,* 11 September 1936.
[179] 'Chesterfield Hospital Carnival. "Shots" at Passing Lorry Realise over £12', *Sheffield Daily Telegraph*, 14 September 1931.
[180] *The Rip. The magazine of Ripley Carnival and Official Carnival Programme 1938*, (G C Brittain and Sons Ltd: Ripley, 1938) p.3.
[181] Derbyshire Royal Infirmary Extension Week 1939 Souvenir Programme.

Figure 5.14: 'Extension Week', Derbyshire Royal Infirmary, 1939.

[182]

An extension was completed and opened as recently as 1936, which still needed to be fully furnished. As well as the furnishing, the Extension Fund needed another £11,000 to add to the £79,000 already raised. The new extension, while primarily aimed at accommodating nursing and domestic staff, also included normal wards and paying wards, operating theatres, as well as various support facilities like sterilising rooms.[183] This was a large undertaking, and serves to show just how complicated, expensive, and versatile contemporary hospital extensions were at this time. It serves to show the scale at which the hospital needed grow, as well as the very large requirement it had for funds. In this latter capacity, it was determined to open the extension free of debt.

The list of events included a charity football match, a concert organised at Rolls Royce, an 'Old Time' dance, a whist drive and Monster whist drive and dance, Skating Carnival, a boxing match, a variety act led by Joan McCarthy, and a 'Grand Dance'.[184] This was a vibrant line-up, tapping into the growing craze for dancing, as well as the ever-popular whist competitions that so many hospitals had been organising for years. The majority of the events did take place in one week in late February, but the boxing match wasn't until March, and the variety act and football match not until April.[185] The 'week' was successful, but the success was tempered by the looming national emergency and subsequent war. By the time the Infirmary was able to use the money to implement the planned

[182] Derbyshire Royal Infirmary Extension Week 1939 Souvenir Programme.
[183] Derbyshire Royal Infirmary Extension Week 1939 Souvenir Programme.
[184] Derbyshire Royal Infirmary Extension Week 1939 Souvenir Programme.
[185] 'Derbyshire Royal Infirmary Extension Fund Week', *Derby Daily Telegraph*, 18 February 1939.

extensions and furnishings, the war slowed it down to a snail's pace as the Infirmary struggled to get the supplies it needed.[186] The war massively limited the ability of the hospitals not only to complete extensions, furnish their wards and theatres, and find staff, but also limited the extent to which they were able to organise public events. This will be explored in the next chapter, but this event was among the last to be organised before the war put a stop to large-scale hospital fundraising. Long Eaton Carnival, Derby Hospital Week, even things as small as the Ladies' Committee House-to-House Canvass were ended due to the conditions of war.

In many ways, community fundraising transcended the class divides of the era, as well as the typical dichotomy of 'philanthropy vs. mutualism' that form the bedrock of the historiography of healthcare before the NHS. It accommodated all those willing to participate. It is true that the key organisers were disproportionately middle-class men and women who either had the time to dedicate to it, or the social influence to be most effective. However, fundraising along the lines of sports events, amateur theatrics, parades and others, meant that just about anybody could become involved in helping to raise money for their local institution. Of course, this type of fundraising was not solely reserved for medical charities, but the hospital exemplar does serve as a prime example of localised communities 'banding together' to serve the greater good of 'giving' to a good cause. Distinct from each other, certainly, but there is little evidence to imply that there was a mode of conflict between the classes, although class was solidly evident.

In so many ways the voluntary hospitals in the 1930s gained momentum. Finances had seen a radical overhaul in the late 1920s and into the 1930s, the Saturday Funds and other mass funds by different names provided income unprecedented levels. Hospital volunteers were able to busy themselves with more and more work in aid of the hospital. The Saturday Funds took on personalities of their own, and the 'shift in entitlement' identified by Gorsky, Mohan, and Willis spurred on ideological as well as administrative change. The changeover to contributory schemes was the next organic step, removing the funds almost entirely from the guise of charity, and more into a form of social contract. If circumstances had been different, and war had not come, the potential of the contributory schemes might have been fully realised. 1938 and 1939 showed positive results for the Derbyshire and Nottinghamshire hospitals, suggesting that the contributory schemes were set to expand as they enfranchised more and more workers, despite some findings by Gorsky, Mohan, and Willis that saw downturns in income for some hospitals across the nation.[187] Income was compounded in many cases by the healthy cultivation of traditional annual subscriptions and

[186] Derbyshire Royal Infirmary Annual Report 1938-9.
[187] Gorsky, Mohan, Willis, *Mutualism and healthcare*, pp.60-64.

multiple forms of fundraising. Hospitals that made efforts to retain their annual subscription schemes, and proliferate donation drives like carnivals and street collections, managed to avoid serious deficits. The vibrancy of the hospital carnivals, even more so than in earlier decades, became a focal point for communities both big and small. Tens of thousands of ordinary citizens were able to attend entertainments while gaining the satisfaction of helping their local hospitals – and thus helping themselves.

Chapter 6: 1939-1948 – War, contribution, and the end of the voluntary hospitals.

The Second World War presented both a new and old set of challenges for voluntary hospitals. As in the Great War, the needs of the nation once again had to be balanced against that of the ongoing everyday medical requirements of the local county populace. But this time there were a number of key differences, not least the government's pre-war planning in anticipation of catastrophic civilian bombing casualties. To combat the threat of mass casualties, the government launched the Emergency Hospital Service (later known as the Emergency Medical Service or EMS). This aimed to coordinate the nation's hospital services around the reception of bombing casualties and war wounded. In this sense, the EMS went much further than co-ordination strategies in the Great War. It sought to ensure the civilian populace, not just the military wounded, were cared for in the event of mass bombing. It has been argued that the EMS was a stimulus for change; that the arenas that the Ministry of Health entered into under the auspices of wartime emergency sparked debate about a planned hospital system.[1] Richard Titmuss, in many ways the linchpin of debate surrounding the EMS, saw it as a remedy to a failing voluntary system, which had decayed into a state of negligence and stubborn mercenary attitudes.[2] Finlayson and Webster both saw the EMS as instigating significantly greater co-operation between the hospitals, as a prelude for the later nationalisation of hospital services.[3] Contemporaneously, the medical journals and presses hailed it as a future model for hospital services, cultivating a mindset of reform amongst medical professionals and the civil service, as well as wakening the voluntary hospitals up to the possibility of change.[4] Rivett argued that the EMS set the wheels of nationalisation and centralised hospital planning in motion, stating that the threat of the Luftwaffe made re-organisation paramount, and forced many hospitals to carry out levels of planning at which they had previously balked.[5] Mohan goes further, and asserted that the EMS was more than an example of successful planning, but also provided a model for the

[1] John Pickstone, *Medicine and Industrial Society. A History of Hospital Development in Manchester and its Region, 1752-1946,* (Manchester University Press: Manchester, 1985). pp.296-299.
[2] Richard M Titmuss, *Problems of Social Policy* (His Majesty's Stationery Office: London, 1950). p.60., p.67.
[3] Geoffrey Finlayson, *Citizen, State, and Social Welfare in Britain 1830-1990,* (Clarendon Press: Oxford, 1994). p.240.; Charles Webster, *The Health Services since the War. Problems of Health Care: The National Health Service before 1957* (TSO: London, 1988). p.7., p.17.; Jose Harris, 'War and Social History: Britain and the Home Front during the Second World War', *Contemporary European History*, 1:1 (1992) p.23.
[4] Frank Honigsbaum, *Health, happiness, and security the creation of the National Health Service* (Routledge: London, 1989), p.20.; Steven Cherry, *Medical Services and the Hospitals in Britain* (Cambridge University Press: Cambridge, 1996) p.77.
[5] G Rivett, *The Development of the London Hospital System, 1823–1982,* (King's Fund: London, 1986). p.240., p.243.

state financing of hospitals as well, illuminating how a centrally controlled funding body could administer equitable funding to hospitals all over the country.[6] Finlayson argued that 'Voluntarism…could not meet the volume of social need' and by the advent of war had accumulated a large number of groups hostile to its ethos – especially from the left.[7]

Not all agree, however. Fox argues that there was already a broad agreement among the medical services that reform and better planning was needed, and that the EMS was not the key stimulus, but a part of the broader narrative.[8] Fox further states that Titmuss' assessment of the pre-war voluntary system was wrong, and that his assessment was more based on polemic than fact. This chapter aims to evaluate the impact of the EMS, reviewing the interrelationship between it and the voluntary system. It does not aim to evaluate the necessity of the welfare state, but instead to focus on the extent to which the EMS transformed or influenced the voluntary system. As such, there are three key themes within this chapter: the EMS and its requirements and operations, the changes in hospital funding in terms of governmental and voluntary incomes, and the changing functions of hospitals in relation to civilian patients. It would be correct to label Titmuss' work as social and political commentary, rather than factual study.[9] But the questions which Titmuss raised are still relevant to intensive historical study, specifically: What was the state of the voluntary hospital's finances throughout the war years? What was the role played by the Emergency Medical Services in the voluntary hospitals?

The wartime experience prompted a variety of immediate reflections on hospital provision, and particularly voluntarism as an ideology. Titmuss argued that the war had revealed that the voluntary hospitals were morally derelict and financially insolvent, their presence led to 'confusion and delay' when the national crisis arrived, and indeed that the whole system was saved only from ruin by the government payments under the EMS.[10] He alleged, too, that voluntary hospitals had manipulated the EMS to maximise government income and minimise expenditure by keeping empty beds which were urgently required by civilian patients.[11] His was a polemical attack, motivated by a desire to rationalise the newly-founded NHS.[12] It is at odds with the more rationalised studies that have been conducted in more recent years, that found the voluntary system to be defined as much by

---

[6] John Mohan, *Planning, Markets, and Hospitals,* (Routledge: London, 2002). p.73., p.80., p.85.
[7] Geoffrey Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History,* 1:2 (1990) p.188., pp.197-8.
[8] Daniel Fox, *Health Policies, Health Politics: The British and American Experience* (Princeton university Press: Princeton, 1986). pp.32-3.
[9] Richard Titmuss, *Social Policy: An Introduction* (George Allen & Unwin Ltd.: London, 1974) pp.150-151.
[10] Titmuss, *Problems of Social Policy*,
p.57., p.61., p.67., p.69., p.72.
[11] Titmuss, *Problems of Social Policy,* pp.448-500.
[12] Titmuss, *Social Policy: An Introduction*, pp.150-151.

participation as charity.[13] Indeed, Titmuss himself confessed that the research required to draw solid conclusions had not been carried out, and that it was not research he was willing to undertake.[14] Nonetheless, and partly because of his existing reputation, his book came to be highly regarded among supporters of the welfare state.[15] But his was not the only view. C L Dunn was a regional hospital officer under the EMS, and wrote extensively of its operations after the war. He asserted that there was good-will between the voluntary hospitals and local authority hospitals in cooperating to deal with the crisis.[16] He found that despite the considerable casualties over the worst nine months of the blitz on London and other cities, and contrary to Titmuss' claim that civilian patients were left without treatment in favour of wartime casualties, there was 'no reduction whatever in admission of ordinary civilian cases'.[17] Sir Arthur MacNalty, Chief Medical Officer during the war, took a different view to Dunn, pointing to the large swathes of local authority TB and mental hospitals that were denuded of staff due to wartime need, and were left without being able to give treatment to their chronically sick patients – a problem that remained even at the end of the war.[18] Yet if he identified specific areas of concern, more generally he argued that the EMS offered significant potential for great organisation, and that generally a 'high level of efficiency' had been maintained throughout its tenure.[19] Titmuss might have been wrong, or misguided, in his conclusions, but the questions he raised still outline debate today.

Titmuss's starting point was that the hospital system generally was in 'poor health', and that in too many hospitals conditions were dire, with overcrowding, poor sanitation, and insurmountable waiting lists.[20] The advent of the war, he argued, highlighted these major shortcomings to the government. His claim that voluntary hospitals were keeping beds empty to collect on EMS grants typified his view that voluntary hospitals maintained a vampiric attitude towards their

---

[13] Daniel M Fox, 'The National Health Service and the Second World War: the elaboration of consensus', Harold L Smith (ed.), *War and Social Change: British Society in the Second World War* (Manchester University Press: Manchester, 1990) p.35.; Martin Gorsky, John Mohan and Martin Powell, 'The Financial Health of Voluntary Hospitals in Interwar Britain', *The Economic History Review*, 55:3 (2002) p.534.
[14] Titmuss, *Problems of Social Policy*, p.70.
[15] Fox, 'The National Health Service', p.36.; Ann Oakley, 'Eugenics, Social Medicine and the Career of Richard Titmuss in Britain, 1935-50', *The British Journal of Sociology*, 42:2, (1991) p.166., p.177.
[16] C L Dunn, *The Emergency Medical Services: Vol 2* (Her Majesty's Stationery Office: London, 1952)., p.199-200., p.253., p.264., pp.328-9.
[17] C L Dunn, *The Emergency Medical Services: Vol 1 England and Wales* (Her Majesty's Stationery Office: London, 1952)., p.116.; Finlayson, Geoffrey, Citizen, State, and Social Welfare in Britain 1830-1990, (Clarendon Press: Oxford, 1994). p.240.
[18] Sir Arhtur MacNalty, *The civilian health and medical services* (HMSO: London, 1953) pp.97-105., pp.187-189.
[19] Sir Arthur MacNalty, *Medical services in war: the principal medical lessons of the Second World War; based on the official medical histories of the United Kingdom, Canada, Australia, New Zealand and India,* (HMSO: London, 1969). P.304.
[20] Titmuss, *Problems of Social Policy*, p.60., pp.66-69.

communities.[21] Alexander McKee later noted on the founding of the NHS, 'The British have a socialized medical service simply because of the deplorable state of the old medical system'.[22] Yet, as discussed earlier, more recent studies have concluded that the degree to which voluntary hospitals were financially viable had been positively transformed since the Great War, and despite economic setbacks in the country as a whole, the voluntary hospitals had streamlined their incomes and broadened their scope, so that they were operating with greater incomes, and serving more patients than ever before. They were not stagnant traditionalist institutions clinging to the few pennies of charitable donations, nor were they dependent upon a few philanthropic magnates. Gorsky, Mohan and Powell, Hayes and Doyle found that years of financial struggle were isolated, new innovations in the form of contributory schemes and patient payments were steadying any erraticism in finances, and that, once again, regional variation was considerable.[23] Evidence from this study generally concurs, with the caveat that there were many and varied external conditions that affected the potential for long-term financial struggle, not least of which was unemployment.

The state had not been heavily involved in the voluntary hospitals since the Great War. Earnest planning for another conflict only began in the late 1930s. Sir John Hebb's account of the preparations shows how the nation was preparing for aerial bombardments after the Spanish Civil War and the Munich Crisis by forming civilian civil defence groups, establishing air-raid procedures, and communicating with hospitals about their upcoming duties. It is true that in many locations demand for hospital services far exceeded capacity to provide, especially in areas where the municipal system was underfunded.[24] However, provision was getting more equitable as the voluntary system matured into the nineteen-thirties.[25] Now, the challenge of another world war, indeed, a 'total war', presented the voluntary hospitals with an intensification of the problems they faced in the previous conflict. As Royle put it, provincial towns 'could not be divorced from the national scene', meaning the economic impact upon the hospitals, their patients, their finances, and their very independence as voluntary institutions was about to be tested. Financially, the war meant two things: rising costs incurred due to increased prices and workload (patients), and financial aid from the state in the form of EMS grants. The financial relationship will be shown to be not so cut and dry as one might assume, as the size and scale of the grant system meant that there was little

[21] Titmuss, *Problems of Social Policy,* p.448-450.
[22] Alexander McKee, *Strike from the Sky* (Souvenir Press: London, 1960) p.23.
[23] Martin Gorsky, John Mohan and Martin Powell, 'The Financial Health of Voluntary Hospitals in Interwar Britain', *The Economic History Review*, 55:3 (2002) p.539., p.547.
[24] John Mohan, 'Voluntarism, Municipalism and Welfare: The Geography of Hospital Utilization in England in 1938', *Transactions of the Institute of British Geographers*, 28:1 (2003) p.59., p.69.
[25] M. Gorsky, J. Mohan and M. Powell, 'British voluntary hospitals, 1871-1938: the geography of provision and utilization', *Journal of Historical Geography*, 25, (1999), pp.468-72.; M. Powell, 'Hospital provision before the NHS: territorial justice or inverse care law', *Journal of Social Policy*, 21, (1992), pp.145-63.

flexibility for the minutiae of individual hospital costs. Furthermore, the hospitals still had a duty to provide the care that their newly-created and much-lauded mass-contribution schemes offered, which relied totally upon the labouring classes to fund the hospitals, and which was received jubilantly by the hospitals as a 'panacea' for curing financial anxieties.[26]

The widely reported effects of bombing in the Spanish Civil War in the late nineteen-thirties greatly affected the attitudes of governments towards the dangers of aerial bombardment, and it became an obvious necessity to the Chamberlain government to attempt to cater for expected bombing casualties in any imminent conflict. As early as 1935 the Air Raid Precautions Department was founded to deal with the rising issue at hand.[27] In 1938, when war with Germany seemed ever more inevitable, the British government decided to organise the EMS to accommodate the predicted 35,000 casualties per day (with a further 17,500 killed) that would be incurred if Germany launched its bombing offensive.[28] Working with the existing system of voluntary hospitals and local-authority controlled hospitals, the EMS was an ambitious attempt to coordinate hospitals so that bombing casualties could be received and treated in the most efficient manner possible, as well as benefit from the lessons learned by the War Office during the First World War.

In the Great War, it was the War Office that coordinated the utilisation of civilian hospitals and the distribution of wounded soldiers. The founding of the Ministry of Health in 1919 meant that by the time preparations were being made for an emergency hospital service in 1938 and 1939, the War Office had much less direct involvement. As a result, for the first time, the voluntary hospitals were looking to a specific health-focussed government body for direct orders. However, it meant that the War Office and the Ministry of Health were jointly (if not equally) responsible for contact with the hospitals; the War Office for the care of armed forces in civilian hospitals, the Ministry of Health for civilian wounded, as well as making grants for the irregular maintenance and repair of the hospitals that came about as a result of the war. Initially, the EMS scheme covered the merchant marines, evacuees, transferred war workers and those civilians injured by enemy action.[29] In reality, in the early months of the war for hospitals generally, including those of Derbyshire and Nottinghamshire, this largely translated into treating wounded servicemen. The Ministry of Health split the nation into regions for organising wartime services and coordinating distribution of war wounded to the hospitals across the country. Almost equal organisation was put into just London as the rest of the

[26] Gorsky, Mohan, Willis, 'Hospital Contributory Schemes and the NHS Debates 1937–46: The Rejection of Social Insurance in the British Welfare State?', *Twentieth Century British History,* 16:2 (2006). p.172
[27] Richard M Titmuss, *Problems of Social Policy*, p.56.
[28] C L Dunn, *The Emergency Medical Services: Vol 1,* p.34.
[29] Eileen M Brooke, 'The Emergency Medical Services', W Franklin Mellor (ed.), *Medical History of the Second World War Casualties and Medical Statistics*, (Her Majesty's Stationery Office: London, 1972). p.800.

nation, with the capital split into ten triangular sectors branching out from the centre into the Greater London area, each with its own respective apex voluntary hospital.[30] Derbyshire and Nottinghamshire were in the 'North Midland Region', which included Derbyshire, Nottinghamshire, Leicestershire, Lincolnshire, Northamptonshire, Rutland, and the Soke of Peterborough.[31] The High Peak area of Derbyshire (the the very north-east) was put in with the 'North Western Region', because it was geographically closer to Manchester.[32] This regional organisation had little direct impact on the voluntary hospitals themselves, and was more for the Ministry of Health's benefit in terms of statistics and logistics. In the first weeks of the war, 190,000 casualty beds were secured for the reception of wounded civilians – this was halved by 1940, with thousands of doctors, nurses, and porters on the EMS payroll.[33] Nationally, in 1940-1, the total expenditure on the EMS (including air raid provisions, staff wages, hutted constructions, etc.) was already at £15,703,000.[34] By the end of 1944, 136,116 civilians (including civil defence members) had received hospital treatment due to enemy action.[35]

The Emergency Medical Service: patients, payments, and prerogatives

The national plan called for hospitals to cater for a high number of expected war casualties. As a consequence across the country hospitals, asylums, and sanatoria were almost totally cleared, whilst the Derbyshire Infirmary, Nottingham General, and Chesterfield Royal were all prepared for the evacuation of their wards, luckily they did not have to carry it through.[36] Some of the local authority hospitals, such as Bretby Hall and Harlow Wood sanatoria, were cleared of patients, but these returned in short time.[37] Convalescent-style hospitals, like sanatoria or orthopaedics, were seen as more readily and safely able to evacuate, whereas the hive of activity that was the general voluntary hospitals were held back. In the Great War, the hospitals initially offered their services for free to the armed forces. This time round, they made no such offer. This was not out of selfishness or a change in the feelings of patriotism at a time of national emergency. Instead, it was a more pragmatic and

[30] MH 76/8 *Fourteenth Report from the Select Committee on National Expenditure Session 1940-1941* (HMSO: London, 1941). P.19.
[31] Dunn, *The Emergency Medical Services,* p.42.
[32] Dunn, *The Emergency Medical Services,* p.42.
[33] MH101/4 *Summary Report by the Ministry of Health for the period from 1st April, 1939 to 31st March, 1941.* pp.22-.23.
[34] MH 76/8 *National Expenditure*, p.31.
[35] *Statistics Relating to the War Effort of the United Kingdom* (HMSO: London, 1944). P.9.
[36] Derbyshire Royal infirmary Annual Report 1939 (January-September).; Chesterfield Royal Hospital Board of Management Minutes 21 September 1939.; Nottingham General Hospital Monthly Board Minutes 19 July 1939.; Nottingham General Hospital Monthly Board Minutes 20 September 1939.; Nottingham General Hospital Monthly Board Minutes 18 October 1939.
[37] Derbyshire Royal Infirmary Annual Report 1939 (January – Sept); Personal Account, Mrs Mary Butcher, 2018. Mrs Butcher's brother was confined to Bretby Hall Tuberculosis Hospital for much of his young life and was brought home at the outbreak of the war for some months, as well as many other children.

complicit approach to the situation both from the hospitals and from the government. At the beginning of the Great War, neither the War Office or the voluntary hospitals were prepared for the extent to which the voluntary hospitals would have to be used for the reception of war wounded. In the Second World War, the planning was far more advanced, and the expectations far more accommodating to an emergency.[38] If the War Office underestimated the casualties in the Great War, the Ministry of Health significantly overestimated the numbers of civilian casualties in the Second World War. Instead of the predicted 35,000 casualties per day, civilian casualties/deaths due to enemy action across the span of the war totalled only some 64,000.[39] During the course of the war, roughly 86,700 civilians were admitted as in-patients to EMS hospitals because of war related injuries, with significantly more receiving out-patient treatment.[40] The hospitals started to receive their first EMS payments in 1939, but it was not until 1940 that significant grants started to be given by the Ministry of Health as more soldiers began to be admitted. The 'Phoney War' through the end of 1939 and into 1940 meant that the hospitals were not yet being fully utilised for war wounded.[41] Payments grew exponentially, roughly doubling year-on-year for Derbyshire Infirmary and Chesterfield Royal from 1939-1941.[42]

Table 6.1: EMS grants to Nottingham General, Derbyshire Infirmary, Chesterfield Royal, 1938-1946

EMS Income	Nottingham General	% of total income	Derbyshire Infirmary	% of total income	Chesterfield Royal	% of total income
1938	0	0	0	0	0	0
1939	502	1	4532	6	7468	18
1940	2955	4	9055	14	10036	19
1941	11674	11	20260	23	19451	43
1942	25490	20	19238	19	23399	33
1943	17861	15	31119	25	27095	34
1944	32516	21	16808	16	26371	31
1945	42823	24	55261	35	22237	24
1946	24455	16	18568	15	23060	22

[38] Sir Arthur MacNalty, 'The Public Health in War Time', *The British Medical Journal* (1940) pp.333-336.
[39] Central Statistical Office, *Statistical Digest of the War* (HMSO: London, 1951), Tables 37 and 38.
[40] Eileen M Brooke, 'The Emergency Medical Services', W Franklin Mellor (ed.), *Medical History of the Second World War Casualties and Medical Statistics,* (Her Majesty's Stationery Office: London, 1972). p.805
[41] Abel-Smith, *Hospitals,* pp.428-430.
[42] Chesterfield and North Derbyshire Royal Hospital Annual Report 1941.; Derbyshire Royal Infirmary Annual Report 1941.; Nottingham General Hospital Annual Report 1941.

Ostensibly, the Nottingham General was in receipt of some of the largest grants from the EMS. However, when the actual percentage of the total incomes of the hospital is considered, the Nottingham General had a far smaller proportion of its income made up by the EMS grants. After the first year of war, the Ministry of Health realised that its calculations had resulted in overly generous grants to the hospitals, far in excess of the cost of services they provided. Subsequently, the Ministry adjusted its bed requirements as it realised that the predicted casualties were nowhere near accurate, allowing hospitals to free up its reserved beds.[43] Nonetheless, the hospitals received only more and more EMS money as their services to the armed forces increased. The EMS grants paid to the hospitals were for services rendered, but also for the retention of spare and 'unused' beds in case of war-related emergency.[44] Titmuss alleged that the hospitals were able to essentially profiteer from this system of payments, by holding an excess of beds empty, refusing local patients, and collecting the EMS grant, points reinforced by Abel Smith who believed the voluntary system to be defined by overarching mercenary attitudes.[45] Titmuss argues, too, that national obligation and overzealous adherence to Ministry of Health requests meant that the EMS and armed forces sick were prioritised over the civilian sick.[46] There are certainly problems with such an analysis. Hospitals made arrangements with the Ministry of Health to receive wounded soldiers. Most of the soldiers were urgent cases, that were thus prioritised over pre-scheduled operations within the hospital, just as would be the case for civilian emergencies. Thus, at critical periods, service needs on emergency surgical and medical grounds crowded out civilian appointments, especially when government also directed that a reserve pool of beds remained vacant to deal with an expected aerial onslaught. However, Dunn disputed the idea that the civilian patients were disadvantaged by the inclusion of wartime casualties, arguing that the flexibility of the bed-transfers meant that civilian patients still had similar levels of access to hospital care to before the war.[47] The mass of civilian sick, the normal peacetime users of the voluntary hospitals, have been used by historians and commentators either as polemical tools to evaluate the hospital system's conduct, but their actual movements and quantities in relation to the war casualties treated has not been properly assessed on a local level.

Increases in the number of service patients had an inevitable effect on the civilian waiting list. More beds were physically made available – brought out of storage or provided by the government to simply provided more room for patients to be in hospital. Wards were crowded out, with the space

[43] Brooke, 'The Emergency Medical Services', p.800.
[44] MH76/2, *Select Committee on National Expenditure Report 1940-1.,* pp.18-22.
[45] Titmuss, *Problems of Social Policy,* pp.142-154.; Abel-Smith, *Hospitals*, p.429.
[46] Titmuss, *Problems of Social Policy,* p.454.
[47] Dunn, *Emergency Medical Service,* p.195.

between beds reduced and wards being reoriented for more effective use of space.[48] However, if the numbers of beds could be marginally increased to allow for a nominal increase in space for more patients, in actual fact there was no equivalent increase in the number of staff or facilities available for treatment (surgery or otherwise). The following table indicates how the war swelled bed numbers considerably.

Table 6.2: Number of Beds, Nottingham General, Derbyshire Royal, Chesterfield Hospital, 1935-1945.

	1935	1939	1945
Nottingham General	386	432	787
Derbyshire Royal	362	362	416
Chesterfield Royal	220	295	319

Hospital bed numbers were augmented with reserved EMS beds, beds within the annexes, and also any other pay-bed services they offered. Nottingham retained its annex for longer than the other hospitals into 1945, and thus had a considerably inflated bed count – removing the annexed beds puts Nottingham's total at 650.[49] Staff shortages across the board, as will be seen later, remained a major problem throughout the war, and was especially intense in such hospitals that were smaller, and had fewer doctors to spare for war service. The hospitals' response was to try to treat patients quicker, and reduce the number of days they spent in the institution – a point which the annexes, approved and funded by the EMS, were able to help with. Average number of days spent in hospitals reduced marginally throughout the war as the medical committees made efforts to discharge patients as quickly as possible, or transfer them to annexes or local authority institutions.[50] Comparing days spent in hospital from 1939 to 1944 (at the height of incoming wounded convoys), it can be seen that there was not a significant decrease in the rate at which patients were processed through the hospital.

Table 6.3: Average number of days spent in hospitals, Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, 1939 and 1944.

	Nottingham	Derbyshire	Chesterfield
1939	15	17	17
1944	13	14	16

[48] *1945 Hospital Survey* (HMSO: London, 1945) p.28.; Derbyshire Royal Infirmary Annual Report 1938-9.; Chesterfield and North Derbyshire Royal Hospital Annual Report 1939.
[49] Nottingham General Hospital Meeting of Governors Annual Report 1945.
[50] Derbyshire Royal Infirmary Annual Report 1943.

The hospital annexes for Chesterfield Hospital, Derbyshire Infirmary, and Nottingham General were essentially large premises converted to the purpose of housing patients who either required simpler non-emergency treatment or were recovering from treatment received in the parent institution. Statistics for the annexes show that days patients spent in those smaller institutions grew as the hospitals transferred their patients.[51] Without those annexes, the situation would have been far more acute.

The more significant charge by the system's detractors was that voluntary hospitals deliberately kept beds empty because it was financially advantageous to do; enabling them to receive fees without incurring costs, all while maintaining plausible deniability by following the direct orders of the Ministry. This argument essentially posits that hospitals benefitted financially in a more general sense from the EMS. This is the other side of the coin to Cherry's argument that the voluntary hospitals, because of existing shortfalls, became 'dependent upon state finance to meet wartime emergencies'.[52] The EMS grants were primarily for two things: the retention of empty beds in periods of high-intensity bombing, and the treatment of war casualties (be that servicemen or civilian casualties), with a third minor element being the repair, maintenance, and limited expansion of hospital premises for specific wartime requirements, like air raid precautions. Hospital accounts are less than transparent in terms of how such income was spent because, quite understandably, they do not separate out the costs incurred by different categories of patients. Similarly, EMS is not recorded separately between patients treated, beds, or the multitude of spares, repairs, and air-raid precautions throughout the hospitals that related to the war. All this was simply marked 'Emergency Medical Service – Grants'. The best that can be achieved is a rough indication of the extent to which the hospitals benefited – or not - from the large sums of money paid to them from the Ministry of Health. The capital costs of the annexes that the hospitals set up were paid for by the EMS. They do not appear in the financial records of their parent institutions, and thus are not receiving any voluntary funding. It explains why an institution such as Chesterfield Hospital, though treating only 5,514 service patients from 1939-1945, received such large grants – it had two such annexes for the transfer and treatment of patients outside of the main institution, which required significant investment to make them usable as hospital annexes.[53] However, despite the enigmatic specifics of itemised EMS income, the real issue is the rising current expenditure, and to what extent the EMS income filled this financial gap.

[51] Nottingham General Hospital Annual Report 1944; Derbyshire Royal Infirmary Annual Report 1945; Chesterfield and North Derbyshire Royal Hospital Annual Report 1945.
[52] Steven Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *The Economic History Review*, 50:2 (1997) p.322.
[53] Chesterfield and North Derbyshire Royal Hospital Annual Report 1945.

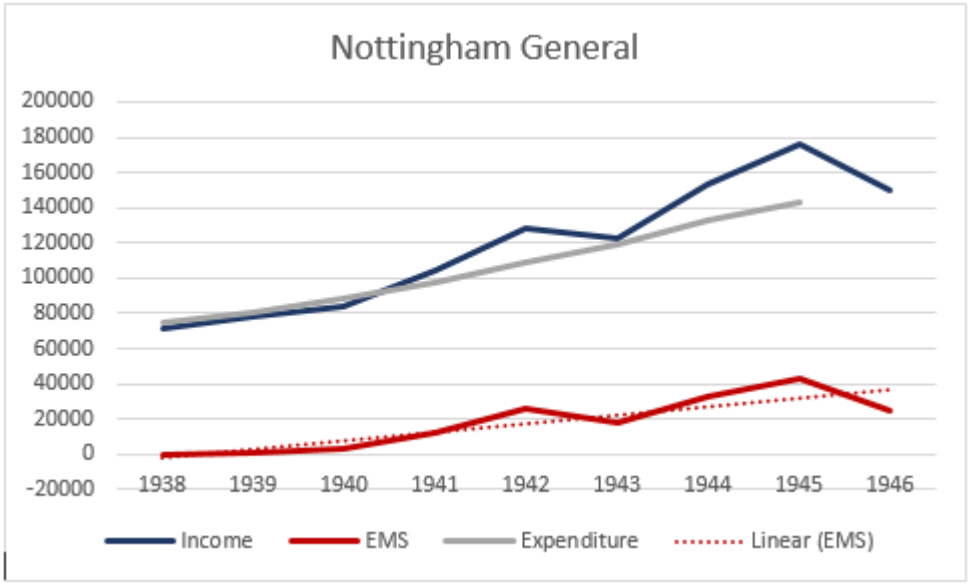
Table 6.4: EMS income as a percentage of total expenditure, Nottingham General, Derbyshire Infirmary, Chesterfield Royal, 1938-1945.

	Nottingham General	Derbyshire Infirmary	Chesterfield Royal
1939	0.6	6.8	17.5
1940	3.3	11.2	18.8
1941	11.9	22.4	29.2
1942	23.4	20.3	32.6
1943	15.0	30.4	33.6
1944	24.5	14.4	29.5
1945	29.8	42.3	23.0

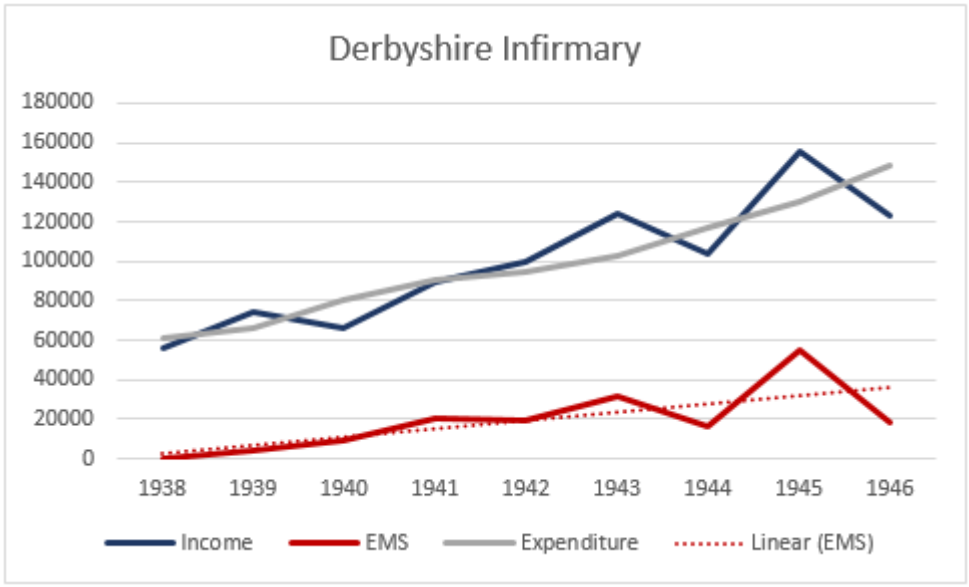
There was significant variation between the neighbouring hospitals. Nottingham General had the lowest relative EMS grants (by its size), and resultantly it was not until 1942 that its EMS percentage of expenditure became even roughly matched to Derbyshire Infirmary or Chesterfield Royal. It had been taking fewer EMS patients and had had fewer war-related adjustments done to the institution, opening its annex later in the war. Increases in EMS grants (as shown in the graph below) did not correlate with the increases in hospital expenses through the war. Although the EMS grants increased, the rate of increase fell behind that of rising expenditure costs, particularly the rapidly rising cost of provisions and fuel (the latter of which saw price increases throughout the war).[54] This casts doubt on Titmuss' and Abel-Smith's claims that hospitals benefitted from the EMS. In broad terms, income was only just keeping up with expenditure; there was no 'profit' to be made.

[54] Expenditure on provisions rose by more than 100% in all three hospitals.

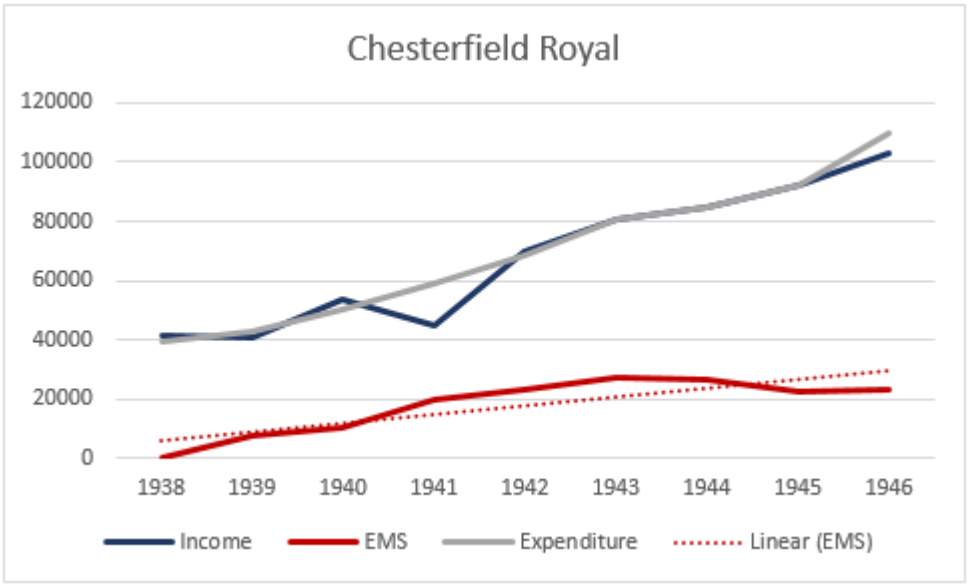
Graph 6.1: Nottingham General Hospital Income, EMS, Expenditure, 1938-1945.



Graph 6.2: Derbyshire Royal Infirmary Income, EMS, Expenditure, 1938-1945.

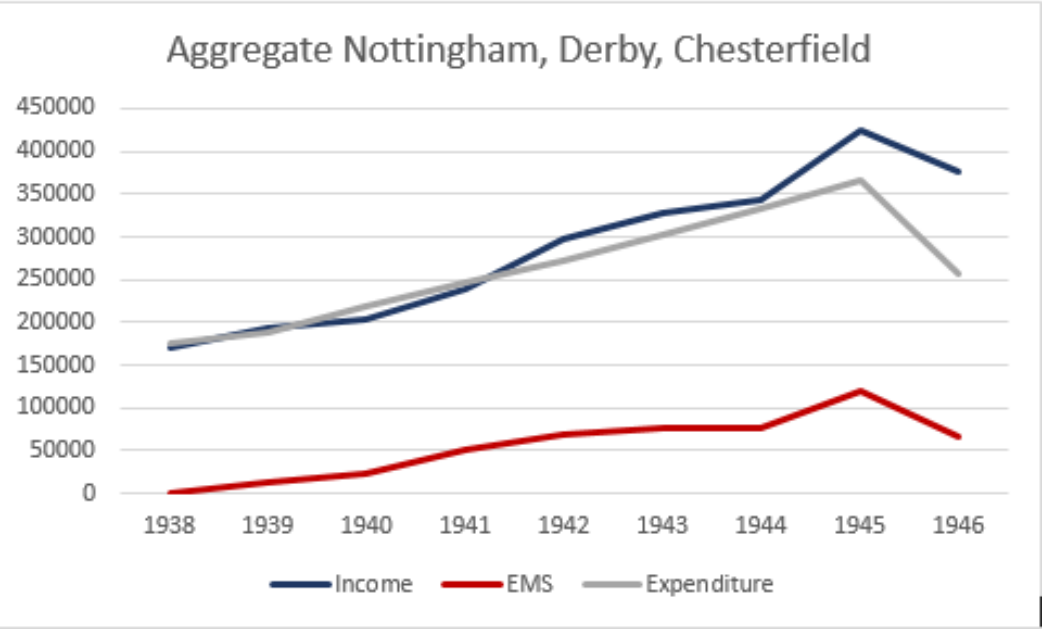


Graph 6.3: Chesterfield and North Derbyshire Royal Hospital Income, EMS, Expenditure, 1938-1945.



These graphs show how income was only just maintaining expenditure, and that the hospitals in Derbyshire and Nottinghamshire were certainly not reaping a net benefit from the EMS. Aggregate numbers show that only in 1945 were there significantly higher incomes than expenditures, as the war drew to a close, and prices and inflation stabilised.[55]

Graph 6.4: Nottingham General, Derbyshire Infirmary, Chesterfield Hospital Aggregated finances, 1938-1946.



[55] Mitchell and Jones, *Second Abstract of British Historical Statistics*, (Cambridge Univeristy Press: Cambridge, 1972). p. 191

Neither were local hospitals dependent on EMS to provide services. At no point in any of the three hospitals did income drop so far below expenditure to produce chronic deficits. The EMS grant system did what it was designed to do: help cover costs of treating war-related injuries and those on war-related duties. If hospitals depended upon EMS income to cover increased expenses associated with higher numbers of in-patients, as we shall see later, there was no dramatic decline of existing voluntary income types, even allowing for the disruptions caused by war, that would necessitate a 'bail-out' from the Ministry of Health.

A study of the surplus and deficit patterns throughout the Second World War reveals that there was no consistent relationship between EMS grant income and a stability in hospital finances. The deficits for the hospitals were not expunged as a result of the EMS grants, with Nottingham General experiencing a large deficit in 1943, and Derbyshire Infirmary in 1944.

Table 6.5: Nottingham General, Derbyshire Infirmary, Chesterfield Hospital EMS income and surplus/deficits on maintenance accounts, 1938-1945.

	Nottingham General		Derbyshire Infirmary		Chesterfield Royal	
	EMS	Surplus/ Deficit	EMS	Surplus/ Deficit	EMS	Surplus/ Deficit
1938	0	-3097	0	-4540	0	1710
1939	502	13160	4532	-13493	7468	-1545
1940	2955	13687	9055	-4589	10036	627
1941	11674	-1883	20260	-1379	19451	-1608
1942	25490	16892	19238	5372	23399	213
1943	17861	-7026	31119	21541	27095	548
1944	32516	1654	16808	-13175	26371	-1755
1945	42823	13166	55261	25362	22237	526

In fact, in broad terms the deficit and surplus patterns established during the 1930s continued though the war. Only in certain years, for example, in 1942 at Nottingham and in 1943 at Derby did EMS payments promote surpluses. In other years, despite hefty payments, rising costs yielded deficits. It must be remembered, too, that increased EMS capacity reduced payment income from civilian patients, either paid directly and through contributory funds. Chesterfield Hospital had accumulated deficits throughout the 1930s and this continued during the war as well. By 1945, despite running a surplus, there were debts within the balance sheet from rolling deficits amounting to £6,148.[56] The hospitals were spared, unlike their counterparts in the larger cities, the monumental task of having to deal with large amounts of regular bombing casualties or cope with physical bomb damage on the institutions in London, Birmingham, and the south coast. The General

[56] Chesterfield and North Derbyshire Royal Hospital Annual Report 1945.

Hospital in Birmingham suffered bombing damage to its nurses' home, as well as the chapel, and one bomb dropping through the full height of the hospital proper and detonating in its basement.[57]. In 1944, the Derbyshire Infirmary incurred heavy deficits at the same time that their responsibilities under the EMS were increased (larger convoys of patients). The drop in EMS income in 1944 which spurred the shortfall was a consequence of the EMS's system of retrospective payment.[58] This culminated in 1946 when the Infirmary incurred a £25,304 deficit which was unable to be cleared before the NHS took ownership of the institution. This deficit was roughly the equivalent amount by which EMS grants decreased, when other incomes all remained stable.[59] Salaries and wages increased by more than £13,000 from 1945 to 1946, which indicates that although there was a drop in EMS grants, the deficit was not as a result of the hospitals having to deal with service or EMS patients without appropriate compensation. Yet in other ways, Chesterfield Hospital, as well as Derbyshire Infirmary, made net gains from the war. Each had new facilities, wider remits, and had overcome significant challenges to do with staffing and patient numbers.

One key concern in need of evaluation is that of flexibility. How did the Ministry of Health and local hospitals respond to changing circumstances? For those alleging civilian disadvantage and financial gameplaying, the underpinning assertion is that both the hospitals and the EMS system, and for different reasons, remained largely intractable in not responding to changing circumstances. However, this does not capture the full picture, which is far more nuanced, where examples of change did occur. Nottingham General, for example, received less funds, fewer service patients, and was instructed to set aside a smaller proportion of emergency beds. In February 1940 the Ministry of Health told the hospital it no longer needed 'to keep beds empty in connection with the Emergency Hospital Scheme,' and that it could 'return to their normal work'.[60] Thus, payment for empty beds was discontinued, and the only funds released were when service personnel were treated in the hospital. However, in June 1940, as the bombing increased and the threat of invasion loomed, the hospital was once again instructed to reserve empty bed capacity.[61] Establishing the exact number count of EMS patients treated is problematic. Hospitals statistics do not separate out the EMS patient numbers from the regular civilian patients; only the number of 'service patients' (armed forces) were recorded, and in the case of Nottingham and Chesterfield, even this only spasmodically.

[57] Mary Ducrow, *A History of the General Hospital Birmingham*, (Unpublished manuscript, no date) p.225.
[58] Derbyshire Royal Infirmary Annual Report 1944.; Derbyshire Royal Infirmary Annual Report 1945; Derbyshire Royal Infirmary Board of Management Minutes Annual Meeting 1944.
[59] Derbyshire Royal Infirmary Annual Report 1946.
[60] Nottingham General Hospital Minutes of the Monthly Board, 21 February 1940.
[61] Nottingham General Hospital Minutes of the Monthly Board, 21 February 1940.

Table 6.6: Nottingham, Derbyshire, Chesterfield In-patients and Out-patients, 1938-1945.

	Nottingham General			Derbyshire Infirmary			Chesterfield Royal		
	In-patients	Out-patients	Recorded Service Patients	In-patients	Out-patients	Recorded Service Patients	In-patients	Out-patients	Recorded Service Patients
1938	8336	46008	0	6504	17605	0	4060	20186	0
1939	8538	47988	Unknown	6877	16497	Unknown	4169	20273	Unknown
1940	8346	47177	Unknown	7696	17845	1217	4554	20932	Unknown
1941	8595	51468	Unknown	6659	19535	739	4995	22768	Unknown
1942	9084	54562	Unknown	8098	21083	468	5532	22451	Unknown
1943	9980	55057	436	8498	23316	493	5626	23019	Unknown
1944	9643	50141	2362	9188	23074	2361	5364	23821	Unknown
1945	9944	51911	1530	9229	22111	1862	4900	22320	1815[62]

But, using Derbyshire Infirmary as an example, the patient figures indicate that, unsurprisingly, the number of civilian patients being treated from the beginning of the war fell markedly, especially in the early years of the war. This despite the capacity of the hospital being increased with the extra beds provided under the emergency scheme. After the nadir of 1941, when numbers fell significantly because of service demands, the situation for civilian patients began to improve. In Nottingham and Chesterfield the situation proved to be more stable. The total numbers of patients treated continued to rise steady from the outbreak of war, rising from 8,538 and 4169 respectively in 1939, to 9,643 and 5,364 by 1944.

Undoubtedly, however, the admittance of large numbers of service patients, impacted on the hospitals' capacity to treat civilian patients. The only way Nottingham was able to continue its levels of service was by not admitting as many service patients. Another problem was that the Nottingham and Derbyshire hospitals had to reduce ward space or close wards in areas vulnerable to air-raids, such as on top floors. Only the later addition of annexes, that were opened up outside of the hospital, rectified this. [63] Early in the war, the Nottingham General came to an arrangement with the City Hospital in Nottingham for them to take the brunt of wounded service patients so as to avoid the General Hospital waiting list becoming too swollen.[64] However, this arrangement was renegotiated as larger convoys of wounded servicemen started to be admitted to the Nottingham General Hospital in 1941.[65] Generally, as the war progressed, the civilian waiting lists grew longer

[62] Chesterfield Hospital states that throughout the war, a total of 5,514 service patients were admitted to the hospital for treatment. Chesterfield and North Derbyshire Royal Hospital Annual Report 1946.
[63] Derbyshire Royal Infirmary Annual Report 1940.; Nottingham General Hospital Monthly Board Minutes 20 December 1939
[64] Nottingham General Hospital Monthly Board Minutes, 20 December 1939.
[65] Nottingham General Hospital Annual Report 1941.; Nottingham General Hospital Annual Report 1942.

and longer (counter to Dunn's assertion), putting considerable pressure on the hospitals.. Nottingham General's civilian waiting list tripled from 1942 to 1944, rising from just 323 to 1,045.[66] By the end of 1945, the Derbyshire Royal Infirmary was working through a backlog of waiting patients nearly 4,000 strong.[67] The annexes, rather than necessarily reducing the waiting lists, instead expanded the capacity of the hospitals to treat military cases without increasing the capacity to treat civilian cases. The only thing that shortened the waiting lists was the reduction in the intake of military cases in 1945 onwards.[68] Interestingly, within the network of EMS hospitals especially built for the national emergency, some acute civilian sick were being admitted to these hospitals.[69] Once the Ministry of Health discovered this, the practice was ended, which shows that the Ministry had taken the decision to relegate any civilian sick underneath the provision of potential service or war wounded.

Just as Derbyshire Infirmary was beginning to make inroads into its waiting list, it was established as a 'Home Base' Hospital in 1944 by the Ministry of Health. It was recognised as a centre of neurological expertise and received as many as nineteen casualty convoys in 1944 alone. This was a total of 1,659 service patients, and the Infirmary was utilised as a key institution for neurosurgery.[70] In the same year, alongside this large convoy, there were also 702 other military inpatients, making a total of 2,361 military cases admitted for inpatient care in the hospital – 25% of total inpatient admissions. Furthermore, 4,871 military cases were admitted on the outpatient register, 21% of the 23,074 total outpatients attending the hospital. The previous year, though there were similar amounts of military outpatients, only had 493 military inpatients.[71] It extended the waiting list, diverted hospital resources, and meant that the hospital significantly shifted focus away from its civilian community and onto the national need. Similarly, with the opening of the 'Second Front' – the D-Day invasions - in 1944, hospitals were instructed to restrict accommodation for civilian patients down to 50% normal capacity. The consequence for Nottingham, for example, was that civilian waiting lists rose from 325 to 1,045 in 1944.[72] In short, there was a strong inverse correlation between the numbers of civilian and service cases treated. For example, the Derbyshire Infirmary saw a reduction in service cases of 499 from 1944 to 1945, the number of civilian cases admitted to the hospital was able to increase by 536.[73] Despite this, at the end of 1945, the civilian waiting list

[66] Nottingham General Hospital Annual Report 1944.
[67] Derbyshire Royal Infirmary Annual Report 1946.
[68] Derbyshire Royal Infirmary Annual Report 1946. A swift reduction of 941 patients on the waiting list from the previous year.
[69] HLG 7/680 *Admission of acute civilian sick to emergency hospitals*, 1940.
[70] Derbyshire Royal Infirmary Annual Report 1944.
[71] Derbyshire Royal Infirmary Annual Report 1943.
[72] Nottingham General Hospital Annual Report 1944.
[73] Derbyshire Royal Infirmary Annual Report 1945.

sat at 3,918 waiting for treatment – a large number when one considers the total inpatients treated altogether in 1945 was 7367 (not including the 1862 service inpatients).[74] As Titmuss noted, the war meant that civilian patients remained disadvantaged against their service counterparts, a point quite at odds with Dunn's assertion that there was little to no impact on civilians from the admission of service cases to the hospitals. There was a clear and direct impact, the amount of civilian patients being treated directly relating to the demands of the EMS

The growing pressure placed on hospitals does not, as Titmuss and Abel-Smith allege, amount to the wilful abandonment of the civilian sick; instead, the hospitals had no choice but to reduce their civilian-facing services in favour of the many hundreds of service patients being admitted. Nor, at least in the East Midlands, is there evidence that voluntary hospitals acted to gain financial advantage by keeping beds unnecessarily empty to maximise income through EMS subsidy. What is in fact clear is that the hospitals retained very few empty beds after the first period of the war, instead filling them with either civilian or service sick.[75] Bed occupancy rates in the hospitals increased by between 15-30% on peacetime. Admitting extra patients, whether EMS or local civilian, came at a cost. The years with the highest number of in-patients and out-patients were the years when hospitals were more likely to experience heavy deficits. In 1943, Nottingham General recorded its highest number of wartime in-patients and out-patients and had its highest deficit of £7,026. Similarly, the Derbyshire Infirmary saw its largest deficit in 1944, when hundreds more patients were admitted to the institution than the previous year.

The Nottingham General found itself up against a crisis across its wards, brought about by the side-lining of renovation throughout the war. The new annex in Selston School was opened in September of 1941 at the suggestion of the Ministry of Health, which helped to alleviate the civilian waiting list.[76] Similar annexes were opened for Chesterfield Royal in 1942 at Brambling House (80-100 beds) and for Derbyshire Infirmary in 1940 at Osmaston Manor (80 beds) and also a flexible auxiliary annex at Babington House in Belper.[77] These helped to alleviate the pressures on the hospitals, and were fully furnished and paid for by the Ministry of Health. In 1942 alone, the Babington House annex of the Derbyshire Infirmary treated 704 inpatients – allowing a total of 1,374 more patients to be

[74] Derbyshire Royal Infirmary Annual Report 1945.; Derbyshire Royal infirmary Annual Report 1946.
[75] Bed occupancy rates in the hospitals increased by between 15-30% on peacetime. Derbyshire Infirmary Annual Report 1944; Chesterfield and North Derbyshire Royal Hospital Annual Report 1944; Nottingham General Hospital Annual Report 1943.
[76] Nottingham General Hospital Monthly Board Minutes, 17 September 1941.
[77] Chesterfield and North Derbyshire Royal Hospital Annual Report 1942.; Derbyshire Royal Infirmary Minute and Order Book, 15 August 1940.; Derbyshire Royal Infirmary Minute and Order Book, 17 August 1940.; Derbyshire Royal Infirmary Annual Report 1942.

treated than the previous year - allowing a large increase in inpatient treatment at the Infirmary.[78] It meant that the focus of the three general hospitals was able to shift more onto the accident and emergency cases, and the annexes could deal with the medical cases and free up beds by offering space for recovery.[79]

Brief mention has already been made of the destabilising impact that EMS payments could have hospital finances. Hospitals received their EMS grants as much as a year after the services had been rendered. For instance, in 1944 the Derbyshire Infirmary received many more service in-patients as a result of the D-Day landings and was further made a 'Home-Base' hospital as a specialist centre for neurosurgery, increasing its duties to the EMS. The total of service personnel treated stood at 2,361, some 1,868 more than in the previous year, but it received one of its lowest EMS grants of the war at £16,808. That financial year it ran a large deficit of £13,175. A year later, with fewer patients, it received its largest ever EMS grant of £55,261 which resulted in its largest ever surplus of the war at £25,362. Thus, the EMS payments system caused major cashflow problems for hospitals in the interim between treatment and payment. In this sense, the EMS scheme was not the cash cow of Titmuss's imagination. The average cost per bed and the general overall expenditure was pushed up as a result not only of the prevailing economic circumstances of the war, but also because of these relatively expensive (per square footage compared to their parent institutions) new annexes. Various annexes were opened across the two counties, administered by the large general hospitals. Their parent institutions were in receipt of the funds, and the annexes treated as extra wards, rather than a separate institution. They were there to allow the overflow of contributing civilian patients and reduce the waiting lists, as the wards in the hospitals were becoming clogged with service patients. The following tables indicate the total expenditure on patients, patient numbers, and average cost per bed, as well as the percentage increase or decrease upon the previous year respectively for each of the hospitals:

[78] Derbyshire Royal Infirmary Annual Report 1942.
[79] Nottingham General Hospital Annual Report 1943.; Derbyshire Royal Infirmary Annual Report 1944.

Table 6.7: Nottingham General Hospital Expenditure, Inpatients, Average cost per bed, actual and percentage, 1938-46.

	1938	1939	1940	1941	1942	1943	1944	1945	1946
Total Expenditure	81079	87453	97606	109050	122038	136707	157835	169695	200456
% difference	-	7.9	11.6	11.7	11.9	12	15.5	7.5	18.1
Total Patient Numbers	80428	80172	79928	85902	87760	91073	84835	86919	89796
% difference	-	-0.3	-0.3	7.5	2.2	3.8	-6.8	2.5	3.3
Average Cost Per Bed	174	192	230	241	261	254	298	248	385
% difference	-	10.3	19.8	4.8	8.3	-2.7	17.3	-16.8	55.2

Table 6.8: Derbyshire Royal Infirmary Expenditure, Inpatients, Average cost per bed, actual and percentage, 1938-46.

	1938	1939	1940	1941	1942	1943	1944	1945	1946
Total Expenditure	60992	66258	80529	90611	94720	102303	116826	130503	148392
% difference		8.6	21.5	12.5	4.5	8	14.2	11.7	13.7
Total Patient Numbers	37642	37097	40514	42561	47058	50108	50642	49563	52267
% difference		-1.4	9.2	5	10.6	6.5	1.1	-2.1	5.5
Average Cost Per Bed	139	158	172	228	211	214	240	244	335
% difference		13.7	8.9	32.6	-7.5	1.4	12.1	1.7	37.3

Clearly rising costs had a significant impact on hospital finances, reflected in the rapidly escalating unit cost of treating patients, whose numbers, too, rose sharply as the war progressed. It was a pattern repeating in other parts of the country.[80] Under such conditions, the war, and war payments, did little to bolster or garnish hospital finances. Instead, the war brought with it clear financial impediments.

The war also brought other problems. Repairs and renewals within the hospitals was limited, and any new buildings or extensions were generally related to air raid defences, or annexing buildings for

[80] Gorsky & Mohan, *Don't Look Back?*, p.45.

the influx of wounded soldiers.[81] Nottingham General's extensions to its nurses home commenced just before the war started, was significantly delayed because of acute shortages of building materials, despite having the ready funds to purchase them.[82] Later in the war, as fear of air raids diminished and the hospitals settled more into the treatment of service war wounded, the hospital boards were able to start planning again, but were limited once again because extensions and improvements had to be run by the government and air raid authorities to make sure that they did not interfere with air raid safety precautions. In a lot of cases, the hospitals opted to wait until after the conflict had ended before attempting to permanently extend their premises. However, even well after the war in 1946, the Ministry of Health was keeping a tight rein on hospital spending on extensions; hospitals, whether they had the ready funds or not, had to sue for permission from the Ministry before they could tender out contracts for construction.[83] Similarly, the Derbyshire Infirmary, in desperate need of new kitchens, had had plans approved by its board of managers in 1939 to extend and remodel its existing facilities.[84] However, the conditions of the war meant that even by 1945, these alterations had never been made.[85]

Nottingham General continued to feel the strain even when the war had finished. This, despite the Ministry allowing them to drop their number of EMS accident and emergency beds down to 60 in September 1946 from as many as 220 in September 1945.[86] On appeal, this was reduced again to 30.[87] In October 1946, the Board had to take the difficult decision to close the Mabel Player Ward due to not being able to provide enough nursing staff across all of the wards. They had narrowly managed to avoid this in the previous year, but they finally found that they were unable to safely staff it without detriment to the performance of the hospital.[88] Instead, they decided to close and deep clean the ward, ready for the reception of children patients in the future. This ward had exclusively been used for HM Forces patients for many months previous to its closure.[89]

[81] Derbyshire Royal Infirmary Annual Report 1942, referring to the annex used in Belper; 'Hospital Expansion. Mansfield Negotiations for West Hill House.', *Nottingham Evening Post,* 26 April 1939. Just before the war, this hospital managed to secure an annex, used later during the war.
[82] Nottingham General Hospital Annual Report 1940.
[83] Nottingham General Hospital Annual Report 1946.
[84] Derbyshire Royal Infirmary Annual Report 1938-9.
[85] Derbyshire Royal Infirmary Annual Report 1945.
[86] Nottingham General Hospital Monthly Board Minutes, 18 September 1946.; Nottingham General Hospital Monthly Board Minutes, 20 September 1945.
[87] Nottingham General Hospital Monthly Board Minutes, 16 October 1946.
[88] Nottingham General Hospital Monthly Board Minutes, 16 October 1946.
[89] Nottingham General Hospital Monthly Board Minutes, 16 October 1946.

Staffing

The increasing demands of the Ministry of Health upon the hospitals resulted in the opening of annexes, the provision of more beds, and large EMS payments to the hospitals, but this only exacerbated the already serious staffing problems. Contemporary commentators and the Ministry of Health itself had identified quickly that high levels of organisation needed to occur if the denuding of hospital staffs like in the Great War was to be avoided.[90] The Ministry of Health was well aware that there was an especial shortage of nurses before the war, and resultantly there was formed a Civil Nursing Reserve.[91] The transfer of nurses for the war effort resulted in the most acute shortages, especially in tuberculosis hospitals, maternity homes, and in the mental hospitals.[92] The Ministry of Health, acting as a filter between the hospitals and the demands of the War Office, was able to prevent the mass exodus of doctors and that occurred in 1914 and 1915. However, difficulties were still experienced as staffing levels were gradually whittled down by the demands of war. Other groups, such as the Red Cross, Voluntary Aid Detachments (VADs), and the Civil Nursing Reserve stepped in to fill the gaps as best they could.[93] The Civil Nursing Reserve was formed to meet the deficit of nurses in Britain just before the war. In 1939, there were 60,000 trained nurses in the UK, but predictions suggested that to meet civilian and military requirements as much as 100,000 were needed.[94] The Civil Nursing Reserve, consisting of a mixture of retirees, trained, semi-trained, and untrained volunteers, managed to provide 20,000 nurses for placement across the country and in the forces.[95] Quite frequently they were deployed initially as domestic staff, until complaints led to them being given more relevant nursing duties. The VADs that replaced student nurses who had joined the armed forces (and who had a range of domestic and nursing duties within hospital) would not engage in typical domestic work, and thus hospitals had to hire more domestic staff.[96]

Even before the influx of wounded service patients, strains were put upon hospital faculties as qualified staff members were called up into the armed forces. As early as December 1939, Nottingham General had to employ auxiliary nurses (essentially with base-level training, and base-level pay) to cope with the loss in regular staff and the increase in bed numbers.[97] Soon, hospitals

---

[90] John B Hunter, 'The Emergency Medical Service and the Future', *The British Medical Journal*, (1 March 1941) p.327.
[91] MH101/4, *Summary Report by the Ministry of Health for the period from 1st Apirl, 1939 to 31st March 1941,* (HMSO: London, 1941). p.11.; Dunn, *Emergency Medical Services,* p.22.; Brian Abel-Smith, *A History of the Nursing Profession* (Heinemann: London, 1966). P.161
[92] Abel-Smith, *Nursing Profession*, p.178.; R Dingwall, A M Rafferty, and C Webster, *An introduction to the social history of nursing* (Routledge: London, 1988).p.105.
[93] Derbyshire Royal Infirmary Annual Report 1942.
[94] Brian Abel Smith, *A History of the Nursing Profession*, (Heinemann: London, 1966) p.161.
[95] Abel-Smith, *Nursing Profession*, p.162.
[96] Abel-Smith, *Nursing Profession,* p.163.
[97] Nottingham General Hospital Monthly Board Minutes, 20 December 1939.

found it necessary generally to increase the salaries and wages of its staffs, to try and retain what remaining staff they had.[98] Other institutions looked for more innovative ways to bolster their nursing staffs. Derbyshire Infirmary resolved in August 1940 to 'utilise…if suitable,' foreign-trained nurses.[99] Chesterfield recruited ever younger probationer nurses, named 'Nursing Cadets', aged 14, straight out of school.[100] Nottingham General, ever the wartime innovator, finally abandoned futile appeals to the War Office for the deferment of conscription for its porters (many were 'dereserved' by 1942, and thus eligible for service), and instead started employing women in that role.[101]

One possible solution, instigated by the Ministry of Health, was to rationalise the medical staffs across the hospitals, while feeding the War Office's demand to fill the ranks of the RAMC. Derbyshire Infirmary, Chesterfield Royal, and Nottingham General placed their doctors in a localised pool within the counties that they might be temporarily transferred to where they would be needed the most in emergency or strained situations.[102] The number of doctors available for loan was negotiated on an individual basis per institution with the Ministry of Health. Chesterfield Royal, for example, decided that fourteen of its medical staff be listed as available for loan, but with the strict stipulation that no more than six be loaned out at any one time.[103] Nottingham General took advantage of a scheme to employ 'on the short-term' exchange doctors from the US, another scheme organised by the Ministry of Health.[104] The American doctors were used by the Nottingham General in a number of different roles across the hospital's departments, and were a useful ad hoc auxiliary for the hospital to supplement whatever department might be feeling the extra strain.[105] That did not stop Nottingham General, and the other hospitals, from constantly appealing to the Ministry of Health and the War Office for the return of their medical staff.[106] As early as 1940, the General it found itself with only one surgeon in the Aural Department, and appealed to the Local War Emergency Committee of the British Medical Association for the return of one of their surgeons, Dr Gilroy Glass, from the war.[107] This was not approved. Neither was the subsequent appeal for a different surgeon to be returned in 1943; the Major Sheehan in question was already serving overseas.[108] A second

[98] Nottingham General Hospital Monthly Board Minutes, 21 June 1940.
[99] Derbyshire Royal Infirmary Minute and Order Book, 19 August 1940.
[100] Chesterfield Royal Hospital Annual Report 1946. 17 ½ years was the standard starting age for nurse probationers.
[101] Nottingham General Hospital Monthly Board Minutes, 18 March 1942.
[102] Nottingham General Hospital Monthly Board Minutes, 19 July 1939.; Chesterfield Royal Hospital Annual Report 1942.
[103] Chesterfield Royal Hospital Annual Report 1942.
[104] Nottingham General Hospital Annual Report 1942.
[105] Nottingham General Hospital Annual Report 1942.
[106] Nottingham General Hospital Monthly Board Minutes, 19 November 1941.
[107] Nottingham General Hospital Monthly Board Minutes, 18 December 1940.
[108] Nottingham General Hospital Monthly Board Minutes, 23 June 1943.; Nottingham General Hospital Monthly Board Minutes, 22 July 1943.

attempt was made to bring back both Dr Gilroy Glass and Major Sheehan from the front in 1944 and 1945, but both were once again refused.[109] It is clear that once the hospitals lost their medical men and women to the RAMC, it was highly unlikely they would return before the end of the war.

To add to the already complicated financial strains on the hospitals, the Rushcliffe Report on salaries for nurses between 1941-1943 added pressure on hospitals to improve nurses' salaries.[110] Nursing, though respected and professionalised by the 1930s, was woefully underpaid, and better-paid and more attractive war work either in the fields, the forces, or even in the Civil Service, was more appealing to young women.[111] Derbyshire Infirmary stated that there was a reduction in the 'number of candidates for the Nursing profession,' and that 'a shortage of nurses is likely to occur in the near future'.[112] A standardised scale of payments meant that many of the voluntary hospitals had to pay their nurses far more than they already were doing.[113] As a result, the hospitals started to receive grants from the government to cover this huge salary increase. It was found that nationally, the salary increases would cost between £1,500,000 and £2,000,000, and the Ministry of Health and the Exchequer, in recognising this huge cost to the hospitals across the country, agreed to pay fifty per cent of the increased expenditure to the voluntary hospitals and local authority hospitals.[114]

The hospitals received lots of help from the Voluntary Aid Detachments; organised groups of (usually female) volunteers that were mobilised for the war effort. Ashbourne Hospital, despite only receiving miniscule amounts of money from the Ministry of Health for the EMS, received hundreds of hours of VAD help, amounting to some 2802 hours between 1941 and 1945, suggesting that staff shortages were more a key issue for this institution.[115] The war had a curious effect where the staffs of these small institutions were stripped away, only to be replaced again by VAD members or other staff (sometimes coming from retirement). It was a circular movement of people that occurred in the large hospitals too. Qualified and experienced staff were stripped from the institution, to be replaced with more junior inexperienced staff, or in many cases, not replaced at all. It had a proportionally stronger effect on the smaller institutions, as shown by the many hundreds of hours of VAD assistance given to Ashbourne, where the institutions employed so few staff in the first

[109] Nottingham General Hospital Monthly Board Minutes, 15 October 1944.; Nottingham General Hospital Monthly Board Minutes, 18 April 1945.
[110] 'Nurses' Salaries: Rushcliffe Committee's Report', *British Medical Journal*, 27 February 1943, p.264.
[111] Arthur Marwick, *The Home Front. The British and the Second World War* (Thames and Hudson: London, 1976). pp.132-138.
[112] Derbyshire Royal Infirmary Annual Report 1942.
[113] MH101/4, *Summary Report by the Ministry of Health for the period from 1st Apirl, 1939 to 31st March 1941,* (HMSO: London, 1941). p.11.
[114] *Hansard*, 11 February 1943, Volume 386, p.12., words of Mr Ernest Brown (Minister of Health).
[115] Ashbourne Victoria Memorial Hospital Annual Reports 1939-1946.

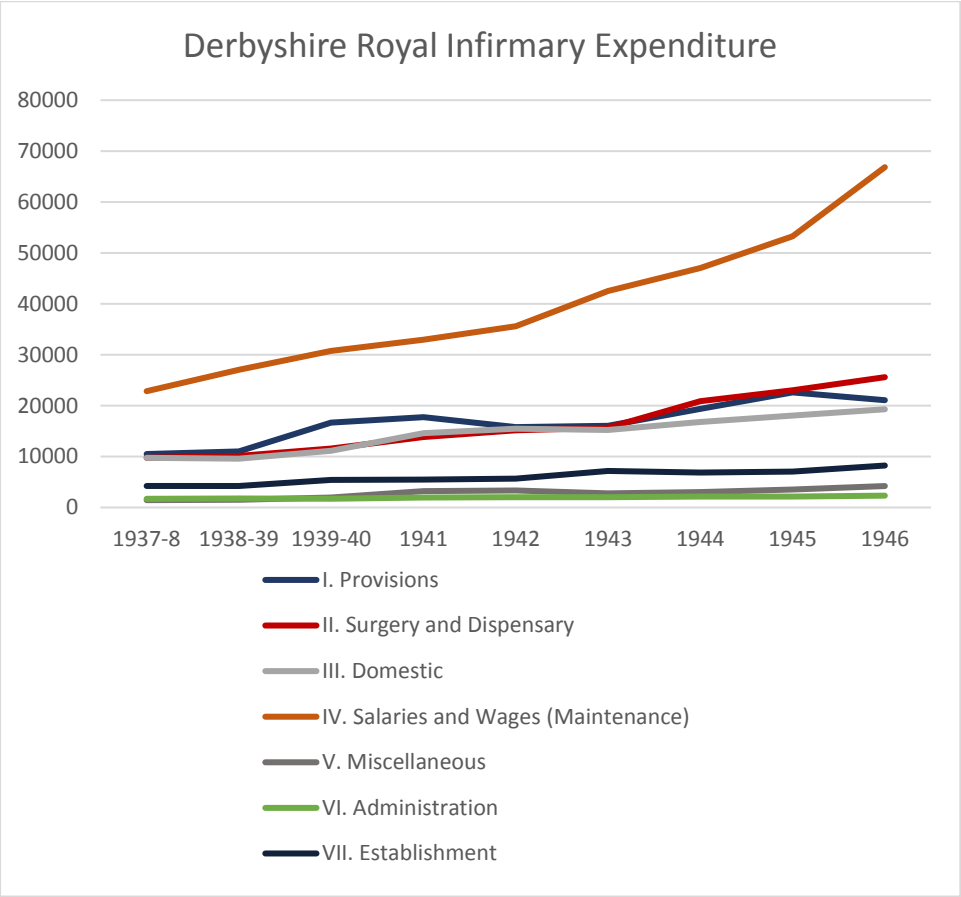
place. Ashbourne's returns to the Ministry of Health showed that they had had minimal involvement with EMS cases, only drawing grants for Air Raid precautions – £21 in total for 1939.[116]

Voluntary Incomes and the War

The money that hospitals received from the EMS was certainly welcome, but not a windfall. The Ministry of Health was paying the hospitals for services provided. Otherwise, the hospitals had to continue to perform their regular duties, providing scheduled and emergency care to civilian patients. The hospitals had reached a rough equilibrium by the war, where contributory schemes provided a buoyant stream of regular income. The war, however, presented new challenges beyond that of providing EMS services. Not least of these were rising costs. The most significant cost for hospitals, overall, was salaries and wages, and it was this component that continued to rise exponentially throughout the war and in the years after. The breakdown of expenditures from Derbyshire Infirmary show a picture of rising costs for the hospital, and while provisions, surgery and dispensary, and domestic costs all increased, they were dwarfed by the huge rise in the expenditure on wages.[117]

[116] Ashbourne Victoria Hospital Papers. Correspondence with Ministry of Health, 1940.
[117] Derbyshire Royal Infirmary Annual Report, 1938-1946.

Graph 6.5: Derbyshire Royal Infirmary Expenditure Breakdown, 1937-1946.



It was a trend that began before the war. Between 1937 and 1939, the wages bill of the hospital increased nearly £10,000. With the advent of the Rushcliffe Committee, which began looking at nurse and midwife salaries from 1941, the hospitals received grants after 1942 from the Ministry of Health to further help them cope with rising costs.[118] For some time there had been pressure on hospitals to increase the salaries of nurses, who, as already mentioned, found themselves woefully underpaid and overworked.[119] The Rushcliffe Committee addressed the problem by formulating a standardised rate of payment for nurses, and encouraged hospitals to conform to these payments, but hospitals had already felt compelled to increase wages for medical, nursing, and domestic staffs to retain their staff for the aforementioned reasons - for other institutions, or more lucrative war-work. Chesterfield Royal received £4,110 and Nottingham General received £7,915 from 1944 to 1946 from grants associated with nursing salaries.[120] However, wartime expenditure on salaries and

[118] 'Salaries and Emoluments of Nurses. First Report of Rushcliffe Committee', *British Medical Journal*, 27 February 1943, p.264.
[119] Martin Gorsky, John Mohan, Martin Powell, 'The financial health of voluntary hospitals in interwar Britain', Economic History Review, *Economic History Review*, 3, (2002) p.546.
[120] Chesterfield and North Derbyshire Royal Hospital Annual Report 1945.; Chesterfield and North Derbyshire Royal Hospital Annual Report 1947.; Nottingham General Hospital Annual Report 1944.; Nottingham General Hospital Annual Report 1946.

wages for these two hospitals had increased astronomically. Between 1940 and 1945, Chesterfield's wages bill increased by £14,269, and Nottingham's increased by some £26,204.[121] Derbyshire Infirmary received a much smaller grant, £2,320, because its salaries for nurses were already closer in line to the Rushcliffe recommendations prior to the war (as illustrated in the graph above). The grants for nurse's salaries were but a drop in the ocean for the hospitals, and added up to between only 10-20% of the total wages bill. Chesterfield Royal pointed out that, in 1943, almost all costs were increasing, but chiefly that salaries were the most burdensome, having to keep in line with the 'nation' in its increases.[122]

Added financial pressure came from the loss of contributions from those workers called up into the armed forces, because, nonetheless, hospitals decided to allow the continued coverage of serving mens' families. There were a number of workforce problems nationally, with the Chamberlain government having introduced the Emergency Power Act in order to control the work force for the war effort in the most effective way.[123] Increasing conscription, despite removing many men from the workforce, replaced them with increasing numbers of women, all of whom were eligible for membership. This in part explains the resilience of the contributory system, because income continued to rise as more members joined. By 1941, Nottingham General was generally satisfied with the progress of its contributory scheme, but recognised that both contractual style of the schemes and the circumstances of the war limited the hospital's ability to reach out via 'special appeals'.[124] Instead, it urged the 'employers of labour' for 'personal subscriptions and donations' to supplement the contributory income provided by their employees.[125]

As discussed in the previous chapter, many of the contributory schemes had income caps. This started to create problems as wages were boosted into the war years. By 1942, with the 'wartime bonuses' and keenness of higher earners to become associated with the hospitals, Chesterfield Hospital decided to increase its contributory scheme income limit to £420, which was quite a comfortable income for the time (sitting at around two thirds of an average male professional income).[126] There had always been a certain reluctance to 'open' the voluntary hospitals to the middle-classes, for fear that the original roots of voluntarism, namely the provision of affordable

[121] Chesterfield and North Derbyshire Royal Hospital Annual Report 1940.; Chesterfield and North Derbyshire Royal Hospital Annual Report 1945.; Nottingham General Hospital Annual Report 1940.; Nottingham General Hospital Annual Report 1945.
[122] Chesterfield and North Derbyshire Royal Hospitals Annual Report 1943.
[123] Mark J Crowley, 'Reducing, re-defining and retaining: the struggle to maintain a stable workforce and service in the British Post Office during the Second World War', *Essays in Economic & Business History*, Vol XXXI, (2013) p.60.
[124] Nottingham General Hospital Annual General Board of Governors Report 1941.
[125] Nottingham General Hospital Annual General Board of Governors Report 1941.
[126] Chesterfield and North Derbyshire Royal Hospital Annual Report 1942.; Routh, *Occupation and Pay*, p.63.

care for the working poor, would be eroded and that it would further be of detriment to medical private practice. However, with the introduction and proliferation of pay beds in the 1920s and 1930s, steps had consciously been taken towards including what was a theoretical dark zone of middle-class individuals who were too well off for the hospital schemes, but not well-off enough to purchase private care. The Sheffield schemes removed all income limits in an effort to maximise their income sweep, an ideologically universalist step that the hospitals of Derbyshire and Nottinghamshire never quite took.

The wartime income figures for the contributory schemes reveal a disparity of fortunes.

Table 6.9: Contributory Income, Nottingham General, Derbyshire Infirmary, Chesterfield Hospital, 1936-1946.

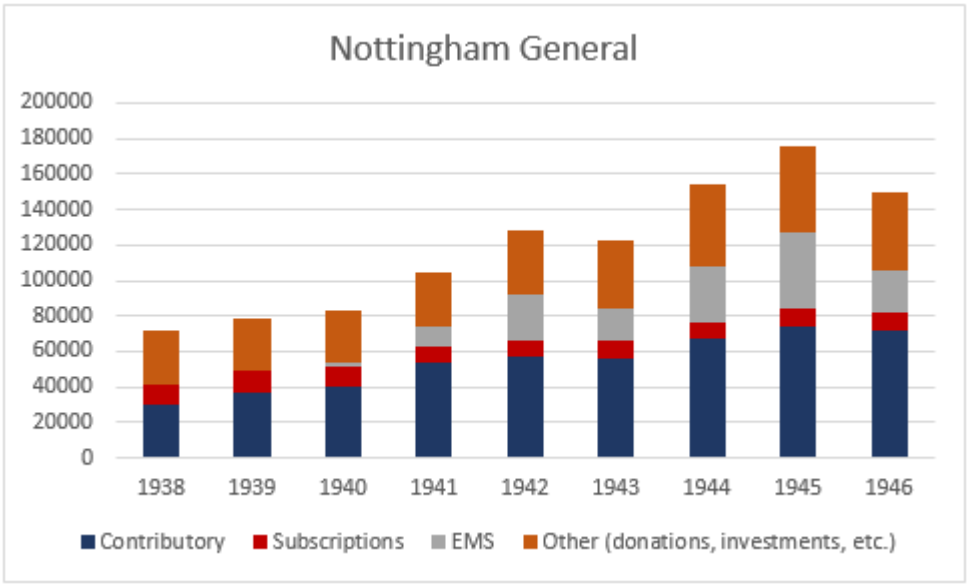
	Nottingham General	Derbyshire Infirmary	Chesterfield Hospital
1936	27593	21415	17812
1937	25951	22551	25209
1938	30443	23161	25521
1939	37199	20394	25589
1940	40455	20639	25671
1941	53267	23850	26636
1942	57608	22193	25720
1943	56384	30503	34500
1944	67332	26185	36397
1945	74024	32680	41562
1946	71996	35080	36546

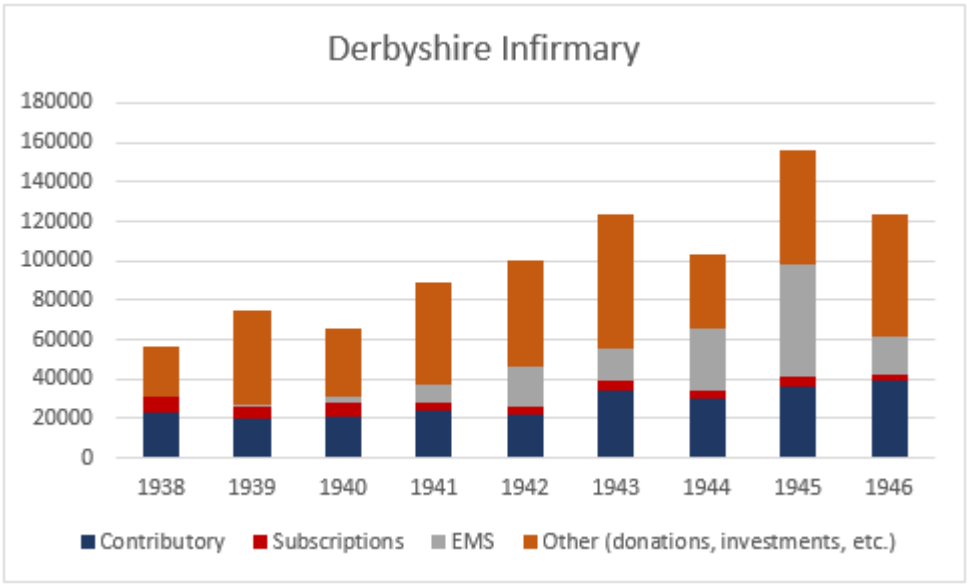
From a 1939 base year, Nottingham General's scheme almost doubled, with largely consistent growth across time to 1945, whereas Chesterfield Hospital and Derbyshire Infirmary grew by 61% and 58% respectively, but in the first three years of war, growth was unenergetic. It must be remembered, however, that in real terms this increase was significantly less because of wartime inflation (running at roughly 30% 1939-45, and being particularly heavy in the first years of the war).[127] So in real terms, Nottingham's income grew by roughly 25% from 1939 to 1946, though in 1940 and 1943 drops in contributory income and increases in EMS in-patients resulted in unexpectedly heavy deficits.[128] Derbyshire Infirmary gained a much smaller income from its contributory scheme as a proportion of its income compared to the other hospitals, primarily because it only established a scheme after the war had begun, and thus did not have the background

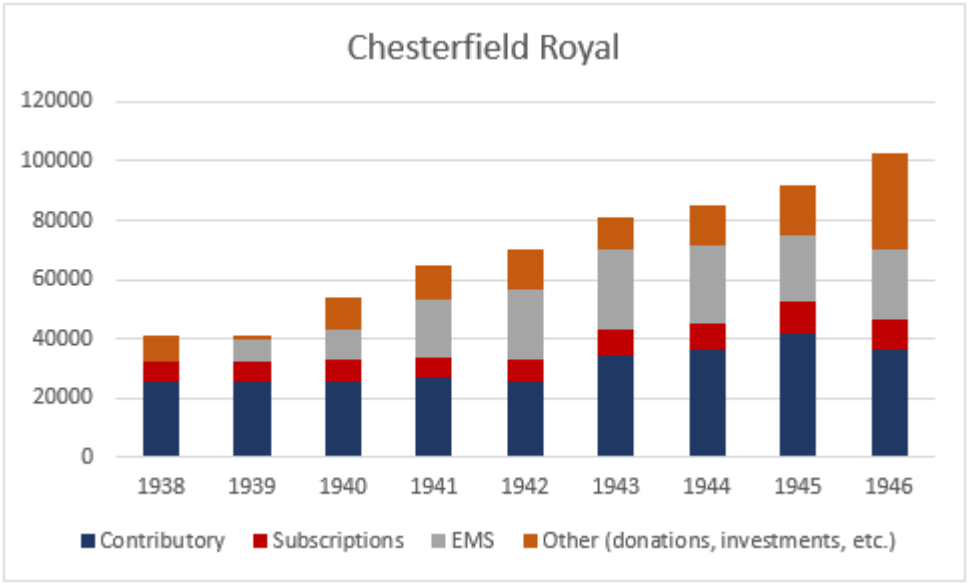
[127] B R Mitchell, *Abstract of British Historical Statistics*, (Cambridge University Press: London, 1962). p.191.
[128] Nottingham General Hospital Annual Report 1941.; Nottingham General Hospital Annual Report 1943.; Nottingham General Hospital Annual Report 1944

of a peacetime economy to allow it to establish itself within the community. It was a disappointing result for the Infirmary, whose subscriptions and other incomes did not grow to accommodate the more sluggish growth of the contributory scheme. Indeed, accounting for inflation, total income for the Derbyshire Infirmary (excluding EMS) shrank considerably, falling by 14% between 1938-1946. This decline was unfortunately aided by the reduction in subscription/donation income throughout the war as well. By contrast, overall growth in Chesterfield and Nottingham hospital incomes meant that their finances remained stable.

Graph 6.6-6.9: Nottingham General, Derbyshire Infirmary, Chesterfield Royal income (actual) breakdowns, 1938-1946.







Subscriptions, once the bastion of income for the voluntary hospitals, were by the Second World War playing a very minor role, and experienced rapid decline in the first years of the war, due in large part to the difficulty in wartime of fundraising. Excluding EMS income, subscriptions at Derbyshire Infirmary fell to less than five per cent of total income during the war years, ten per cent less than during the 1930s. The Mayoress' Ladies Committee, who organised collections, had to be stopped due to ARP regulations and inability of the women to participate due to other war duties. Many of ladies on the organising committee became demoralised and felt anyway that the contributory scheme had superseded the need for subscription fundraising activities like house-to-house collections. It was decided 'That in view of the difficult circumstances which have arisen in consequence of the War, the House to House Canvass be suspended for the time being', effectively ending a century-old tradition. However, by this time, the income they might have garnered was no great loss. In 1940, the committee of some dozen or more women and a further few dozen volunteers, raised only £50, against £43,000 raised by contributory schemes. Nottingham's traditional income experienced a similar pattern, though not to the same degree, falling from an average eighteen per cent of total income, to twelve per cent in 1940, and then some seven per cent until 1946. Nottingham General was still receiving a lot of its income from legacies, which on a number of occasions through the war (1939, 1940, and 1944) prevented the hospital from incurring serious deficits in the tens of thousands.[129]

[129] Nottingham General Hospital Annual Report 1939.; Nottingham General Hospital Annual Report 1940.; Nottingham General Hospital Annual Report 1944.

In Ashbourne Hospital by 1939, donations and patient payments respectively dwarfed annual subscriptions, and in Ripley Hospital, annual subscriptions only brought in £24 to the £1280 total income.[130] Compare this to the £183 in donations, £364 from 'Employees of Firms', and the £389 from the collective 'Derbyshire Hospital Contributory Association', it goes to show that subscriptions were barely a consideration. Almost across the board, the cottage hospitals saw a reduction in subscriptions in a similar pattern to the larger hospitals, but while they replaced them with the typical incomes (payments and contributory schemes) they managed to uphold donations as a key source of income. Their strong grassroots connections to their local communities has already been explored in earlier chapters, but this is evidence that this strong connection continued in a way that meant cottage hospitals were able to secure relatively large amounts of donations, when larger establishments with much bigger catchment populations were not able to drum up quite so much 'casual' one-off support. Subscription percentages for the cottage and smaller hospitals hovered around 10% at the start of the war, having dropped from the 1930s.[131] All voluntary hospitals in Derbyshire and Nottinghamshire found their 'traditional' annual subscriptions diminished in the face of other sources of income.

While subscriptions by the nineteen thirties were very much reduced in importance and focus, the Second World War resulted in them dropping off almost totally. The combination of a changing workforce and the promotion of the more convenient and beneficial contributory schemes meant that subscriptions were ceasing to find relevance in the hospital-seeking public. Annual Subscriptions had quite simply ceased to be relevant, practicable, or useful to the hospitals under the pressures of war. The old bonds between small businesses and middle-class families to the hospital via subscriptions were being undermined by the Saturday and Contributory Schemes. Subscriptions were no longer a mode of hospital coverage, but a formalised and regular way for people to simply donate to charity. Employees could acquire their own coverage, and the raising of the contributory income ceiling as well as the opening of pay bed wards meant that the middle classes were able to get better guarantee of coverage without the old fashioned and precarious subscription ticket system. The conditions of war tipped this trend over the edge, and all but ended the annual subscription system as a means of hospital coverage.

The fall in income was a part of the larger decline of the traditions cultivated in the Derbyshire and Nottinghamshire voluntary hospitals consequent on the war. Ashbourne's September Flag Day and

[130] Ashbourne Victoria Memorial Cottage Hospital Annual Report 1939, 1940.; Ripley and District Cottage Hospital Annual Report 1940.
[131] Newark District, 1937, 11%; Mansfield General, 1938, 13%; Worksop, 1936, 6%; Ashbourne, 1939, 9%; Wirksworth, 1940, 12%.

the November rummage sale were cancelled because of the hostilities. By 1941, the rummage sale and street collection were held again, but rationing restrictions meant the pound day and egg collection week became impossible. By the end of the war, the hospital managed to secure some 600 donated eggs a year, from 'friends of the hospital', as well as the Egg Packing Centre, but this was a far smaller amount than the many thousands that they would regularly receive in peacetime. Derbyshire Infirmary, usually receiving upwards of thirty thousand eggs a year (with considerable savings of £600 and more for the hospital as a result) received just two-thirds of that in 1940. As eggs became scarcer, the *Nottingham Evening Post* even published official notices on a few occasions stating that there were 'No Eggs This Week' for distribution in the Nottingham area. The Nottingham General Egg Week, once so wildly successful, collapsed – down to 72,533 eggs in 1940 and only 10,641 in 1941, down from hundreds of thousands before the war. Unsurprisingly, rationing had taken its toll.[132] Similar results rolled in for the flag days, and the potato and vegetable weeks, which slumped against pre-war success. Tradition and cohesion were being superseded by necessity in a time of war, in a way that never happened in 1914-18. The large- and small-scale carnivals, like Derby Hospital Day, Long Eaton Carnival, and Ripley Hospital Carnival all had to be put on hold. New Air Raid restrictions and strict rationing limited the physical ability for people to organise fundraisers, while there was a lack of entertainments and volunteers, who were now occupied with the work of war. In some cases, small events like collections and flag days were held, but for the most part, the pageantry was absent. Suspension or cancellation meant that the teams of previously well-organised volunteers were disbanded and never reformed. The war forced an end to traditions that had become a staple part of hospital voluntarism in Derbyshire and Nottinghamshire over the last 20 years and more.

These extraneous forms of hospital voluntarism, which maintained the hospitals as a visible entity within the community beyond their bricks and mortar institutions, had been valuable tools in the voluntary hospitals' arsenal. That the war prevented such activities meant, in one sense, that the hospitals became more removed from their communities. The trend is confirmed with a glance at the total donations, subscriptions, etc., that the hospitals were receiving. From 1939 onwards, in real terms donations, annual subscriptions, even Sunday collections, all fell dramatically. In the Derbyshire Infirmary, donations dropped by half from 1939 to 1940, as did the Sunday collection from 1939 to 1941.[133] The low ebb for the Nottingham General was in 1941, where from 1939 Sunday collections dropped by 36%, general donations and box collections by 40%, and income from organised entertainments by as much as 82%. They slowly recovered, but they were unable to ever

[132] Hayes and Doyle, *Eggs, rags, and whist drives*, p.736.
[133] Derbyshire Royal Infirmary Annual Report 1939-40.; Derbyshire Royal Infirmary Annual Report 1941.

recoup their initial losses in the first couple of years. The famed Derby Hospital Day never reappeared after the war. Smaller groups, that helped to donate either cash or gifts in kind without having to make public appearances, did continue to help. Linen leagues, sewing circles, gardening groups, and church congregations were still able to offer their support.[134] The balance, that had been struck in the early 1930s between the large mutualist schemes and the continuation of the traditional charitable incomes was starting to shift, as the charitable elements became smaller and smaller. This was unlike the Great War, where hospitals were still able to host carnivals and bazaars (the large bazaar in Chesterfield in 1917 is testament to this) and air raid precautions were non-existent.[135] Indeed, many hospital flag days had their origins during that period.

The EMS spilled over from being an organ of the war, into one of social policy. The funding of a fracture clinic at Chesterfield, though ostensibly a service that was specific to the reception of civilian bombing casualties, was actually used by the institution and other neighbouring institutions as a hub for ordinary civilian patients.[136] Indeed, the EMS had a pattern of funding expansion and equipment of Chesterfield Hospital all through the war. In 1940 alone, the EMS directly approved and paid for a new 'Blood Bank', a new modern operating theatre, fully furnished the X-Ray department with new machinery, new office spaces for administrative staff, as well as an extensive expansion of the storage department for the clothing and effects of the patients.[137] In 1941, more improvements were approved, including a 36,000 gallon water storage tank, gas decontamination unit for stretcher cases, new and larger plaster theatre, numerous new pieces of equipment for the kitchens, including four new gas ovens and an electric potato peeler, renovation of the electric lifts, an extension to the Dispensary stores, and largest of all, the outright purchase of 'The Laurels' house on Newbold Road to accommodate the increased nursing staff.[138] These changes, of course, were nothing but beneficial to the institution. The Ministry of Health recognised Chesterfield Hospital's potential, and as the hospital stated themselves, the expectations placed upon them necessitated 'the supply of much additional equipment'.[139] It had to hire a 'special clerical assistant' to help with the administration of the EMS scheme within the hospital.[140] Other hospitals, larger, better furnished with greater funding, were already more up to date, and thus proportionally needed less

[134] Derbyshire Royal Infirmary Annual Report 1945.
[135] Chesterfield and North Derbyshire Hospital Annual Report 1917.; Ian Castle, *The First Blitz: Bombing London in the First World War* (Osprey Publishing: Oxford, 2015) pp.7-8., pp.17-20.
[136] Chesterfield and North Derbyshire Royal Hospital Annual Report 1945.
[137] Chesterfield and North Derbyshire Royal Hospital Annual Report 1940.
[138] Chesterfield and North Derbyshire Royal Hospital Annual Report 1941.
[139] Chesterfield and North Derbyshire Royal Hospital Annual Report 1941.
[140] Chesterfield and North Derbyshire Royal Hospital Annual Report 1941.

funding to bring them up to a standard that the Ministry of Health required.

In the Great War any and all hospitals were utilised for the treatment of wounded soldiers. In the Second World War, this changed somewhat. Better organisation of the larger hospitals and military hospitals meant that, after the initial panic, there was less interest from the authorities in the use of small locations. The value of cottage hospitals was suspect even among their supporters. It was based on a supposition that only cottage hospitals of a certain size were viable, and this was mostly in those larger fifty-plus bed institutions in and around London.[141] The examples around Derbyshire and Nottinghamshire are far smaller than this.[142] During the war, these small hospitals struggled to find their place. In staffing terms alone, cottage hospitals often containing only a matron and a nurse as full-time staff, and were thus limited in what they were able to provide for the war effort. Prior to the outbreak of war, Wirksworth Hospital Management Committee were very keen to offer the institution's facilities to the war effort. The Ministry of Health expressed disinterest. The hospital appealed to the Ministry of Health for grants and the approval of plans for a poison gas treatment centre. These were not approved.[143] However, in August 1939 the Ministry of Health requested the closure of the hospital to ordinary patients in the anticipation of bombing casualties at the outbreak of the war. The hospital closed on 30th August – four days prior to the actual declaration of war - for sixteen days, receiving £60 compensation from the Ministry for this break in their usual services. Three nurses from the Civil Nursing Reserve Scheme were issued to the hospital.[144] Despite Wirksworth Hospital Committee's enthusiasm to kit out its hospital with war-related apparatus, the hospital was ignored by the authorities, only wanted initially for the emergency space it provided. Ashbourne, after an uninterested start to the war, faired much the same. By 1941, neither of them were receiving any significant amount of money from the Ministry of Health, and Wirksworth received no EMS money from 1941 onwards.

In December 1942 the government published its *Social Insurance and Allied Services Report* – or, as it is better known, the Beveridge Report. This, the post-war passing of the National Health Service Act in 1946, and the final handing over of the voluntary hospitals to the NHS in 1948, meant the end of a two-hundred-year voluntary tradition. The report is now remembered most keenly for its introduction of comprehensive health services, but its key purpose was to establish a universal social insurance scheme and to extend the local authority services currently available. Beveridge aimed to

[141] Major Du-Plat-Taylor, John Coleridge, Dr J J Abraham, *Cottage Hospitals*, (Ernest Benn Limited: London, 1930). pp.11-13.
[142] Ilkeston General Hospital Annual Report 1937.
[143] Wirksworth Cottage Hospital Annual Report 1939.
[144] Wirksworth Cottage Hospital Annual Report 1939.

create a blueprint for a fairer welfare system; one that was based on real evidence from social surveys and cost of living, rather than the arbitrary pre-war system.[145] However, the system that Beveridge envisaged, and the system that the 1945 Labour government under Clement Attlee formed, were starkly different. Beveridge, a Liberal, laid out three main points that would bring the nation to a better standard of living: a national health service, tax-funded allowances for minors, and comprehensive social security funded by universal contribution from full employment.[146] The 1942 report detailed the many aspects of the new scheme, but most important for the voluntary hospitals was the 'Assumption B. Comprehensive Health and Rehabilitation Services', which provided, albeit in very broad terms, a blueprint for health services funded by universal contribution. Assumption B asserted that medical treatment be provided to every citizen, no matter what that treatment might be; 'domiciliary or institutional, general, specialist or consultant…dental, ophthalmic and surgical…nursing and midwifery and rehabilitation after accidents,'.[147] Essentially, both preventative and curative, and rehabilitation too. It stated, further, that 'Restoration of a sick person to health is a duty of the State and the sick person…'.[148] It intended for the people of the nation to cease turning to the voluntary and charitable systems, and instead vest their health (and money) with a state-coordinated system, which would then provide the services required of the individual.

However, its outline was vague. Unlike the system introduced by Labour after the war, it focussed heavily on insurance contributions (albeit compulsory) rather than centralised taxation, and wished to retain the existing voluntary services. Beveridge highlighted that hospital treatment was not covered by the current health insurance contributions under the National Health Insurance Act. He argued that the rise of contributory schemes in the years before the war showed that the nation was in want and need of a more comprehensive (and compulsory) hospital contribution system.[149] Treatment, it was stated, should not be '…delayed by any financial considerations. From this point of view, previous contribution is the ideal, better even than free service supported by the tax-payer,'.[150] The proposed system of compulsory contributions from workers to a central 'Social Insurance Fund', which would then distribute money to the existing voluntary institutions. However, he was keen to have the state work hand-in-glove with the current voluntary hospitals, rather than abolish them,

[145] Nicholas Timmins, *The Five Giants A Biography of the Welfare State* (Harper Collins Publishers: London, 2001). p.51.
[146] Timmins, *The Five Giants,* p.20.
[147] *Beveridge Report,* p.158.
[148] *Beveridge Report,* p.159.
[149] *Beveridge Report,* p.160.
[150] *Beveridge Report,* p.161.

asserting that they still maintain their independence by virtue of the fact that they retain sovereign power over spending 'in whatever way best fits their hospital policy,'.[151]

Historians have suggested that the EMS prepared hospitals for the NHS. It introduced standardised salaries for staff, unified certain services, and showed how effective government grant systems could be.[152] According to Webster, the EMS softened the resistance to government intervention in the hospitals and in the civil service, cultivating a favourable climate for reform.[153] It provided precedent for a centrally planned hospital service, fulfilling calls from the political left that had echoed unheard for decades.[154] Prochaska argued that it had created a momentum, something of which the new Minister of Health after the war, Aneurin Bevan, took advantage.[155] But in reality, the EMS meant different things for different hospitals. The London hospitals, in the midst of sustained bombing in a densely populated urban area, received far more financing, physical aid, and administrative intervention from the EMS than did the hospitals around Derbyshire and Nottinghamshire, or indeed elsewhere in the country.[156] Rivett claimed that the Luftwaffe provided the key compulsion for hospital reform in the UK. Again, that might be true from a London-centric perspective, but it is not sustained by the evidence coming from the two counties. Nottingham sustained few air raids, with eleven in total through the course of the war, with 178 deaths and 350 injured.[157] The most significant raid, the 'Nottingham Blitz' was on 8-9th May 1941, where the key issue that the city's authorities had to deal with was not mass casualties, but some hundreds of citizens made homeless by the destruction of their homes.[158] Compare this to somewhere like Sheffield, which had as much as 700 people killed, and tens of thousands of people made homeless.[159] Derby and Chesterfield, although surrounded by some pockets of heavy industry, were similarly not key targets for bombing, and thus their hospitals' main interaction with the EMS was via the reception of wounded service patients, and *not* bombing casualties.

With reference to the data in this chapter, the question has to be asked as to what impact the EMS truly had on the Derbyshire and Nottinghamshire voluntary hospitals? The war presented acute

[151] *Beveridge Report*, p.160.
[152] Pater, *Foundation of the NHS*, p.167., p.174.
[153] Charles Webster, *The Health Services since the War. Problems of Health Care: The National Health Service before 1957* (TSO: London, 1988). P.16.
[154] Webster, *Health Services since the War*, pp.22-28.
[155] F K Prochaska, *Philanthropy and the Hospitals of London,* (Clarendon Press: Oxford, 1992) pp.155-6.
[156] Prochaska, *Philanthropy and the Hospitals in London,* pp.134-8.
[157] 'Map showing the localities most affected by the 479 H.E. bombs dropped upon the City of Nottingham during the war', *Nottingham Evening Post*, 17 May 1945.
[158] HLG 7/380, 'Regional Operational Reports, No.3 Region', pp.1-4.
[159] Sheffield City Council, *Sources for the Study of the Sheffield Blitz of 1940*, (Sheffield Libraries Archives and Information: Sheffield, 2016). p.4.

challenges: more patients, higher prices and inflation, greater expenditure, shortages of staff, and the limiting of voluntary activity. Of these, the EMS only helped with greater expenditure, providing grants for the services rendered by the hospitals for service patients. However, it did little else to actually alter the way the voluntary hospitals operated, even in the context of world war. Examples from the Ministry of Health and Ministry of Housing and Local Government indicate that there was comparatively little interaction with provincial hospitals compared to those in London. But this did not mean that the EMS was a distant, rarely utilised entity for the provincial hospitals. Not when the EMS had direct contact with hospitals, and it had a network in place to deliver convoys of wounded service patients to the hospitals, as well as beds and other equipment. The establishment of annexes in the two counties was at the direct behest and permission of the EMS and Ministry of Health, and these annexes were furnished with the help of central grants.[160] The face of the hospitals was changed by the EMS, but it was not transformed. The annexes were closed near to the end of the war, the grants, once stretching into the tens of thousands of pounds, reduced once the number of service patients reduced. The crowded-out wards, bristling with new beds provided by the Ministry of Health at the start of the war, were eventually put back to normal as the requirement for extra capacity was stood down. Voluntarism was changed during the war, with voluntary events and charitable organising curtailed, but those were not as a result of the EMS pushing that traditional mode of fundraising out, but the restrictive social conditions of the war imposing upon volunteers.

In certain circumstances, the EMS altered or disrupted the usual pattern of work conducted by the voluntary hospitals, and in others it advanced them. On balance, the evidence from the Derbyshire and Nottingham general hospitals has shown that the EMS had no great impact other than reducing the capacity of the hospitals to treat the patients in their communities. This point is unequivocal: waiting lists increased significantly during the war, especially in periods when larger convoys of wounded servicemen were being brought into the hospitals for treatment. Indeed, even in areas where there was excess capacity in specially-built EMS hospitals, civilian sick were prevented from getting treatment there.[161] Like the response to the voluntary hospital crisis of the early 1920s, the steps that the government took were based on evidence it had gleaned from the London hospitals, not the provinces. London hospitals, already in financial difficulty before the war, were presented with an impossible situation that could not be tackled with the means that voluntarism possessed: they needed state aid. However, the case was not the same for Nottingham General, Derbyshire Infirmary, and Chesterfield Royal. In spite of some years of deficits, and struggles with staffing levels and patient waiting lists, the EMS never took a major role in the running of the hospitals, and always

[160] MH76/2 *EMS Select Committee on National Expenditure Report 1940-1.* pp.18-22.
[161] HLG7/680 *Admission of acute civilian sick to EMS hospitals 1940.*

remained a junior contributor towards their finances. The war had limited expansion of the hospitals, shown by the restrictions put upon the Nottingham General Nurses Home, and Derbyshire Infirmary's new kitchens that were never built under the voluntary mantle. But it was the EMS, with the authority of the Ministry and the government, that was a further limiting factor. Repairs for bomb damage, or for emergency maintenance, were sanctioned by the EMS authorities without quibble – but they kept a strict control over certain controlled construction materials, like timber, even when there was no shortage.[162] It meant that even with the conditions of war, there may have been potential for the hospitals to make their renovations and extensions, but constant appeals throughout the war years to the authorities were always met with refusal.

While the types of patients covered by the EMS were expanded to 'theoretically' cover large swathes of the population, in actual fact few civilian patients in Nottinghamshire and Derbyshire were admitted under its auspices. Comparison to the War Office in the Great War shows real similarities in terms of the impact that they had on the hospitals. However, the foresight, vision, and careful planning of the EMS was definitely progress from the narrow-minded, ad-hoc, and of the War Office's relationship with the voluntary hospitals. The staffing situation never became as acute as during the Great War, where hospitals were dangerously drained of trained doctors by the RAMC. The convoy system was better planned, so that hospitals in the region were allocated more manageable numbers of casualties (and of course, the Second World War presented fewer casualties as a whole) which meant that the hospitals were at least still able to carry on their normal civilian treatments, albeit in a limited capacity. There was no refusal, as there was in Chesterfield in 1915, of any fresh convoys of wounded soldiers, meaning there was better levels of communication between the hospitals and the Ministry of Health, as well as better-managed expectations from the hospitals about what they were able to achieve. Further, it took a more detailed 'stock-take' of the voluntary hospitals, identifying which hospitals were most suited to the treatment of wounded soldiers, as was the case for Derbyshire Infirmary, identified as a specialist centre for neurosurgery.[163] But despite its greater success as managing the hospitals under its control than the War Office twenty-five years earlier, the EMS caused difficulties for the hospitals. Civilian waiting lists increased, planned building works were put on hold indefinitely, and at times the payments made by the EMS for services rendered were inadequate for covering costs.

More grand feats of organisation such as the National Emergency Blood Transfusion Service indicate

[162] MH101/4 *Summary Report by the Ministry of Health for the period from 1st April 1939 to 31st March 1941*, p.15.
[163] MH101/4, *Summary Report by the Ministry of Health for the period from 1st April, 1939 to 31st March 1941,* (HMSO: London, 1941). p.24.

that the EMS did have the scope and vision to enact things that the fragmented voluntary hospital service would either never have done, or would have taken decades to do.[164] But again, it wasn't fundamentally transformative to the voluntary hospitals, but an ancillary service, of much more pertinent use down in London than in the provincial hospital networks. Such progress was unlikely to be undone. Indeed, as Pater points out, the government was making plans, even after the release of the Beveridge Report, for the 'winding up' of the Emergency Medical Scheme, concentrating more on the shape of medical services in the eyes of the medical profession, rather than from a societal standpoint.[165] It was already recognised across many hospitals before the war that rationalisation in the voluntary system had to occur in order to prevent wastage and confusion.[166] So the rationalisation of the voluntary hospitals was not just a consequence of the EMS, or the Beveridge Report. The Nottingham General implemented plans to coordinate pathological services between hospitals in the county, as well as unify the nursing staffs of the General Hospital and the Children's Hospital.[167] It reluctantly reasoned that under the NHS, this cooperation would be enforced anyway, and so it was appropriate to try and achieve these plans under its own volition rather than be compelled into it by the state at a later date.[168] It also carried through an ambitious plan amalgamate the Ear, Nose, and Throat Hospital with the General Hospital as of 1st December 1947, meeting with approval from both the Ministry of Health and the Charity Commissioners.[169] Derbyshire Infirmary had the same idea, and decided to make a call to joint action alongside the Women's and Children's Hospitals of Derby in 1946 as a result of the 1946 White Paper.[170]

Local responses from the hospitals to the Beveridge Report were similar in many ways to the reactions back in 1929 to the Local Government Act. Mixtures of suspicion, confusion, and anger filled the annual reports, as the voluntary hospital boards suddenly saw their way of life threatened. By far the most militantly anti-NHS institution was the Nottingham General Hospital. Like all the voluntary hospitals, it claimed to have no issue with the principal of the NHS; rather it had serious issues with how it was proposed to be organised and instituted. Its first public statement on the matter, in 1943, iterated that, like 'successive Ministers of Health', it desired a system that unified

[164] MH76/305 *Statistics on Emergency Blood Transfusion Service 1942-7*.
[165] John E Pater, *The Making of the National Health Service*, (King Edward's Hospital Fund for London: London, 1981). pp.64-65., p.93., p.108.
[166] Enid Fox, 'Universal Health Care and Self-help: Paying for District Nursing before the National Health Service', *Twentieth Century British History*, 7:1 (1996), pp.95-96., p.105.
[167] Nottingham General Hospital Monthly Board Minutes, 17 September 1947.
[168] Nottingham General Hospital Monthly Board Minutes, 17 September 1947.
[169] Nottingham General Hospital Monthly Board Minutes, 19 November 1947.
[170] Derbyshire Royal Infirmary Minute and Order Book, 20 June 1946.

the work of the local public authorities and the voluntary hospitals.[171] It made no reference to centralised funding, and reserved public judgement until parliament had fully debated the matter. In 1944, with a better knowledge of the proposed service, the hospital completed a questionnaire issued by the Ministry of Health. Here, the Monthly Board gave are a scathing condemnation of the outlined system that it saw as marking the end of voluntarism. Although it agreed, at one level, with the principal of provide universal healthcare to all citizens, it rejected centralised funding and administration.[172] Specifically, it saw that receipt of public funds to the voluntary hospitals would result in both a loss of control of the voluntary hospitals by their volunteers, as well as a definite loss in voluntary income. The board asserted that it was of the 'utmost importance' for the hospital to retain such things as the contributory scheme, '…failing that necessary funds can only come from the Government or Local Government, and that means the end of the Voluntary Hospitals'.[173] As a result of this, the hospital confirmed that it would join with other voluntary hospitals in an effort to modify or prevent the National Health Service scheme from going through in that present state.

Derbyshire Infirmary did not appear overly concerned with the Beveridge Report, simply stating that it hoped the voluntary system would remain, but that state assistance would help to relieve the financial stresses of the hospital.[174] It was happy to receive government aid, as it had done in the past and was presently during the war, as long as it was able to retain its financial and administrative independence. Furthermore, by 1944 when the NHS had been further discussed in both Parliament and amongst the various voluntary groups, the Derbyshire Infirmary was willing to allow the interests of the voluntary system be looked after by the British Hospitals Association, British Medical Association, and the British Hospitals Contributory Association, excepting that individual hospitals held little sway on the outcome.[175] So, either through apathy or the more pressing concerns of running the hospital in wartime, it had a relatively passive stance to the NHS. This was in stark contrast to the efforts of the Nottingham General Hospital, which continued to attempt to build a local momentum against the NHS. In February 1946, the latter sent out thousands of postcards to current and former patients, iterating that the voluntary hospitals were under attack, and that if the people of Nottingham and the county valued democratically run hospitals, they should make every effort to write to their MPs to try and have the NHS changed or prevented.[176] The following month saw a very positive response to this campaign, with the Board receiving 'overwhelming' support for

[171] Nottingham General Hospital Annual Report 1943.
[172] Nottingham General Hospital Minutes of the Monthly Board, 22 March 1944.
[173] Nottingham General Hospital Minutes of the Monthly Board, 22 March 1944.
[174] Derbyshire Royal Infirmary Minute and Order Book, 17 December 1942.
[175] Derbyshire Royal Infirmary Minute and Order Book, 15 June 1944. 'The chairman expressed the idea that the interests of the voluntary hospitals were being well looked after'.
[176] Nottingham General Hospital Monthly Board Minutes, 20 February 1946.

the voluntary hospitals. The local MP, James Harrison (Labour Party) asserted that he would do all he could to try and appeal to the Ministry of Health.[177] Between the 1942 report and the 1944 White Paper released by the government entitled *A National Health Service*, there was little difference between the two in their plans for the future hospital system; the real transformation came after the war, with the Labour government's National Health Service Act in 1946 and the subsequent 'Appointed Day' in May 1948 when all hospitals were transferred to the state. The hospital seemed adept in organising local support. Letter of support from appreciative patients suddenly started flooding into the post room of the *Nottingham Evening Post*. H Norman Smith, M.P. (Labour) writing in the newspaper, commented that 'there is an organised piece of propaganda afoot', as letters in support of the hospital started to come pouring into his office,too.[178] Smith was less sympathetic to the effort than his colleague Mr. Harrison, and stated that: 'Many parts of England are less fortunate than Nottingham in the matter of their hospitals, and the Government's advisers are satisfied that it is necessary to take a national and not a local view. We intend to go ahead with a long-overdue National Health Service'.[179] These comments by Smith echoes the very concerns that Chesterfield Royal had, namely that the national focus may subsume and be to the detriment of the local voice.

Indeed, not all voluntary hospitals were resistant to the presence of the state. Chesterfield Royal, despite initial reservations, was more open to the concept of the NHS than either Nottingham or Derby. Whether the board was either politically aligned with the idea, or whether it saw a broader picture of British healthcare is not clear, but its own financial position and its limited resources played a significant role in determining its position. The board supported the British Hospitals Association's rallying cry to the voluntary hospitals, in efforts to change the initially proposed scheme, but it did see that there was a need for an expansion to local hospital services beyond the ability of their local voluntary system.[180] A report compiled for Chesterfield Royal by the University of Manchester found that the North Derbyshire district required a general hospital of six hundred beds; ordinarily the hospital only had a third of that number.[181] The government's own wartime survey concluded:

[177] Nottingham General Hospital Monthly Board Minutes, 20 March 1946.
[178] 'Editor's Letter Bag. Appreciation of The Hospitals', *Nottingham Evening Post,* 23 February 1946.
[179] 'Editor's Letter Bag. Appreciation of The Hospitals', *Nottingham Evening Post,* 23 February 1946.
[180] Chesterfield and North Derbyshire Royal Hospital Annual Report 1943.
[181] Chesterfield and North Derbyshire Royal Hospital Annual Report 1943.

> The buildings at the hospital are crowded on a site in the centre of town, with very limited pace. The building themselves are largely out of date…The accommodation for nurses is inadequate…At present special cases from Chesterfield go to Sheffield.[182]

Chesterfield's finances were also on a far less secure footing than that of its larger neighbouring institutions. Internal planning for the future meant taking steps to coordinate with Chesterfield Corporation, firstly to try and find a jointly funded solution, and secondly to find a site within the district to fit a hospital of six hundred beds on. Yet the Manchester report also noted that a centralised service would not allow for this sort of local planning and local responsiveness. It was a legitimate concern that the needs of the local district populace might be subsumed within a county- or region-wide system. Indeed, the hospital prided itself on its broad network of volunteers, from Board members to Sick Club organisers, who provide the hospital with the needs and requirements of the people of Chesterfield and North Derbyshire.[183] Nationalisation meant that this knowledge base would be lost, and the hospital would not be able to connect with its most vital associates: its community.

This thesis has shown that the people of Nottinghamshire and Derbyshire had great fondness and displayed real support for their hospitals. But the quiet support they showed for the hospitals at this time was totally dwarfed by the momentum of the Labour government elected after the war. While the electorate did not necessarily see real need for change in the hospital system, the 1945 mandate given to the Labour government meant it chose to go further than Beveridge ever intended, and abolish the long-cherished voluntary system.[184] The Second World War was a transformative time for the voluntary hospitals. No more carnivals, no more public events, very few street collections. A reduction in the 'visible face' of hospital voluntarism was replaced instead by a direct semi-contractual link established via the contributory schemes. It was the broader machinations of the war, rather than the Emergency Medical Service and the Ministry of Health that affected how the hospitals operated. The war meant longer waiting lists and a shift in focus to the service patients ferried to the respective hospitals, an end to house canvassing because of the threat of air raids, an end to carnivals, and the disbandment of volunteer networks. It was not the EMS that slowed the influx of material donations into the hospitals, but the effect of food scarcity and rationing. The 'local patriotism' of the provincial hospitals lauded by those members on the Cave Committee back in the 1920s came into conflict with the national patriotism that required side-lining local community

[182] Ministry of Health, *The Hospital Services of the Sheffield and East Midlands Area* (HMSO: London, 1945). pp.32-3.
[183] Chesterfield and North Derbyshire Royal Hospital Annual Report 1943.
[184] Nick Hayes, 'Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948', English Historical Review, CXXVII:526 (2012). p.640., p.642., pp.652-4.

patients in favour of service patients. It was a crisis of focus that echoed the Great War, where considerable War Office payments meant the hospitals were beholden to their new benefactor: the government. There were certain elements that all hospitals, irrespective of size or patient remit, had to deal with. Inflation, and the rising price of fuel and provision were the unavoidable consequences of a wartime economy, and shortage. It meant that the hospitals, simply to remain as they were, let alone expand or treat more patients, had to increase their revenue if they were to remain free of debt. Throughout this thesis it has been argued that the hospitals needed diverse revenue streams to achieve secure income. Once this balance was thrown, hospitals ran into issues. This could be seen after the Great War, during the tumultuous year of 1926, and again in the Second World War.

The voluntary hospitals never operated in a vacuum. Even in the stable and peaceful days before the Great War, the hospitals were still victims of the cost of supplies, the broader employment situation, and the generosity or paucity of donations from the great and the good (and increasingly the ordinary people). But the two world wars created a sort of 'artificial' situation, where assessment of the voluntary hospitals in their own right is altered by the fact that non-voluntary elements were foisted upon the hospitals. The injection of funds from the government, which though we have largely established were not carte blanche grants but directly costed cheques for services rendered, still altered the face of the hospitals. The contributory schemes, lynchpin of so much debate around voluntary hospitals grew, were not able to grow in an 'ordinary' environment in the same way that the Saturday Funds did in the early-mid 1930s, and it will never be known if the contributory schemes would have gone on to flourish or flounder under an ordinary peacetime context. The Second World War was the final test for the voluntary hospitals, and in Derbyshire and Nottinghamshire, as elsewhere, the combination of a matured financing system, government grants, and continued local support, meant that they were able to carry out their duties as local institutions of acute civilian care, and national refuges of casualty treatment. But their futures, ultimately, were to be determined elsewhere, driven by Westminster and a new great vision for healthcare that was based on socialism, rather than reformed voluntarism. The voluntary hospitals ended in 1948, when the Ministry of Health took them under its control.

Conclusion

The key research question of this thesis was: to what extent were the voluntary hospitals of Derbyshire and Nottinghamshire reflections of their community? This has been answered in a number of ways: by looking at the development of mass-contribution schemes, be they working men's subscriptions, Saturday funds, colliery workmen's subscriptions, penny-in-the-pound schemes, or official 'contributory' schemes; by looking at how the hospitals responded to crises, and how they rallied their communities around them to shore up their defences again deficit and dearth; and by looking at how volunteers organised fundraising events to provide augmentations to their hospital finances, as well as evangelise the cause of the hospital to the ordinary citizens of the community. The large general hospitals had the biggest communities, and thus were able to be far more dynamic in their organisation of fundraising. However, the cottage hospitals were dealing with a more limited population and a more limited demographic. They were not able to develop broad contributory schemes or host giant fundraisers. Instead they were dependent on multiple small fundraisers organised by their volunteers throughout the year, which were limited in scope by the population of these smaller towns and villages. The social calendars for places like Wirksworth and Ashbourne were defined by the events hosted by volunteers in aid of the local cottage hospitals. In this, the presence of the hospitals defined the community, as much as the community defined the hospitals. The same could be said for the Derby Hospital Day and the Long Eaton Carnival; they created unique events that entailed entertainment and spectacle as much as they did charitable fundraising and became important social events on the civic calendar. They united the benevolent philanthropy of the Victorian era with the mutualist organisation of the modern era.

From the start of the 20th Century to the late 1940s, the hospitals in Derbyshire and Nottinghamshire metamorphosised from their classic Victorian origins into modern, democratic, and mutualist sites of cutting-edge medical care. Two world wars, economic crashes and slumps, a general strike, inflation, rapidly increasing costs, declines in old incomes, and the fight to develop new ones: all challenged the fragile integrity and independence of the voluntary hospitals. Institutions that were so intrinsically linked to the economic welfare of their communities were potentially at the mercy of the winds of fate; one might have assumed that a poor economy might mean poor hospitals. But time and again, down to the proactive nature of the volunteers, the open-mindedness of the hospital boards, and the generosity and determined self-preservation of the citizenry, the voluntary hospitals in the two counties overcame countless obstacles. The hospitals had no choice but to innovate, as their independent nature meant that no help (outside of times of national crisis) was coming from the state. The expansion of contributory schemes from nucleic Saturday funds, the growth of huge festivals and carnivals from tiny parades and fetes, and the proliferation of countless

volunteers from the small but dedicated teams of committees were all testament to the interest that communities had in procuring decent and affordable healthcare for themselves and their fellow man. The voluntary hospitals system never had the scope and vision of the nationalised service that overtook it, but for communities in the first half of the 20th Century, the voluntary hospitals in Derbyshire and Nottinghamshire provided effective provision as a result of community stimulus. The moral bankruptcy identified by Titmuss was not evident, and although one might level accusations of stubborn independence that impeded the formation of an effective service before the Second World War, the attitude of the voluntary hospitals was united with that of their communities.[1] The community defined demand, and it defined provision with the finances it donated and contributed. Voluntary hospitals were not able to be closed institutions denying care to their patients in efforts to save money, even if they wanted to. The patients were on the executive boards. The patients were volunteering on the wards. The patients were organising the carnivals, whist drives, and the sports competitions. The patients were the ones making the decisions within the Saturday fund boards, and on the board of governors and management.[2] This it was not a relationship between hospital and community – the hospital was the community. The shift in entitlement – or as Cherry also identified, the right of admittance – was associated with the fundamental need for communities to acquire affordable healthcare.[3] The Nottingham and Derbyshire Saturday funds, and the Chesterfield Workmen's subscriptions, although different in nuanced ways and growing at varied rates, were evidence that the voluntary hospitals in the two counties were following similar paths, and finding that mass subscription was beneficial, but maximum success was found when hospitals utilised their full cohort of volunteers to encourage all forms of income.[4]

Hospital boards of management and governors were small and nucleic at the turn of the century. However, as the Saturday funds grew, and workplace contributions started to become a significant portion of income, the executive bodies of the hospitals were opened up to a new raft of representatives from the community. Further, as fundraising events became larger and more frequent, the amount of volunteers from the community that became involved in organising and participating inevitably grew. However, the number of participants in organising and physically helping in the hospitals was a much smaller number than the wider host of passive contributors,

[1] Richard Titmuss, *Problems of Social Policy*, (HMSO: London, 1950) pp.68-72.
[2] Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', Midland History, 37:1 (2012), p.84., p.95.
[3] Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006). p.3., p.30. ; Steven Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *The Economic History Review*, 50:2 (1997) p.317.
[4] Nick Hayes, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013) pp.720-724.

which reached into the tens of thousands. There was a distinction between the types of hospital supporters – those who volunteered their time, and those who volunteered their money. And without the former, the latter would likely not be offering their money up. Nottingham General, Derbyshire Infirmary, and the communities around the smaller hospitals like Ripley, Ashbourne and Wirksworth, were very effective at organising events to bolster the funds of the hospital. However, Chesterfield neglected larger events after the Great War, and although its mass schemes were successful and had many members, it struggled with more severe patterns of deficit into the 1930s. The carnivals, 'Hospital Days', and other smaller events like garden fetes and whist drives proved vital to the augmentation of hospital finances, while creating a physical presence of the hospital beyond its doors. But this isn't to say that philanthropy was something confined to the Edwardian era. The hospitals still had their benefactors, and their aristocratic patrons, even after when some historians might assume them to have become removed from civil society.[5] The influence of the Players and the Boots in Nottingham continued into the 1920s and 1930s, and aristocrats appeared on the hospital boards of governors as frequently in the 1930s as in the 1910s.[6] The Dukes of Devonshire were still the presidents of Chesterfield and North Derbyshire Royal Hospital after the Second World War, and had involvement as patrons into the NHS era.

Something notable, and different from the studies conducted by Doyle, Curtis, and Thompson in the working-class areas of Middlesbrough, Leeds, and the South Wales coalfields, is the lack of conflict between the hospital institutions and leadership, and the recipients of care. Only in a few instances was there overt friction between classes, such as in the founding of Ripley Hospital. But overall, other than the rejection of the more traditional modes of hospital fundraising in favour of more mutualist forms (which in itself is indicative of a certain evolving class-consciousness), there was little tension between the classes, likely because the services provided by the strong traditions of hospital voluntarism in the hospital communities of Derbyshire and Nottinghamshire were able to meet the demands of the populace. Only in times of war, when the waiting lists were increased and local patients side-lined in favour of the emergency treatment of service patients, were there complaints. Only then did demand outstrip supply, and issues around entitlement of a patient were tested. But luckily these were temporary situations, soon remedied once hostilities ended the hospitals' duty of care towards the nation's soldiers was reduced. The hospitals, and the communities that supported them, were reactive to need. Thus, in places like Chesterfield and Mansfield, fracture clinics were founded to deal with the sort of industrial accidents prevalent in the

[5] John Garrard, 'Urban Elites, 1850-1914: The Rule and Decline of the New Squirearchy?', *in Albion: A Quarterly Journal Concerned with British Studies,* 27:4 (1995) p.604.
[6] Hayes and Doyle, 'Eggs, rags and whist drives', p.738.

local workforce. Similarly, the founding of new hospitals in places there were none before meant that more and more of the population was covered by local hospitals. Trade unions, although very active in Derbyshire and Nottinghamshire, were only really interested in the relationship between workers and their employers, not between the workers and the services they were able to access. Unlike South Wales, the workers in Derbyshire and Nottinghamshire enjoyed access to at least three large institutions in their area from as far back as the mid-Victorian era, and this provision only expanded. The trade unions clearly felt that there was little need to turn their attention on areas that were already well provided for.

Mohan and Gorsky's national view of the voluntary hospitals between 1900 and 1938 showed that incomes quadrupled.[7] Broadly speaking Derbyshire and Nottinghamshire hospital incomes far more than quadrupled in this time. From 1900-1946, the Derbyshire Infirmary income grew by thirteen times, Nottingham General by fourteen times, and Chesterfield Hospital by a monumental thirty-seven times.[8] These were huge increases that illustrate the ambitious nature of the Derbyshire and Nottinghamshire voluntary hospitals, as well as the considerable increase in demand for hospital services. These figures were matched in the smaller hospitals; Ashbourne's income grew by eighteen times, and Newark's income by six times. Across the board, the hospitals had grown their incomes significantly. But income was only part of the picture. In-patient numbers massively increased too, as much as five times in the larger hospitals, and six times in the smaller hospitals. Without a doubt, growth and expansion took on exponential trends when looking at the era as a whole. But it was at certain points in the course of their history that these booms occurred. They also assert that a third of voluntary hospitals were in deficit before the Second World War.[9] But while deficit was a concern to the hospitals, often in Derbyshire and Nottinghamshire deficits were only temporary, ameliorated by the gradual growth of mass-schemes that overcame financial hardship. Even in areas like Chesterfield and Mansfield, whose income was more closely tied to industries that were in peril, managed to sustain healthy incomes. The Second World War put an end to large-scale fundraising, but the contributory schemes were able to remain strong, and putting aside the servicemen, the number of patients only increased. Demand for hospital service increased throughout this era, because communities had grown closer and closer to their institutions.

The shift from charity-based hospital provision to mutualist hospital provision developed at different rates. Most of the hospitals started the century with very small Saturday funds. There were few hospital communities that did not experience the 'shift in entitlement' that Gorsky, Mohan, & Willis

[7] Mohan, Gorsky, *"Don't Look Back"* p.53.
[8] Derby: £10,703-£150,262; Nottingham: £9,501-£123,087; Chesterfield: £2,904-£109,773.
[9] Mohan, Gorsky, *"Don't Look Back"* p.53.

identified, but these were usually the smaller hospitals like Ashbourne and Wirksworth, that developed an associative relationship with external contributory schemes just before the Second World War. However, some hospitals already had a mutualist-style scheme in place early in the century, even if it wasn't highly developed. Chesterfield had its own mass-subscription scheme organised via workplaces that dated back into the mid-1800s, something that defined the personality of the hospital, and its interaction with its community, in the 20th Century. Mansfield's highly-organised colliery subscription system was in place well before the First World War, and the Nottingham General, although the oldest and perhaps most traditional institution, had started to develop its Saturday Fund in the early 1910s, and by the 1920s had one of the strongest of its type in the region. Conversely, the Derbyshire Infirmary was sluggish compared to its neighbouring institutions when it came to developing mutualist mass-schemes. Its Saturday fund was not competitive with other such funds in other hospitals until the mid-1920s. The contributory schemes were never able to fully spread their wings; as soon as they were properly established in Nottingham and Chesterfield, the war began, and Derby didn't fully convert its Saturday fund to a contributory fund until 1940. The war meant that the normal progress of events (a steady increase in the contributions from workmen) was warped by the economy and social upheaval of the war. They saw a levelling off that, although it did not spell financial distress for the hospitals, clearly indicated the effect that the war had on the displacement of the workforce.

Even outside of wartime, hospitals often had to respond to crises. In fact, there were few periods throughout the first half of the 20th Century that weren't defined by some sort of crisis. The period from 1921-1926 saw a rollercoaster of different issues that the hospitals had to deal with, not least severe unemployment and underemployment. While the flashpoint of 1926 saw a damaging year for most of the hospitals, especially Chesterfield and Mansfield, they were able to recover once unionised workers were back at work. Similarly, there were issues during the 'Slump', as unemployment in some areas of Nottinghamshire reached well above average for the nation. However, it is testament to the buoyancy of the voluntary hospital system that they were able to climb out of these doldrums and recover. Most effectively, hospitals managed to overcome their deficits if, once again, they cultivated their traditional incomes alongside an expansion of their mass schemes. As a result, Chesterfield struggled to pull itself out of debt (having accrued significant deficit in 1926) and was still recovering right into the 1930s. Nottingham General, however, although experiencing nowhere near the same difficulty as hospitals like Mansfield, Chesterfield, and Newark during the strikes and unemployment crisis, was quickly able to stabilise its finances and avoid debts.

The Saturday fund and contributory schemes cultivated in the voluntary hospitals were the cause célèbre both of the hospitals themselves, contemporary commentators, and many subsequent

historians. The 'shift in entitlement' is a vital concept in understanding how the voluntary hospitals were democratised, and their 'ownership' shifted away from the small cabal of upper- and upper-middle-class volunteers and into the hands of ordinary hospital users.[10] The mass schemes gave the hospitals an opportunity not just to garner more ready cash, but also evangelise the voluntary hospital cause within a community that was not just on its doorstep but spread throughout the county. However, adoption of these schemes was no guarantee of freedom from deficit. Chesterfield's early adoption of the Workmen's Subscription Scheme defined Chesterfield Hospital's unique personality as an institution that decided to avoid traditional charity, and other traditional voluntary incomes, and instead concentrated on a mass scheme. However, like the examples drawn from Sheffield by Hayes and Doyle, neglecting other incomes in favour of the mass schemes could prove to be a mistake.[11] Contributory schemes could prove to be a silver bullet fallacy, wherein their image as a panacea for all financial ills (and subsequent neglect of other incomes) meant that there was often financial trouble when the contributory schemes were leaned on too heavy under the assumption that they would lead the hospital out of financial peril all on their own.

Traditional incomes, like annual subscriptions and donations, held a diminishing position in hospital finances as the decades passed, illustrative of the innovation and expansion of hospital financial networks, as well as the increasing demand on hospital services by the populace. However, that did not mean traditional incomes became unimportant. Hospitals that maintained some solid baseline of traditional incomes were the ones that had more robust financial patterns.[12] Without the strong annual subscription schemes, places like Derbyshire Infirmary found themselves with far less secure financial footing than places like Nottingham General, which had cultivated its annual subscriptions even as it grew its Saturday fund. It was not an appropriate tactic to abandon the traditional incomes in favour of the more cutting-edge methods of procuring income.[13] Instead, for the hospitals to avoid deficits, they needed to step forward into mass schemes while cautiously retaining the support of traditional hospital charity.

However, 'charity' in the voluntary hospitals changed significantly through the period. Ordinarily with charitable endeavours, there was a degree of separation; a relationship in which there is a giver and a receiver, but without material reciprocity.[14] But charity within the hospitals after the Great

[10] Gorsky, Mohan, Willis, *Mutualism in Healthcare*, p.30.; J E Stone, *Hospital Organization and Management (Including Planning and Construction),* (Faber & Gwyer Ltd: London, 1927) p.46., pp.198-200.
[11] Hayes and Doyle, 'Eggs, Rags, and Whist Drives', p.717.
[12] Hayes and Doyle, 'Eggs, Rags, and Whist Drives', pp.738-740.
[13] John Mohan and Martin Gorsky, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001) p.42.
[14] Marcel Mauss, *The Gift The form and reason for exchange in archaic societies* (Routledge: London, 2002) pp.3-5.

War was not quite so simply defined. The large-scale fundraisers such as the carnivals, parades, concerts, and parties, all had the object of charity. They were chiefly for collecting donations for the hospital from the citizens of their respective cities, towns, and villages. However, the ethos, structure, and spirit was far more mutualist, and quite different from the more typical 'top-down' middle- and upper-class philanthropy seen by many hospital historians of the Late-Victorian and Edwardian era.[15] Volunteers were raising funds for a hospital that they already had a vested interest in; they wanted to shore up a hospital service that they knew they might need to rely on one day. The levels of organisation required to organise these events went beyond a simple charity collection, and came to embody a true communal undertaking. They needed a team of volunteers to organise the whole event: publicise in magazines and newspapers, book acts, prepare displays, decorate floats, design costumes, liaise with the local authorities, communicate with the hospitals, participate in sports events and competitions, and so much more. They took on the scale of festivals, with music, dancing, food and drink, costumery and pageantry. By the 1930s, they had become part of the civic calendar, and although the financial success of the events was sometimes compromised by higher costs, they were an excellent evangelisation opportunity for the hospitals. They presented the hospitals to the community not just as a backstop of medical care, but as sources of fun and community engagement. Magazines like *The Rip* and *The Ram-Page* raised money by presenting a comical version of local people and events, written by local people for local people.

The fact that this study focussed on local sources, rather than a national picture, means that the hospitals have been shown in their context, forming their own narratives, rather than part of a broader narrative that might distort their data. As such, it can be seen that the voluntary general hospitals of Derbyshire and Nottinghamshire were able to buck a number of trends that other historians, focussing on national data, had identified. Doyle's examples in Yorkshire, and Hayes' other examples in Nottingham, both show how hospitals were keen to enlist the financial impetus offered by the mass of working class in their communities.[16] However, what this thesis has shown is that the innovation was not always at the behest of already established networks of hospital volunteers, but could instead come from within the community itself. Ripley Hospital's formation really illustrates the ability of a community to band together to make sure vital services were made

[15] Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Boydell Press: Woodbridge, 2000). Pp.135-140.; F K Prochaska, *Philanthropy and the Hospitals of London The King's Fund 1897-1900* (Clarendon Press: Oxford, 1992) p.143.

[16] Barry Doyle, 'Power and Accountability in the voluntary hospitals of Middlesborough 1900-1948', in Anne Borsay and Peter Shapely (eds.), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550-1950*, (Ashgate Publishing Limited: Aldershot, 2007). p.207., pp.212-214.; Barry M Doyle, 'Competition and Cooperation in Hospital Provision in Middlesborough, 1918-1948', *Medical History*, 5:3 (2007) pp.343-345.; Nick Hayes, ''Our Hospitals?' Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS', *Midland History*, 37:1 (2012). pp.94-95.

available, and mirrors in many ways the sort of healthcare foundations in South Wales.[17] It suggests that there was significant power in an organised working class that was able to focus its efforts on self-provision. The case of Long Eaton, too, where the community decided that instead of forming its own hospital, it would form strong contributory relationships with the Derbyshire Infirmary and Nottingham General. Clearly, working class activism among the voluntary hospitals was a strong element in and of itself, creating provision where there was none before. There was an obligation created by the fundraisers and contributors that had to be fulfilled by the voluntary hospital; it had to prioritise the care of the community that was directly funding it.

The hospitals were unequivocally community-facing, but in the First and Second World Wars, the hospitals had to negate this social obligation to their communities in favour of the treatment of wounded soldiers. While it was recognised as an absolute necessity to offer up the services of the hospitals for the good of the nation, it directly affected the hospitals' ability to treat local people – in spite of some claims that this never occurred.[18] Waiting lists were longer, staff were fewer, and wards were crowded. What was more, the voluntary hospitals were in receipt of government grants for the treatment of these soldiers. In a short space of time, the hospitals had two masters: their community, and their nation. The Great War caused problems for the voluntary hospitals, and the subsequent 'crisis' presented problems for many hospitals (though not in Derbyshire and Nottinghamshire) but the Second World War really affected the sorts of income hospitals were able to garner effectively. Annual subscriptions were all but gutted, and large- and small-scale fundraisers had to be stopped due to the dangers of war. The different natures of the wars meant that while one left the voluntary hospitals in the two counties largely untouched, the other had a more all-consuming effect upon them.

Instead of a distant and rarely used service (as they were in the Victorian era), the voluntary hospitals had become integral parts of their community, and society as a whole. By the time the NHS came about, people expected medical cover as a part of their professional and personal life. They had spent years paying into subscriptions, then Saturday funds, and finally contributory funds. They had attended whist drives, parades, concerts, dances, fairs and fetes, football matches, cricket matches, plays and recitals, carnivals and festivals. They had spent their money on comical magazines, on the stalls at bazaars, and put their spare coppers into collection boxes. They had

[17] Steven Thompson, 'The mixed economy of care in the South Wales Coalfield, c.1850-1950.', Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014). P.150.
[18] C L Dunn, *The Emergency Medical Services: Vol 1 England and Wales* (Her Majesty's Stationery Office: London, 1952). p.195.

entered fancy dress competitions, decorated their bicycles, maybe even stood on a parade float and waved to the crowds. All in aid of their hospital services. The voluntary hospitals were more than reflections of their community, they were ingrained within their community; a component of it, rather than an extraneous ancillary element. The lines of division between the hospital institutions and the people they served were blurred by the hundreds upon thousands of volunteers across the two counties who both worked in aid of the hospitals and used their services. Self-help and the active provision of hospital services were the object of these volunteers as much as the idea of charitable work for a good cause. Furthermore, the challenges that the hospitals faced were mirrored by the challenges faced by their communities; the stripping down of the workforce to go to war, the gradually increasing prices, the displacement and hardship of unemployment and underemployment, and the difficulties in real estate expansion and redevelopment. But similarly, they reflected their successes. They grew as their communities grew, expanding their remit to care for more and more people as the citizenry started to pay into the hospitals for care. The realisation that hospital care was both a necessity and an inevitability for most people resulted in new mutually beneficial relationships that put more money into the hospitals than ever before. But the rising success of hospital voluntarism from the new contributory schemes was to be cut short. The National Health Service Act in 1946 was the death knell for the voluntary system, and the 'appointed day' in 1948 was an end to voluntary fundraising for the hospital system.

Bibliography

Primary Sources

Derbyshire Record Office

- 'Long Eaton Hospital Carnival 1934', *Derby on Film*, DRO
- 'Surveys of Hospital Services', Assorted Papers, Ashbourne Victoria Memorial Hospital, 1939-1943.
- *A Souvenir and Official Handbook. Chesterfield Trader's Effort 1917*.
- Alexandra Rose Day Committee Minutes 1913.
- Anonymous, 'Our Hospital: Its abuses exposed and remedies suggested in a letter to the Governors of the Derbyshire General Infirmary by a Clerical Governor', (W Bemrose and Son: Derby 1852). [Pamphlet]
- Ashbourne District Nursing Association Minutes 1901-1949.
- Ashbourne Victoria Annual Reports 1898-1947.
- Ashbourne Victoria Cottage Hospital, *Rules, Preliminary Statement, List of Officers, Subscribers, &c*., 1898.
- Ashbourne Victoria Hospital Ladies Committee Minutes 1905-39.

  Ashbourne Victoria Hospital Minutes of Management Committee 1905.

- *Bakewell and District Memorial Hospital General Report,* [Bakewell Collected Papers]
- Buxton and District Cottage Hospital Annual Report 1923.
- Chesterfield and North Derbyshire (Royal) Hospital Annual Reports 1854, 1900-1947.
- Chesterfield and North Derbyshire (Royal) Hospital Rules 1906.
- *Chesterfield and North Derbyshire Royal Hospital Contributory Scheme 1944*
- Chesterfield and North Derbyshire Royal Hospital Contributory Scheme Minutes, 1936-9.
- Chesterfield and North Derbyshire Royal Hospital Sub-Committee Re Contributory Scheme, 30th June 1936.
- Derbyshire Royal Infirmary Annual Reports 1900-1947.
- *Derby & Derbyshire Royal Infirmary Saturday Committee Jubilee Year 1874-1924: An Interesting Souvenir of 50 Years' Work,* 1924.

- Derby and Derbyshire Nursing & Sanitary Association, 'Revised Report of the Honorary Medical Staff re Training of Midwifery Pupils and other matters concerning the Management of the Nightingale Home', 1914.
- Derby and Derbyshire Royal Infirmary Saturday Committee Minutes 1927-39
- Derby Children's Hospital Annual Report 1938.
- *Derby On Film DVD 0022*, DRO
- Derbyshire Children's Hospital Annual Reports 1910-1938.
- Derbyshire Royal Infirmary Committee Reports, 'British Hospitals Association Report of Annual Meeting', 3,4,5 June 1931.
- Derbyshire Royal Infirmary Extension Week 1939 Souvenir Programme.
- Derbyshire Royal Infirmary General Purposes Committee Minutes 1938
- Derbyshire Royal Infirmary Minutes and Order Book 1919-46.
- Derbyshire Royal Infirmary Rules 1904.
- Derbyshire Royal Infirmary Saturday Committee Souvenir Booklet 1924,
- Derbyshire Royal Infirmary Saturday Committee Souvenir Booklet, 1927.
- Derbyshire Royal Infirmary Saturday Fund Rules, 1931.
- Derbyshire Royal Infirmary Sunday Committee Minutes 1901-1925.
- Derbyshire Royal Infirmary, 'Letter to Mr Forster from E Collier Green Hon. Sec. of Medical Staff, with regards calling up of staff to RAMC', 1917.
- Derbyshire Voluntary Hospitals Committee Minutes 1921-3
- Devonshire Hospital and Buxton Bath Charity Annual Reports 1900-1938.
- Etwall District Nursing Association Minutes 1901
- Ilkeston General Hospital Annual Report 1947.
- Long Eaton Carnival Committee Minutes, 1934-6.
- Mayoress of Derby Ladies Committee Minutes 1900-1941.
- Rev. William Francis Wilkinson, M.A., 'Remarks on the letter of a Clerical Governor to the Governors of the Derbyshire General Infirmary', (W. and W. Pike: Derby, 1852). [Pamphlet]

- *Rules of the Derbyshire Royal Infirmary Saturday Fund*, 1931.
- Saturday Fund Souvenir Booklet, 1922.
- Stanley District Nursing Association 'Assorted Papers' D331/5/30-40.
- Strutt, G Herbert, *Letter to Edmund Forster (Secretary of Derbyshire Royal Infirmary)*, 30 December 1907.;
- *The Chesterfield and North Derbyshire Royal Hospital Contributory Scheme,* 1st October 1944.
- The Derbyshire Royal Infirmary Saturday Fund Year Book 1939.
- The Derbyshire Royal Infirmary Saturday Fund Year Book 1939.
- *The Rip. The magazine of Ripley Carnival and Official Carnival Programme 1938*, (G C Brittain and Sons Ltd: Ripley) 1932-8.
- The Royal Derby and Derbyshire Nursing and Sanitary Association Annual Report 1900-1902.
- The Whitworth Hospital Annual Reports, 1911-1912, 1914.
- Unknown Author, *Three Weeks In the Devonshire By An In-Patient*, (Buxton Advertiser: Buxton, 1874).
- *Voluntary Hospitals Commission Final Report*, 1921, p.4.
- Walton, Sydney, 'Sir Napier Burnett: An Appreciation', *The Hospital and Health Review*, 3:54 (1924) p.54.
- Wirksworth Cottage Hospital Annual Reports 1900-1947.
- Wirksworth Cottage Hospital Carnival Wakes Official Programme, 1927.

University of Nottingham Manuscripts and Special Collections Archive

- Nottingham Children's Hospital Annual Reports 1922, 1930, 1937
- Nottingham General Hospital 'Proposed Report of the Hospital Saturday Committee to the Monthly Board of the Nottingham General Hospital', 2 April 1921.
- Nottingham General Hospital Annual Reports 1900-1947.

- Nottingham General Hospital House Committee Minutes 1930-1939.
- Nottingham General Hospital Monthly Board Minutes 1900-1942.
- Nottingham General Hospital Monthly Board Minutes and House Committee Minutes 1921.
- Nottingham General Hospital Report of the Monthly Board 1940.
- Nottingham General Hospital Report of the Monthly Board 1940.
- Nottingham General Hospital Saturday Committee Minutes 2 December 1929.
- Nottingham General Hospital Saturday Fund Minutes 1927.
- Nottingham General Saturday Committee Minutes 1900-1939.
- Nottingham Saturday Fund Executive Committee Minutes 1911-1938.

Nottinghamshire County Archives

- Worksop Victoria Hospital Annual Report 1928
- Worksop Victorian Memorial Hospital Annual Reports 1928-38.
- Newark Town and District Hospital and Dispensary Annual Report 1900-1939.
- Nottinghamshire Nursing Federation Annual Reports 1898-1940.
- Mansfield District General Hospital Annual Reports 1921-1938.

British Newspaper Archive

- *Derby Daily Telegraph*
- *Derbyshire Advertiser and Journal*
- *Derbyshire Courier*
- *Derbyshire Times and Chesterfield Herald*
- *Dundee Evening Telegraph*

- *Ilkeston Advertiser*
- *Long Eaton Advertiser*
- *Nottingham Evening Post*
- *Nottingham Journal*
- *Nottinghamshire Guardian*
- *Reading Mercury*
- *Retford Times*
- *Ripley and Heanor News and Ilkeston Division Free Press*
- *Sheffield Daily Telegraph*
- *Sheffield Independent*
- *West Bridgford Times & Echo*
- *Yorkshire Post and Leeds Intelligencer*

National Archives, Kew

- HLG 7/380, 'Regional Operational Reports, No.3 Region'.
- HLG 7/680 *Admission of acute civilian sick to emergency hospitals*, 1940.
- MH58/178. Voluntary Hospitals Commission, 'Definition of the term Voluntary Hospital'.
- MH58/187. Voluntary Hospitals Commission, 'Conference with Local Voluntary Hospital Committees' 1924.
- MH58/188. Voluntary Hospitals Commission, 'Conference with Local Voluntary Hospital Committees' 1924.
- MH58/189. Voluntary Hospitals Commission, 'Report of Conference with Local Voluntary Hospitals Committees'.
- MH58/203 Voluntary Hospitals Commission, 'Constitution and Terms of Appointment'.
- MH58/204. Voluntary Hospitals Commission, 'Ministry of Health Departmental Committee To Investigate the Financial Position Of Voluntary Hospitals'.

- MH58/205. Voluntary Hospitals Commission,
- MH58/207 'Voluntary Hospitals Financial Position Report of Committee 1921'.
- MH76/2, *Select Committee on National Expenditure Report 1940-1.*
- MH76/305 *Statistics on Emergency Blood Transfusion Service 1942-7*.
- Ministry of Health, *Voluntary Hospitals Committee Final Report*, (His Majesty's Stationery Office: London, 1921).
- Ministry of Health/Viscount Cave, *Voluntary Hospitals Committee – Interim Report,* (His Majesty's Stationery Office: London, 1921).
- The Labour Party, *The Hospital Problem: The Report of a Special Conference of Labour, Hospital, Medical and kindred Societies, held in Caxton Hall, Westminster, on April 28th and 29th, 1924* (The Labour Party: London, 1924).

Digital Databases

- Voluntary Hospitals Database, http://www.hospitalsdatabase.lshtm.ac.uk/.
- Imperial War Museum, Posters, https://www.iwm.org.uk/collections/item/object/12339, [accessed 09/08/2019]
- Labour Party Manifesto 1929, http://www.labour-party.org.uk/manifestos/1929/1929-labour-manifesto.shtml.

Private and other collections

- *The Ram-Page,* 1930-37.
- *Souvenir of the Ripley Cottage Hospital, Being a Record of Incidents leading up to the Establishment of the Institution with a few notes on the Town of Ripley,* 1911
- Ilkeston General Hospital Annual Report 1890, 1914-15, 1935, 1947.

- Griffiths, Joseph, 'The Hospital Problem and a New Hospital Service', *The Lancet* XX:XX *(*1921), pp.633-634.
- Hansard, 11 February 1943, Volume 386, p.12., words of Mr Ernest Brown (Minister of Health).
- 'The Calling Up Notice', *British Medical Journal*, 1:2939 (1917)
- 'The National Relief Fund', *The Hospital*, 12 June 1920.
- 'Voluntary Hospitals Commission', *British Medical Journal,* 2:81, 16 July 1921.
- 'War Office Call On All Medical Men Under 41', *Supplement to the British Medical Journal*, (1917)
- 'Future of Hospitals', *The British Medical Journal*, 4 December 1920.
- 'National Relief Fund', *Hansard,* Vol 85, 14 August 1916 https://hansard.parliament.uk/commons/1916-08-14/debates/11326aab-ad1f-44e3-a802-5ea23217b50a/NationalReliefFund [accessed 22/08/19]
- 'Nurses' Salaries: Ruchcliffe Committee's Report', *British Medical Journal*, 27 February 1943.
- Royal Crown Derby Hospital Day Cup, dated 1939, https://rcdcollections.com/royal-crown-derby-presentation-pieces [accessed 27/12/2019]
- 'Sir Henry Bemrose', https://www.npg.org.uk/collections/search/person/mp84453/sir-henry-howe-bemrose [accessed 29/11/2019].
- 'Vision of Britain', Census Data, http://www.visionofbritain.org.uk/ [accessed 25/10/19]

Secondary Sources

Printed Sources

- Abel-Smith, Brian, *A History of the Nursing Profession* (Heinemann: London, 1960).
- Abel-Smith, Brian, *The Hospitals,* (Heinemann: London, 1960).
- Acworth, W M, 'Grouping Under The Railways Act', *The Economic Journal,* 33:129 (1923) pp.19-38.
- Aldcroft, Derek, *The British economy between the wars* (Philip Allan: Oxford, 1983).
- Aldroft, Derek, *The British Economy: The Years of Turmo8il 1920-1951* (Harvester: London, 1984).
- Amies, Hardy, The Englishman's Suit (Quartet Books Ltd.: London, 2009).
- Barnes, Alison, *The History of the SSAFA, Part Two: First World War*, (SSAFA, 1985) https://www.ssafa.org.uk/media/z2kf3ij5/ssafa-history-part-two.pdf [accessed 09/08/19].
- Barthes, Roland, *The Fashion System* (University of California Press: London, 1990).
- Berghoff, Harmut, 'British Businessmen as Wealth-Holders, 1870-1914: A Closer Look', *Business History*, 33:2 (1991). pp.222-240
- Beveridge, William Henry, A F Wells, A F, *The evidence for voluntary action: being memoranda by organisations and individuals and other material relevant to voluntary action*, (George Allen and Unwin: London, 1949).
- Blake, Robert, *The Conservative Party from Peel to Churchill* (Eyre & Spottiswoode: London, 1970).
- Bourne, John, *Britain and the Great War 1914-1918* (Edward Arnold, London, 1989).
- Boyns, Trevor, 'Strategic Repsonses to Foreign Competition: The British Coal Industry and the 1930 Coal Mines Act, Business History, 32:3 (1990). pp.133-145.
- Bridgen, Paul, 'Voluntary Failure, the Middle Classes, and the Nationalisation of the British Voluntary Hospitals, 1900-1946', Harris, Bernard, Bridgen, Paul (eds.) *Charity and mutual aid in Europe and North America since 1800* (Routledge: London, 2007). pp.212-234.

- Brooke, Eileen M, 'The Emergency Medical Services', W Franklin Mellor (ed.), *Medical History of the Second World War Casualties and Medical Statistics*, (Her Majesty's Stationery Office: London, 1972). pp.635-826.
- Burke, Peter, *Popular Culture in Early Modern Europe*, (Ashgate Publishing Limited: Aldershot, 1994).
- Carden-Coyne, Ana, The Politics of Wounds: Military Patients and Medical power in the First World War, (Oxford Univeristy Press: Oxford, 2014).
- Castle, Ian, *The First Blitz: Bombing London in the First World War* (Osprey Publishing: Oxford, 2015).
- Chandler, Andrew, 'Faith in the nation? The Church of England in the 20th century', *History Today*, 47:5 (1997). pp.9-15.
- Chapman, Stanley, 'Economy, Industry and Employment', in John Beckett (ed), *A Centenary history of Nottingham* (Manchester University Press: Manchester, 1997). pp.480-512.
- Cherry, Steven, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *The Economic History Review*, 50:2 (1997) pp.305-326.
- Cherry, Steven, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Scheme: A Regional Study', The Society for the Social History of Medicine, 5:3 (1992). pp.454-482.
- Cherry, Steven, 'Change and Continuity in The Cottage Hospitals c.1859-1948: The Experience in East Anglia', *Medical History,* 36:27 (1992). pp.271-289.
- Cherry, Steven, *Medical Services and the Hospitals in Britain* (Cambridge University Press: Cambridge, 1996)
- Christian, Roy, *Butterley Brick 200 years in the Making*, (Henry Melland: London, 1990).
- Church, Roy, Hall, Alan, Kanefsky, John, *The History of the British Coal Industry, Volume 3*, 1830-1913 Victorian Pre-Eminence (Oxford University Press: Oxford, 1986).
- Clark Kennedy, A E, *London Pride The Story of a Voluntary Hospital*, (Hutchinson Benham: London, 1979).
- Crowley, Mark J, 'Reducing, re-defining and retaining: the struggle to maintain a stable workforce and service in the British Post Office during the Second World War', *Essays in Economic & Business History*, Vol XXXI, (2013) p.60.

- Curtis, Ben and Thompson, Steven, '"A Plentiful Crop of Cripples Made by All This Progress": Disability, Artificial Limbs and Working-Class Mutualism in the South Wales Coalfield, 1890-1948', *Social History of Medicine*, 27:4 (2014). pp.708-727.
- Curtis, Ben, Steven Thompson, Steven, '"This is the Country of Premature Old Men" Ageing and Aged Miners in the South Wales Coalfield, C. 1880-1947', Cultural and Social History, 12:4 (2015). pp.587-606.
- Curtis, Ben, Thompson, Steven, '"This is the Country of Premature Old Men" Ageing and Aged Miners in the South Wales Coalfield, C. 1880-1947', Cultural and Social History, 12:4 (2015). pp.587-606.
- Daunton, M J, 'Payment and Participation: Welfare and State-Formation in Britain 1900-1951', *Past & Present*, 150 (1996). pp. 169-216.
- Daunton, Martin, '"Gentlemanly Capitalism" and British Industry 1820-1914', *Past and* Present 122 (1989). pp. 150-170
- David Cannadine, 'The Transformation of Civic Ritual in Modern Britain: The Colchester Oyster Feast', *Past and Present*, 94:1 (1982). pp.107-130.
- Deacon, Alan, 'Systems of Interwar Unemployment Relief', Sean Glynn and Alan Booth (eds.) The Road to Full Employment (Allen & Unwin: London, 1987) pp.31-42.
- Dean, Dennis, The Character of the Early Labour Party, 1900-1914', in Alan O'Day (ed.) *The Edwardian Age: Conflict and Stability, 1900-1914,* (MacMillan Press Ltd: London, 1979). pp.97-112
- Delbert Evans, A, Redmond Howard, L G, *The Romance of the British Voluntary Hospital Movement*, (Hutchinson & Co Ltd: London, 1930) p.286.
- Digby, Anne, 'Medicine and the English State, 1901-1948', in S J D Green, R C Whiting (eds.) *The Boundaries of the State in Modern Britain*, (Cambridge University Press: Cambridge, 1996). pp.213-230.
- Dingwall, Robert, Rafferty, Anne Marie and Webster, Charles, *An Introduction to the Social History of Nursing* (Routledge: London, 1988).
- Dowie, J A, '1919-20 is in Need of Attention', The Economic History Review, 28:3 (1975). pp.429-450.
- Doyle, Barry, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919-1938', *Social History of Medicine*, 23:2 (2010). pp.374-392.

- Ducrow, Mary, *A History of the General Hospital Birmingham*, (Unpublished manuscript, no date).
- Dunn, C L, *The Emergency Medical Services: Vol 1 England and Wales* (Her Majesty's Stationery Office: London, 1952).
- Dunn, C L, *The Emergency Medical Services: Vol 2*(Her Majesty's Stationery Office: London, 1952).
- Du-Plat-Taylor, Major, Coleridge, John, Abraham, Dr J. J., *Cottage Hospitals*, (Ernest Benn Limited: London, 1930).
- Eckstein, Harry, *The English Health Service* (Harvard University Press: Cambridge, 1958).
- Eichengreen, Barry, *Hall of Mirrors The Great Depression, The Great Recession, and the Uses – and Misuses – of History* (Oxford University Press: Oxford, 2015).
- Fegan, Thomas, *'The Baby Killers' German Air Raids on Britain in the First World* War (Pen & Sword Military: Barnsley, 2012).
- Fielding, Steven, Thompson, Peter, Tiratsoo, Nick, *"England Arise" The Labour Party and Popular Politics in 1940s Britain* (Manchester University Press: Manchester, 1995).
- Finlayson, Geoffrey, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History,* 1:2 (1990). pp.183–206.
- Finlayson, Geoffrey, *Citizen, State, and Social Welfare in Britain 1830-1990,* (Clarendon Press: Oxford, 1994).
- Fox, Daniel M, 'The National Health Service and the Second World War: the elaboration of consensus', Harold L Smith (ed.), *War and Social Change: British Society in the Second World War* (Manchester University Press: Manchester, 1990). pp.32-57.
- Fox, Daniel, *Health Policies, Health Politics: The British and American Experience* (Princeton university Press: Princeton, 1986).
- Fox, Enid, 'District Nursing in England and Wales Before the National Health Service: The Neglected Evidence', Medical History, 38:3 (1994). pp.303-321.
- Fraser, Derek, *The Evolution of the British Welfare State* (Palgrave: Basingstoke, 1984). P.181.
- Garrard, John, 'Urban Elites, 1850-1914: The Rule and Decline of the New Squirearchy?', in *Albion: A Quarterly Journal Concerned with British Studies*, 27:4 (1995). pp.583-621.

- Garrard, John, ‘Urban elites, 1850-1914: the rule and decline of a new squireachy?’, *Albion,* 27 (1995). pp.583-621.
- Gately, Chris, ‘”Peace Day” Celebrations in Derby’, *East Midlands History and Heritage,* 8 (2019) pp.10-12.
- Gilbert, Martin, *First World War*, (BCA: London, 1994).
- Gittings, F C B ‘Contributory Schemes for Hospitals’, *British Medical Journal*, 17 December 1927, p.1166.
- Gorsky, M, Mohan, J and Powell, M, ‘British voluntary hospitals, 1871-1938: the geography of provision and utilization’, *Journal of Historical Geography*, 25, (1999). pp.468-72.
- Gorsky, Martin , John Mohan, John, Powell, Martin, 'The financial health of voluntary hospitals in interwar Britain', Economic History Review, Economic History Review, 3, (2002) pp.533-557
- Gorsky, Martin, Mohan, John, ‘London’s Voluntary Hospitals in the Interwar Period: Growth, Transformation or Crisis?’, *Nonprofit and Voluntary Sector Quarterly*, 30:2 (2001). pp.247-275.
- Gorsky, Martin, Mohan, John, Willis, Tim, *Mutualism and Healthcare: British hospital contributory schemes in the twentieth century* (Manchester University Press: Manchester, 2006).
- Gorsky, Martin, '"Threshold of a New Era": The Development of an Integrated Hospital System in Northeast Scotland, 1900-39', Social History of Medicine, 17:2, (2004) pp.247-267.
- Gorsky, Martin, ‘Community Involvement in Hospital Governance in Britain: Evidence from Before the National Health Service’, *International Journal of Health Services*, 38:4 (2008). pp.751-771.
- Gorsky, Martin, Mohan, John, Powell, Martin, ‘British Voluntary Hospitals, 1871-1938: The Geography of Provision and Utilization’, *Journal of Historical Geography* 25:4 (1999) pp.463-482.
- Gorsky, Martin, Mohan, John, 'Uses of Yearbooks: The Voluntary Hospitals Database', Social History of Medicine, 24:2 (2011). pp.478-483.
- Gorsky, Martin, Mohan, John, Willis, Tim, ‘Hospital Contributory Schemes and the NHS Debates 1937-1946: The Rejection of Social Insurance in the British State?’, *Twentieth Century British History*, 16:2 (2005) pp.170-192.
- Gourvish, T. R., 'The Standard of Living, 1890-1914’, in Alan O’Day (ed.) *The Edwardian Age: Conflict and Stability, 1900-1914,* ((MacMillan Press Ltd: London, 1979). pp.13-33.

- Grant, Peter, 'Voluntarism and the impact of the First World War', Matthew Hilton and James McKay, The Ages of Voluntarism How we got to the Big Society, (Oxford University Press: Oxford, 2011). pp.27-47.
- Griffin, A R, Mining in the East Midlands 1550-1947, (Frank Cass & Company Limited: London, 1971)
- Griffin, Alan R, *The Miners of Nottinghamshire 1914-1944 A History of the Nottinghamshire Miners' Unions* (George Allen & Unwin: London, 1962).
- Griffin, Colin P, '"Three Days Down the Pit and Three Days Play": Underemployment in the East Midlands Coalfields between the Wars', *International Review of Social History*, 38 (1993). pp.321-343.
- Guthrie, Douglas, *A History of Medicine*, (Thomas Nelson & Sons Ltd: London, 1945).
- Haig, Alan, *The Victorian Clergy* (Croom Helm: London, 1984).
- Hampton, F, 'A Brief Survey of Nottingham Employment', July 1936, Nottingham Central Library.
- Hannington, Wal, *Problem of the Distressed Areas* (Victor Gollancz Ltd: London, 1937).
- Harris, Bernard, 'Government and Charity in the Distressed Mining Areas of England and Wales, 1928-30', in Barry, Jonathan and Jones, Colin (eds.), *Medicine and Charity before the Welfare State* (Routledge: London, 1991). pp.207-225.
- Harris, Jose, 'War and Social History: Britain and the Home Front during the Second World War', *Contemporary European History*, 1:1 (1992) pp.17-35.
- Hart, Harold W, 'Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System', *Medical History*, 24. p.447-460.
- Hayes, Nick , 'Things Ain't What They Used To Be! Elites and Constructs of Consensus and Conflict in Twentieth Century English Municipal Politics', Doyle, Barry M (ed.) *Urban Politics and Space in the Nineteenth and Twentieth Centuries: Regional Perspectives* (Cambridge Scholars Publishing: Newcastle Upon Tyne, 2007) pp.47-61
- Hayes, Nick, ''Our Hospitals?' Voluntary Provision, Community and Civic Conscious ness in Nottingham Before the NHS', *Midland History*, 37:1 (2012). pp.84-105.
- Hayes, Nick, 'Counting civil society: deconstructing elite participation in the provincial English city, 1900-1950', *Urban History*, (2013). pp.1-28.

- Hayes, Nick, 'Did We Really Want a National Health Service? Hospital, Patients and Public Opinions before 1948', *English Historical Review*, CXXVII:526 (2012) pp.625-661.
- Hayes, Nick, Barry M Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, 86:234 (2013). pp.712-740.
- Hennock, E. P., *Fit and Proper Persons, Ideal and reality in nineteenth-century urban government*, (Edward Arnold: London, 1973).
- Hey, David, 'Industrialized Villages', in G E Mingay (ed.) *The Victorian Countryside Volume 1* (Routledge & Kegan Paul: London, 1981). pp.353-364.
- Honigsbaum, Frank, *Health, happiness, and security the creation of the National Health Service* (Routledge: London, 1989).
- Hopkins, Eric, *A Social History of the English Working Classes 1815-1945* (Hodder & Stoughton: London, 1979) p.247.
- Hopkins, Eric, *Working Class Self-Help in nineteenth Century England* (UCL Press: London, 1995).
- Hunter, John B, 'The Emergency Medical Service and the Future', *The British Medical Journal*, (1 March 1941) pp.326-330.
- Hutt, Allen, *The Post-War History of the Working Class*, (Victor Gollancz Ltd: London, 1937).
- Hutton, Ronald, *The Stations of the Sun A History of the Ritual Year in Britain* (Oxford University Press: Oxford, 1996).
- Jarboe, Andrew Tait, 'Healing the Empire: Indian Hospitals in Britain and France during the First World War', *Twentieth Century British History*, 26:3, (2015). pp.347-369.
- Jeffreys, Kevin, 'British Politics and Social Policy during the Second World War', *The Historical Journal*, 30:1 (1987).
- Joseph, Nathan, *Uniforms and Nonuniforms: Communication Through Clothing* (Greenwood Press Ltd.: Westport, 1986)
- Klein, Rudolf, *The Politics of the National Health Service* (Longman: London, 1983).
- Knight, Frances, *The Nineteenth-Century Church and English Society* (Cambridge University Press: Cambridge, 1995).

- Langham, Mike, and Wells, Colin, *A History of The Devonshire Royal Hospital at Buxton and the Buxton Bath Charity* (Churnet Valley Books: Leek, 2003).
- Leach, John, *Coalmining Around Whaley Bridge*, (Derbyshire Library Service: Matlock, 1992).
- Lee, J. M., *Social Leaders and Public Persons A Study of County Government in Cheshire since 1888* (Oxford University Press: Oxford, 1963).
- Leff, S, *The Health of the People* (Victor Gollancz: London, 1950).
- Leveaux, V. M., *The History of the Derbyshire General Infirmary* (Scarthin Books: Cromford, 1999).
- Lewis, Jane, 'The Boundary between Voluntary and Statutory Social Service in the Late Nineteenth and Early Twentieth Centuries', *The Historical Journal*, 39:1 (1996) pp.155-177.
- Loch Mowat, Charles, *Britain Between the Wars 1918-1940*, (Methuen & Co. Ltd: London, 1955).
- Lowe, Rodney, 'The Erosion of State Intervention in Britain, 1917-24', *The Economic History Review,* New Series 31:2 (1978) pp.270-286.
- Luckham, L S, 'Hospital Contributory Schemes', *British Medical Journal,* 31 December 1927, p.1245.
- MacNalty, Sir Arthur, 'The Public Health in War Time', *The British Medical Journal* (1940) pp.333-336.
- MacNalty, Sir Arthur, *Medical services in war: the principal medical lessons of the Second World War; based on the official medical histories of the United Kingdom, Canada, Australia, New Zealand and India,* (HMSO: London, 1969).
- MacNalty, Sir Arthur, *The civilian health and medical services* (HMSO: London, 1953).
- MacPherson, Major General Sir W G, *History of the Great War Based on Official Documents Medical Services General History Vol I.,* (His Majesty's Stationery Office: London, 1921).
- *Marketing Survey of the United Kingdom & Census of Purchasing Power Distribution* (Business Publications Ltd: London, 1938).
- Marland, Hilary, 'Lay and Medical Conceptions of Medical Charity during the Nineteenth Century: The Case of the Huddersfield General Dispensary and Infirmary', Barry, Jonathan and Jones, Colin (eds.), *Medicine and Charity before the Welfare State* (Routledge: London, 1991) pp.149-151.
- Marwick, Arthur, *The Home Front* (Thames and Hudson: London, 1976).
- McConaghey, R. M. S., 'Evolution of the Cottage Hospital', *Medical History*, 11:2 (1967). Pp.141-160.

- McKibbin, Ross, *The Ideologies of Class: Social Relations in Britain 1880-1950* (Oxford University Press: Oxford, 1994).
- Meyer, Jessica, 'Neutral Caregivers or Military Support? The British Red Cross, the Friends' Ambulance Unit, and the Problems of Voluntary Medical Aid in Wartime', *War & Society*, 34:2 (2015). pp.105-120.
- Millis, H A, 'The British Trade Disputes and Trade Unions Act, 1927', *Journal of Political Economy*, 36:3 (Jun 1928) pp.305-6.
- Mitchell, B R, *Abstract of British Historical Statistics* (Cambridge University Press: London, 1962) p.67.
- Mohan, John and Gorsky, Martin, *Don't Look Back*? *Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (Office of Health Economics: London, 2001).
- Mohan, John, *Planning, Markets, and Hospitals,* (Routledge: London, 2002).
- Mohan, John, 'The caprice of charity": Geographical variations in the finances of British voluntary hospitals before the NHS', in Gorsky, Martin and Sheard, Sally (eds.), *Financing Medicine: The British experience since 1750* (Routledge: London, 2006). pp.77-92.
- Mohan, John, 'Voluntarism, municipalism and welfare: the geography of hospitals utilization in England in 1938', *Transactions of the Institute of British Geographers*, 28:1 (2003). pp.56-74.
- Mohan, John, *Planning, markets and hospitals* (Routledge: London, 2002).
- Morris, J., *Religion and Urban Change: Croydon, 1840-1914* (Woodbridge, 1992), pp. 128-46; Green, S J D., *Religion in the Age of Decline: Organisation and Experience in Industrial Yorkshire, 1870-1920* (Cambridge, 1996), pp. 351-79.
- Neville, Julia, 'Cottage Hospitals and communities in rural East Devon, 1919-1939', Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014). pp.117-140.
- Neville, Julia, 'Explaining Local Authority Choices on Public Hospital Provision in the 1930s: A Public Policy Hypothesis', *Medical History*, 56 (2012). pp.48-71.
- Newman, Sir George, 'The Health of the People' in Laski, Harold (ed.), *A Century of Municipal Progress* (George Allen & Unwin Ltd: London, 1935). pp.153-182.

- Oakley, Ann, 'Eugenics, Social Medicine and the Career of Richard Titmuss in Britain, 1935-50', *The British Journal of Sociology*, 42:2, (1991). pp.165-194.
- Palmer, H M, Wynn-Jones, S E, 'Stanley, Sir Arthur 1869-1947', https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-36242 [accessed 27/12/2019].
- Pater, John E*, The Making of the National Health Service*, (King Edward's Hospital Fund for London: London, 1981).
- Perkin, Harold, *The rise of Professional Society: England Since* 1880 (Routledge, 1989).
- Pickstone, John V, *Medicine and Industrial Society: A history of hospital development in Manchester and its Region, 1752-1946*, (Manchester University Press: Manchester, 1985).
- Pickstone, John V., *Medicine and Industrial Society* (Manchester University Press: Manchester, 1985).
- Pickstone, John, 'Production, Community and Consumption: The Political Economy of Twentieth-Century Medicine', Cooter, Roger and Pickstone, John (eds.), *Medicine in the twentieth Century* Harwood Academic Publishers: Amsterdam, 2000).
- Pinker, Robert, *English Hospital Statistics 1861-1938*, (Heinemann: London, 1964).
- Porter, Roy, *The Greatest Benefit to Mankind A Medical History of Humanity from Antiquity to the Present* (Fontana Press: London, 1999).
- Powell, M, 'Hospital provision before the NHS: territorial justice or inverse care law', *Journal of Social Policy*, 21, (1992). pp.145-63.
- Powell, Martin , 'Hospital Provision before the National Health Service: A Geographical Study of the 1945 Hospital Surveys', The Society for the Social History of Medicine, 5:3 (1992) pp.483-504
- Prochaska, F K, *Philanthropy and the Hospitals of London The King's Fund 1897-1900* (Clarendon Press: Oxford, 1992).
- Reeder, David and Rodger, Richard, 'Industrialisation and the city economy', in Daunton, Martin (ed.), *Cambridge Urban History*, (Cambridge University Press: Cambridge, 2000). pp.553-592.
- Reid, Douglas A., 'Interpreting the Festival Calendar: Wakes and Fairs as Carnivals', in Robert D Storch, *Popular Culture and Custom in Nineteenth Century England* (Croom Helm: London, 1982). pp.125-153.

- Reinarz, Jonathan, 'Investigating the 'deserving' poor: charity and the voluntary hospitals in the nineteenth-century Birmingham', Anne Borsay and Peter Shapely (eds.), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550-1950*, (Ashgate Publishing Limited: Aldershot, 2007). pp.111-134.
- Reinarz, Jonathan, 'The funding of Birmingham voluntary hospitals in the nineteenth century', in Martin Gorsky, Sally Sheard (eds) *Financing Medicine: The British Experience Since 1750* (Routledge: Oxon, 2006).
- Reinarz, Jonathan, 'The Funding of Birmingham's Voluntary Hospitals in the Nineteenth Century', in Gorsky, Martin and Sheard, Sally, *Financing Medicine: The British Experience since 1750*, (Cambridge University Press: Cambridge, 2007).
- Reinarz, Jonathan, *Health Care in Birmingham The Birmingham Teaching Hospitals 1779-1939* (Boydell Press: Woodbridge, 2009).
- Research Committee of the Economic Science and Statistics Section of the British Association, *Britain in Depression A Record of British Industries Since 1929* (Sir Isaac Pitman & Sons: London, 1935).
- Reznick, Jeffrey S., *Healing the Nation Soldiers and the Culture of Caregiving in Britain Curing the Great War*, (Manchester University Press: Manchester, 2004).
- Richards, Jeffrey, *The Age of the Dream Place: Cinema and Society in Britain 19301939* (Routledge and Kegan Paul1984).
- Richardson, Harry W, Aldcroft, Derek H, *Building in the British Economy Between the Wars*, (George Allen & Unwin: London, 1968).
- Rivett, G *The Development of the London Hospital System, 1823–1982,* (King's Fund: London, 1986).
- Rivett, Geoffrey*, The Development of the London Hospital System 1823-1982* (King Edward's Hospital Fund for London: London, 1986).
- Rose, Sonya O, 'Sex, Citizenship and the Nation in World War II Britain', *The American Historical Review*, 103:4 (1998). pp.1147-1176.
- Rossano, Geoffrey L Rossano, Thomas Wildenberg, *Striking the Hornet's Nest. Naval Aviation and the Origins of Strategic Bombing in World War* I, (Naval Institute Press: Annapolis, 2015).
- Routh, Guy, *Occupation and Pay in Great Britain 1906-79* (Macmillan: London, 1980).

- Rubinstein, Bill, 'Britain's elites in the inter-war period, 1918-39', in Kidd, Alan J and Nicholls, David (eds.), *The Making of the British Middle Class?* (Sutton: London, 1998).
- Rubinstein, William, D., 'Britain's Elites in the Inter-War Period, 1918-1939: Decline or Continued Ascendency?', British Scholar, 3:1 (2010). pp.5-23.
- Savage, Michael, *The Dynamics of Working-class Politics The Labour Movement in Preston, 1880-1940* (Cambridge University Press: Cambridge, 1988).
- Scambler, Graham, *Health and Social Change* (Open University Press: Buckingham, 2002).
- Scott, Peter and Spadavecchia, Anna, 'Did the 48-hour week damage Britain's industrial competitiveness?', Economic History Review, 64:4 (2011). pp.1266-1288.
- Sheffield City Council, *Sources for the Study of the Sheffield Blitz of 1940*, (Sheffield Libraries Archives and Information: Sheffield, 2016).
- Skidelsky, Robert, *Politicians and the Slump. The Labour Government of 1929-1931* (Penguin Books Ltd: Harmondsworth, 1970).
- Smith, Harold L, 'The Womanpower Problem in Britain during the Second World War', *The Historical Journal*, 27:4 (1984). pp.925-945.
- Snape, Robert, 'The New Leisure, Voluntarism and Social Reconstruction in Inter-War Britain', *Contemporary British History* 29:1 (2015). pp.51-83.
- Stevenson, John and Cook, Chris, *Britain in the Depression Society and Politics 1929-1939* (Longman: London, 1994).
- Stevenson, John, *British Society 1914-1945,* (Penguin Books Ltd: London, 1984).
- Stevenson, John, Cook, Chris, *The Slump Society and Politics During the* Depression (Quartet Books Ltd: London, 1979).
- Stewart, John, *The Battle for Health. A political history of the Socialist Medical Association, 1930-51* (Ashgate: Aldershot, 1999) .
- Stone, J E, *Hospital Organization and Management (Including Planning and Construction)*, (Faber & Gwyer Ltd: London, 1927).
- Supple, Barry, *The History of the British Coal Industry, Volume 4, 1913-1946 The Political Economy of Decline*, (Clarendon Press: Oxford, 1987).

- Taylor, A. J. P., *English History 1914-1945*, (Book Club Associates: London, 1965).
- Teeboon, Alfred, 'The Nottingham and Nottinghamshire Hospital Saturday Fund, 1873-1948', *Transactions of the Thoroton Society,* Vol LXXXIV, (1980). Pp.68-72.
- Thompson, Steven, 'To Relieve the Sufferings of Humanity, Irrespective of Party, Politics or Creed?: Conflict, Consensus and Voluntary Hospital Provision in Edwardian South Wales', *The Journal of the Society for the Social History of Medicine*, 16:2 (2003). pp.247–262.
- Thompson, Steven, 'The mixed economy of care in the South Wales Coalfield, c.1850-1950.', Donnacha Sean Lucey and Virginia Crossman (eds.) *Healthcare in Ireland and Britain from 1850: Voluntary, regional and comparative perspectives* (University of London School of Advanced Study Institute of Historical Research: London, 2014). pp.141-160.
- Titmuss, Richard, *Problems of Social Policy*, (His Majesty's Stationery Office: London, 1950).
- Titmuss, Richard, *Social Policy: An Introduction* (George Allen & Unwin Ltd.: London, 1974).
- Unknown, 'Rehabilitation After Accidents: Final Report of Interdepartmental Committee', *British Medical Journal,* 2:4102, (1939) p.417.
- Waddington, Keir, *Charity and the London Hospitals, 1850-1898* (Boydell Press: Woodbridge, 2000).
- Watson, Janet S. K., 'Wars in the Wards: The Social Construction of Medical Work in First World War Britain', Journal of British Studies, 41:4 (2002). pp.484-510.
- Webster, Charles, 'Healthy or Hungry Thirties?' *History Workshop Journal*, 13 (1982) pp.110-129.
- Webster, Charles, *The Health Services since the War. Problems of Health Care: The National Health Service before 1957* (TSO: London, 1988).
- Webster, Charles, *The Health Services since the War. Problems of Health Care: The National Health Service before 1957* (TSO: London, 1988).
- Welshman, John, 'Evacuation and Social Policy During the Second World War: Myth and Reality', *Twentieth Century British History*, 9:1 (1998). pp.28–53.
- White, Bonnie J., 'Volunteerism and Early Recruitment Efforts in Devonshire, August 1914-December 1915', *The Historical Journal*, 52:3 (2009). pp.641-666.
- Whiteside, Noel, 'The Social Consequences of Interwar Unemployment', Sean Glynn and Alan Booth (eds.) The Road to Full Employment (Allen & Unwin: London, 1987) pp.17-30.

- Williams, Guys, The Age of Agony (Academy Chicago Publishers: Chicago, 1975).
- Williams, J. E., *The Derbyshire Miners* (George Allen & Unwin: London, 1962).
- Winter, Jay, 'Some paradoxes of the First World War', in Richard Wall & Jay Winter (eds) *The Upheaval of War Family Work and Welfare in Europe, 1914-1918* (Cambridge University Press: Cambridge, 1988). pp.9-42.
- Wollacott, Angela, *On Her Their Lives Depend: Munitions Workers in the Great War*, (University of California Press: Berkeley, 1994).
- Woodward, John, *To Do The Sick No Harm: A Study of the British Voluntary Hospital System to 1875* (Routledge & Kegan Paul: London, 1974).
- Wrigley, Chris, *Lloyd George and the Challenge of Labour: The Post War Coalition 1918*-1922 (Harvester: Hemel Hempstead, 1990).
- Wyncoll, Peter, 'The East Midlands', in Jeffrey Skelley (ed.), 1926 The General Strike (Lawrence and Wishart: London, 1976). pp.173-192
- Zijderveld, Anton, *A Theory of Urbanity: The Economic and Civic Culture of Cities* (Transaction Publishers: New Brunswick, 1998).

Appendices

1. Nottingham General Condensed General Income Table

Year	Total Ordinary	Full Total	Total Expenditure	Annual Subs	Donations	Workmen's Collections	Congregational Collections	Entertainments	Invested Property	Services to Patients	Other Receipts
1900	10703	11568	11637	2967	398	2943	2300	328	1470	58	236
1901	15134	15134	13786	3130	394	3273	2381	394	2054	103	394
1902	14056	14056	14094	3163	303	3574	2283	303	1903	79	296
1903	12379	12379	14554	3208	256	3830	2304	256	1948	73	180
1904	14061	14061	15572	3137	1258	4136	2142	1258	1788	91	341
1905	20449	20449	16130	3197	445	4179	1326	445	1553	69	305
1906	11829	13408	15914	3103	695	4535	1326	337	1616	82	223
1907	12030	14266	16279	3105	417	4800	1203	468	1634	127	270
1908	13506	20371	15418	3173	511	5454	1156	459	2040	124	358
1909	14455	18022	15745	3159	637	6774	1442	331	1974	78	228
1910	16115	18228	17162	3212	701	7935	1375	212	2358	84	240
1911	17227	17537	18007	3168	637	9232	1361	223	2146	173	235
1912	17244	20670	17719	3076	1434	8448	1121	242	2464	160	326
1913	15092	23171	17729	2944	499	6811	1266	119	3052	115	286
1914	15472	17641	19956	2858	811	6931	1281	301	2961	99	290
1915	24109	24707	26049	2852	1658	6206	1678	71	2825	8518	291
1916	28291	36908	31265	2895	2017	6388	1664	115	3124	11881	207
1917	31977	32672	38473	2897	4648	6735	1809	189	2764	12661	277
1918	40547	47245	53692	3343	6249	7051	1507	258	2939	18729	381
1919	31591	44061	53265	4457	2429	7231	1735	302	2952	13301	293
1920	56200	76314	66519	7040	5477	17073	2231	1606	5707	13433	237
1921	60320	68101	56120	8239	3231	24375	2361	3018	3263	13718	513

1922	55529	61129	50218	8367	3729	22559	2251	2653	5043	10445	540
1923	52144	55947	47131	10301	3058	23171	2365	2797	3214	5790	314
1924	51953	53693	52885	10661	2654	23140	2353	2428	5393	4571	325
1925	54186	62481	50330	10685	3042	24203	2364	2556	5859	4649	417
1926	50492	55014	54914	11121	2209	22921	2716	1579	5876	4039	531
1927	55364	57730	57703	11415	3123	23128	2441	3440	6850	4380	587
1928	57674	61810	69976	11880	3730	24545	2243	3777	6328	4379	597
1929	58911	65357	67239	11583	4173	25028	2316	4069	6434	4629	689
1930	60806	65153	64735	11456	5766	26177	2798	3482	5873	4532	733
1931	59727	66269	71129	11388	4195	26164	2151	3954	7056	4104	714
1932	55075	76910	68363	14119	3963	24952	1981	3927	7081	4405	641
1933	55699	62065	68517	10938	3550	24674	1781	3859	7265	4035	547
1934	60469	60028	68876	10831	4032	25604	1990	3563	9430	4597	423
1935	65952	68990	72854	11053	4010	26325	1810	7380	10484	4348	536
1936	66400	69367	74349	10789	6595	27593	1849	4347	10609	4309	456
1937	67488	72016	77556	12027	5438	25951	1769	4014	10233	4519	507
1938	71816	77432	81459	11347	6302	30443	3204	3768	11680	5125	947

2. Derbyshire Infirmary Condensed General Income Table

	Total Ordinary Income	Subscriptions	Sunday Fund	Saturday Fund	Anniversary	Dividends, Interests, Invested Property etc.	Miscellaneous	Donation (Ordinary)	Boxes	Patient's Payments	Approved Societies	Mayor's Hospital Fund	Gifts in Kind
1900	9501	3231	938	1230									
1901	9917	3651	1022	1408	95								
1902	9278	3700	1023	1423	105	1586	397						
1903	10326	3744	1091	1542	93	1599	456						
1904	10627	3701	1262	1478	106	1633	387						
1905	10575	3744	1421	1553	110	1667	462						
1906	9892	3701	1258	1725	87	1604	606						
1907	9986	3776	1010	1688	73	1689	427						
1908	10118	3751	1118	1723	86	1699	604						
1909	11424	4062	1214	1992	93	1669	681						
1910	12372	4419	1277	2462	66	1764	711						
1911	12730	4361	1215	2784	69	1772	791	1464	266				
1912	13163	4347	1007	2861	74	1867	1001						
1913	13170	4278	1108	2667	60	1957	1046						
1914	14006	4329	1156	2922	71	1814	1145						
1915	16734	4350	1255	3341	74	1814	3514						
1916	19902	4360	1328	3681	73	1903	5404						
1917	22452	4245	1336	4953	108	2079	8981	586	334	901			
1918	31340	4414	1595	6078	99	2220	13351	782	450	983			
1919	34791	4473	1726	7090	89	2505	13180	2445	589	1390			
1920	40314	4706	1891	9765	74	2567	11503	1366	909	1591			
1921	40788	5334	2511	10309	82	2763	11432	1364	1080	1304			
1922	43514	5774	2190	12309	108	2461	10535	1661	110	1316			
1923	44241	5458	2108	13500	99	2665	9095	1311	1070	1211			

1924	42481	6115	2171	15000	114	2848	6739	1370	1105	1210			
1925	43102	6228	3203	15300	62	3308	5241	1573	1323	1108			
1926	45451	6154	3115	15900	97	3512	5277	2672	1391	1516			
1927	46421	5915	2088	16800	73	3805		1514	1335	1734	2164	1588	1048
1928	48497	6216	1963	18000		4346		1395	1311	2028	2119	1684	1093
1929	49776	6228	2159	19600		4463		1564	1347	1600	1861	2125	903
1930	51012	6112	2039	19751		4494		1658	1368	1621	2207	2157	704
1931	47833	6026	1847	17688		4563		1649	1280	2067	1258	2141	764
1932	47594	5877	1789	17641		4485		1547	1191	2733	973	1542	805
1933	47272	5726	1752	17836		4429		1702	1119	2914	796	1773	729
1934	49842	6649	1523	18865	14	4813		1584	1191	3345	676	1571	650
1935	51076	7464	1625	19768	10	4768		1546	1296	3092	626	1000	762
1936	51437	7396	1496	21415		4932		1339	1255	3339	284	1050	698
1937	53056	7639	1548	22551		4670		1662	1360	3741	75	1056	512
1938	56452	8011	1512	23161		5481		1538	1452	3710	316	1561	506

3. Chesterfield Hospital Condensed General Income Table

Year	Total Ordinary Income	Annual Subscriptions	Workpeople's Collections	Hospital Sunday/Church collections	Donations	Women's Med Ward Fund	Hospital Committees	Saturday and Rose Day	School Collections	Boxes	Investments
1900	2904	459	963	73	71	0		0			432
1901	3256	1075	1338	164	39	0		0			363
1902	4932	1474	2050	225	0	213		65			561
1903	5002	1410	2149	199	0	258		71			581
1904	5006	1384	2089	216	217	224		60			310
1905	4980	1367	2150	191	100	236		55			512
1906	5488	1345	2346	180	405	261		57			571
1907	5379	1316	2551	196	85	258		56			587
1908	5602	1312	2857	186	0	252		47			578
1909	6055	1339	3140	187	0	264		39			576
1910	6061	1384	3403	177	0	267		44			314
1911	7004	1373	4259	160		267	229	22	24	18	298
1912	7143	1404	4534	180		272	189	36	36	21	292
1913	7332	1362	4630	147		291	211	39	37	13	273
1914	8377	1417	5464	192		273	243	74	32	13	292
1915	8482	1377	5474	207		308	240	85	42	28	409
1916	9179	1384	5366	212		330	278	79	33	28	393
1917	11130	1505	5504	219		344	322	73	62	28	440
1918	15758	2128	7614	266		417	382	67	17	26	599
1919	16079	2508	8486	293		488	558	86	134	69	696
1920	19905	3185	10609	306		493	681	73	140	138	762
1921	20458	3288	12247	359		488	630	137	95	177	762
1922	25576	5585	14230	311		489	612	67	77	127	762
1923	23143	4827	13099	334		531	756	88	104	147	762

1924	24424	4820	13687	361	569	836	104	123	167	7602
1925	25316	4924	13913	321	589	863	115	120	318	1175
1926	19072	3356	10089	303	557	969	121	115	122	1157
1927	25953	4839	14677	329	565	1126	124	133	385	1031
1928	24374	4203	13909	309	646	1188	122	108	303	692
1929	24553	4600	13950	309	627	1213	152	108	144	995
1930	27364	5122	15250	298	635	1187	147	104	224	1245

4. Hospital Beds (c/o Voluntary Hospitals Database)

	Derbyshire Royal Infirmary, Derby	Chesterfield and North Derbyshire Royal Hospital	Mansfield and District Hospital	Nottingham General Hospital
1901	185	80	28	233
1903	185			233
1906	229			233
1907	229	80		223
1909	229	80		223
1911	256	120	58	251
1913	256	120		254
1915				
1916	337	140		254
1917	367	162		554
1921	320	150	104	373
1922				
1923	320			310
1924	320	190		317
1925	330	190		317
1926	330	190		317
1927	330	190		324
1928	338	190	130	377
1929	338	190	130	377
1930	346	190	140	397
1931	347	190	140	391
1932	347	220	135	383
1933	347	220	145	386
1934	351	220	145	386

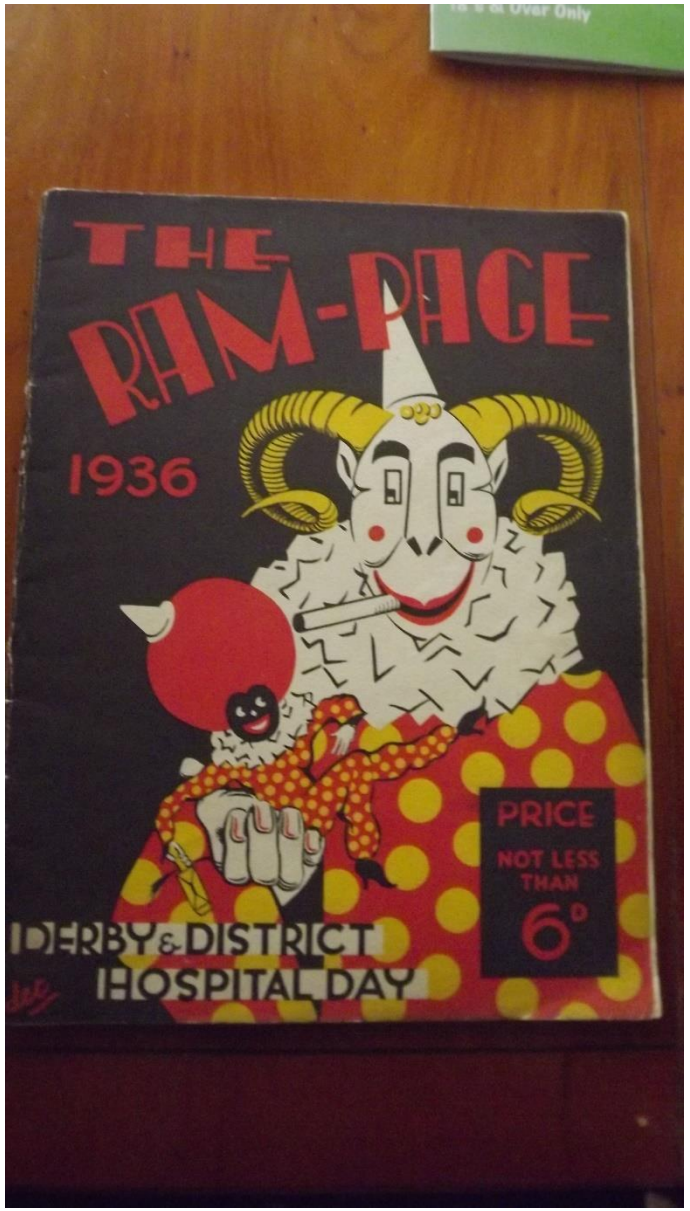
1935	362	220	145	386
1936	362	220	140	386
1937	362	220	145	389
1938	362	220	146	432
1939	362	295	181	432
1940	497	380	252	432
1941	416	380		464
1942	416	460	265	565

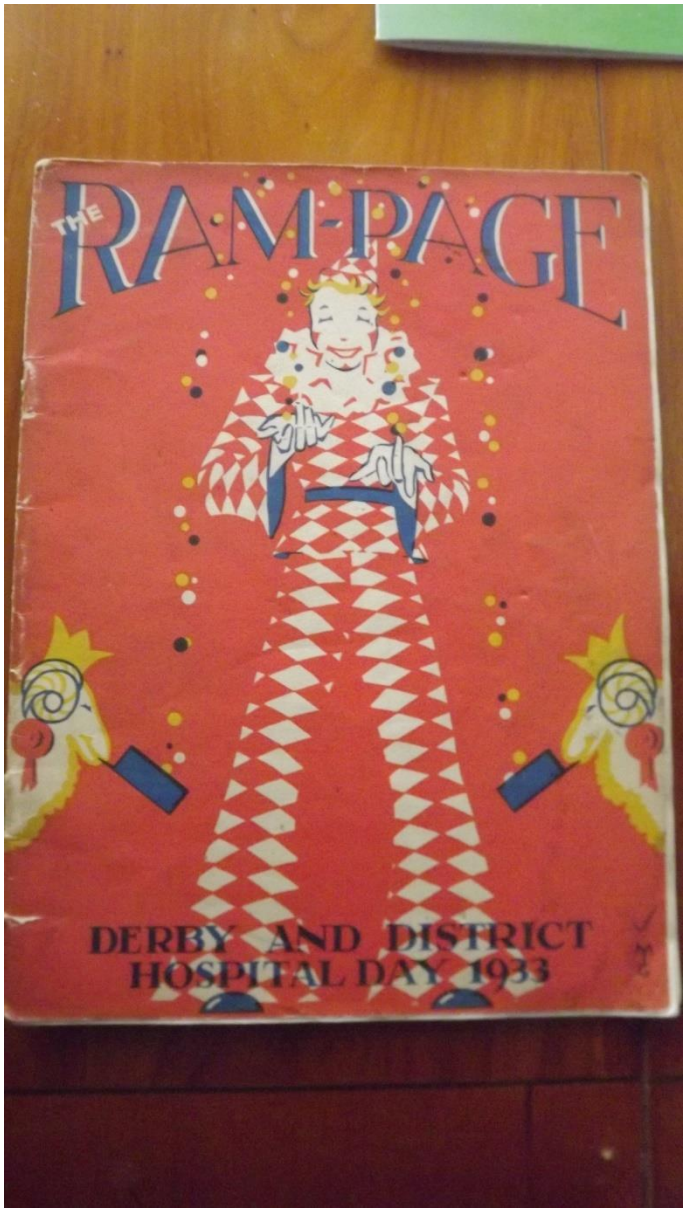
5. *Ram-Page* Front Covers

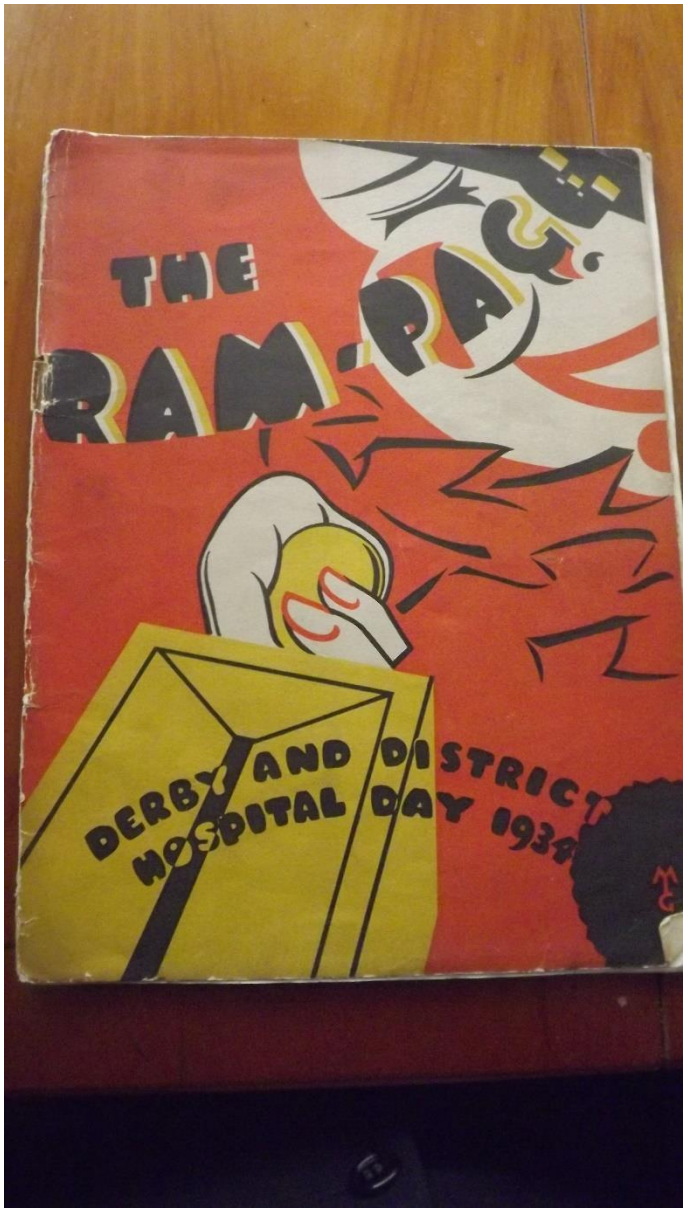

THE
RAM-PAGE
19 37
DERBY & DISTRICT HOSPITAL DAY
PRICE NOT LESS THAN 6D

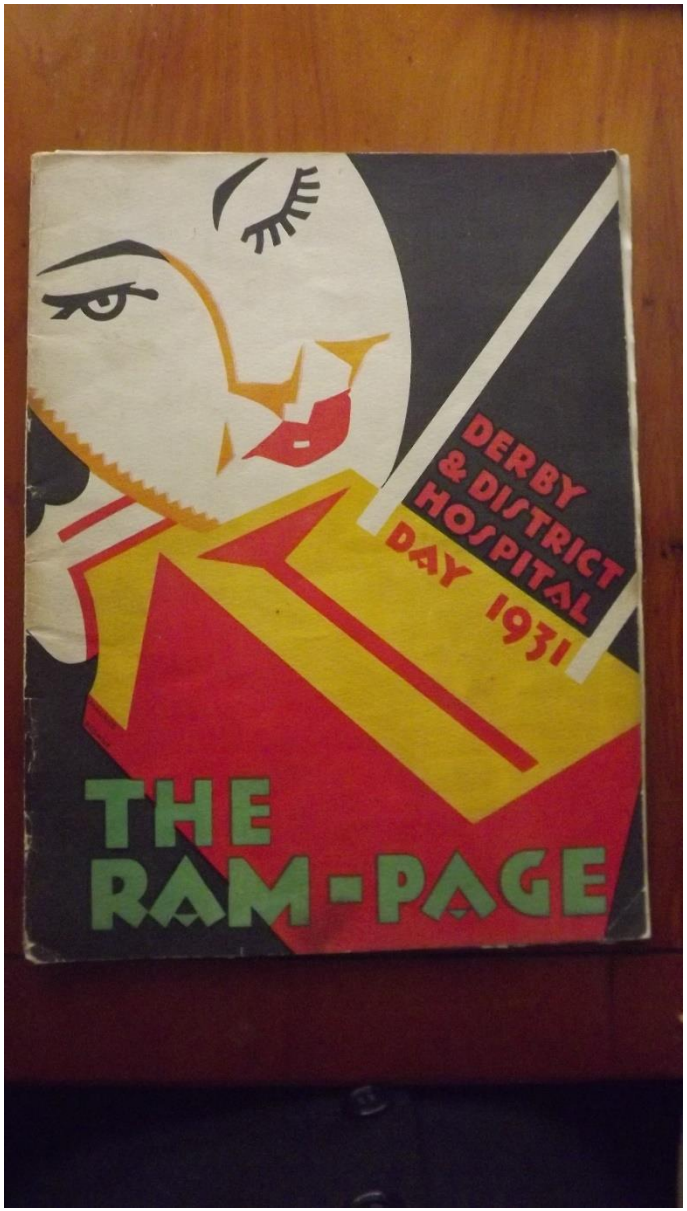

The RAM-PAGE
DERBY & DISTRICT HOSPITAL DAY 1938
PRICE NOT LESS THAN 6d


RAM-PAGE
DERBY AND DISTRICT
HOSPITAL DAY 1935
PRICE
NOT LESS THAN
6D

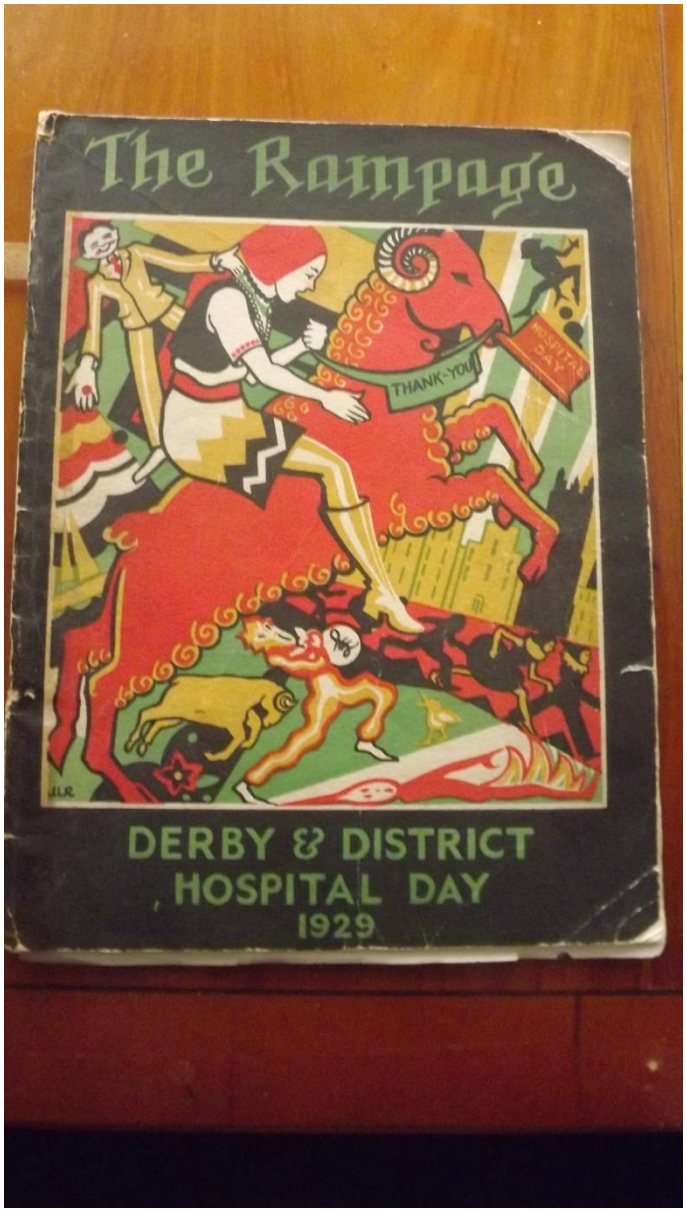

THE RAM-PAGE
1936
PRICE
NOT LESS THAN
6D
DERBY & DISTRICT
HOSPITAL DAY

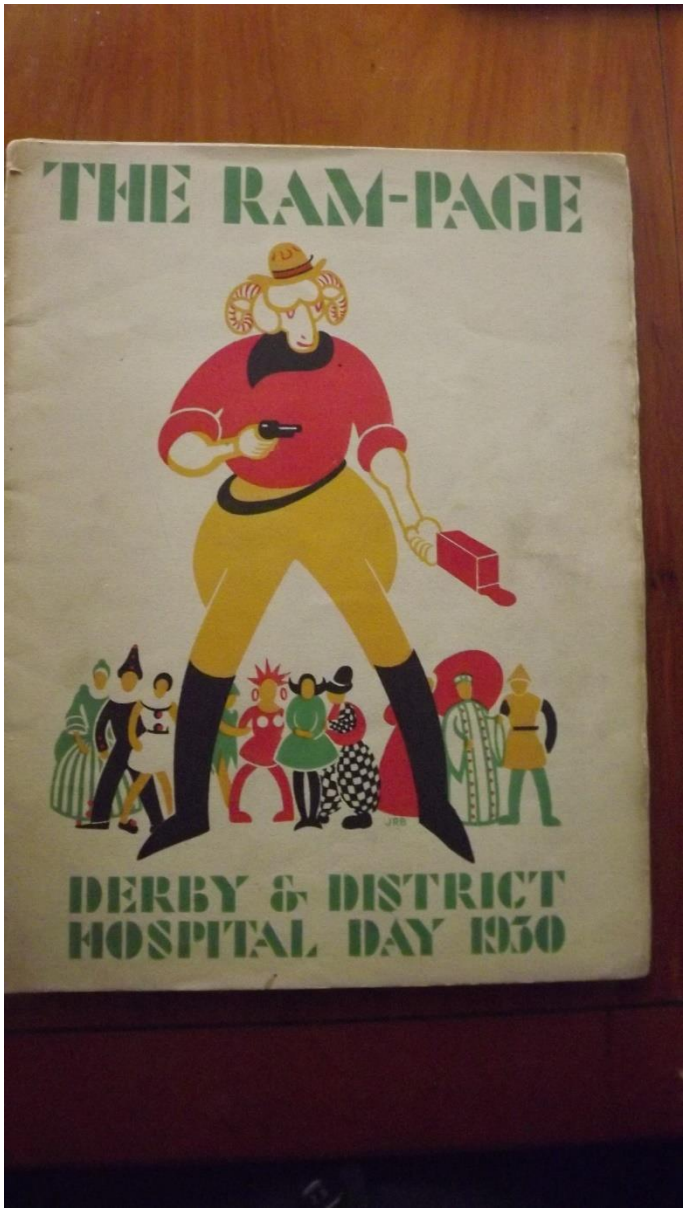

THE RAM-PAGE
DERBY AND DISTRICT
HOSPITAL DAY 1933


THE
RAM-PAGE
DERBY AND DISTRICT
HOSPITAL DAY 1934

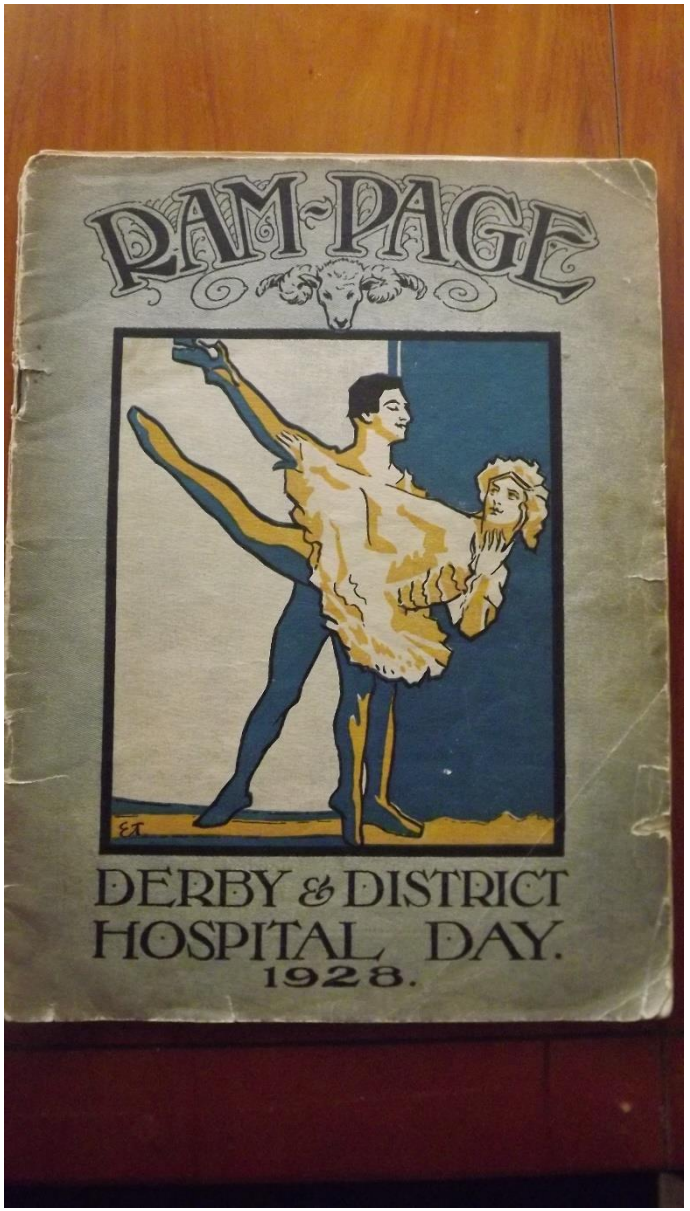

DERBY
& DISTRICT
HOSPITAL
DAY 1931
THE
RAM-PAGE


THE RAM-PAGE
DERBY AND DISTRICT
HOSPITAL DAY 1932


The Rampage
THANK-YOU
DERBY & DISTRICT
HOSPITAL DAY
1929


THE RAM-PAGE
DERBY & DISTRICT
HOSPITAL DAY 1930


DERBY & DISTRICT HOSPITAL DAY 1939
THE RAM·PAGE
PRICE NOT LESS THAN 6d


RAM-PAGE
DERBY & DISTRICT
HOSPITAL DAY.
1928.