

## **Comparing patient and community representation in the NHS in South Cumbria, 1974-82**

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### **ABSTRACT**

The separation of Westmorland and Furness from Cumbria created the newest Healthwatch in England, launched on 18<sup>th</sup> October 2023. Squeezed between regulators, local authority scrutiny, and democratic organisational accountability, Healthwatch occupies an awkward position as both patient and consumer champion in the National Health Service (NHS). This awkwardness is amplified by Cumbria's geography, which has distinct historical communities with differing service priorities to the north and south. Within the south, these are divided between west and east. This paper uses the creation of separate South West and South East Community Health Councils (CHCs) from 1974 until their unification in 1982 as South Cumbria to explore patient and community representation in the NHS.

### **INTRODUCTION**

The dissolution of Cumbria with the establishment of Westmorland and Furness, and Cumberland, also created the newest Healthwatch in England which launched on 18<sup>th</sup> October 2023.<sup>1</sup> Created in the 2013 Lansley reforms, each Healthwatch promotes patient and community representation in the National Health Service (NHS), acting as a consumer champion sensitive to local needs. Commissioned by local authorities, Healthwatch occupies an awkward stakeholder position; squeezed between the Care Quality Commission (CQC), local government Health Overview and Scrutiny Committees (HOSCs), and NHS Foundation Trust governors and members. This ambiguity has produced differing interpretations of how Healthwatch represents communities and patient interests for each locality.<sup>2</sup>

Collaboration, consultation and co-production of change underpinned Healthwatch Cumbria's vision prior to its split,<sup>3</sup> although this remained a mirage. Part of the explanation lies in geography. Healthwatch Cumbria's attention was divided between rival NHS systems – comprising commissioners and providers – located in the north and south. These have only solidified with new local authorities and integrated care boards (ICBs) since 2022. As I have discussed previously,<sup>4</sup> aligning jurisdictional and territorial boundaries to suit geography created very recognisable difficulties at the inception of the NHS in 1948 and accompanied its first major reorganisation in 1974. These difficulties also mapped onto consumer representation which was first introduced into the NHS in 1974. Separate Community Health Councils (CHCs) served South West (SW, Barrow) and South East (SE, Kendal) Cumbria until their merger in 1982, reflecting different patient and community interests across the north-south divide.

This paper explores the relational and spatial dimensions of patient and community representation in South Cumbria from 1974 to 1982 by comparing and contrasting the histories of its SW and SE CHCs. Using their minutes, annual reports and commissioned surveys, it relates their histories in four ways. First, through a brief background of CHCs. Second, by a discussion of their leadership and membership. Third, by considering their relationships with other NHS organisations. Fourth, in a case study concerning their responses to hospital building programmes and closures linked with rationalisation. These histories demonstrate how relationality and spatiality continue to influence patient and community engagement in the NHS.

## INSTITUTIONALISING REPRESENTATION

Introduced as part of the 1974 reforms, CHCs were the first attempt to institutionalise representation of patients as consumers into the NHS. This has three sources. First was user frustration. Many felt marginalised as capital development fomented local hospital closure, whilst patient care scandals – primarily concerning long-stay mental and geriatric institutions – raised problems of quality and voice in decision-making.<sup>5,6</sup> Second was politics. CHCs were first conceived by the Conservatives to reign in faceless bureaucracy in 1971, subsequently reimagined by Labour as a form of industrial democracy in 1974. By the time the reforms were implemented, both conceptualisations were diluted, leaving tokenistic involvement.<sup>7</sup> Third was the continuation of visits to hospitals and General Practitioner (GP) surgeries by lay members. This role had extensive history otherwise missing within the reorganised policy apparatus because District Management Teams (DMTs) were designed as local executive instruments and Area Health Authorities (AHAs) as more distant accountable bodies.<sup>8</sup>

These plural origins of CHCs created confusion over patient and community involvement in the NHS. As statutory bodies their membership comprised 1/2 local authority members, 1/3 voluntary organisation delegates and 1/6 nominated by the Regional Health Authority (RHA), above AHAs in the NHS hierarchy. Their ‘rights, powers and functions’ were ‘weak, vague and ill-defined’, conferring a ‘persistent crisis of legitimacy and identity’ throughout their existence.<sup>9: 249-50</sup> Rooted in the technocratic corporatism of the 1974 reforms, CHCs brought patient voices to the table of fashionable consensus management. This has led to criticisms that they served as a *sheepdog*, herding patient participants to consultations and providing a veneer of transparency to closed decision-making.<sup>10</sup> Although idealised across the political spectrum as a consumer *watchdog*, they lacked teeth from the outset, being easily bypassed when posing a nuisance.<sup>11</sup> Indeed, CHCs saw their eventual abolition and replacement in 2003 as institutional preference for a docile *lapdog*.<sup>12</sup>

Following these canine analogies, the official historian of the NHS – Charles Webster – notes that despite limitations, ‘CHCs made their mark’.<sup>13: 634</sup> In terms of their three sources – frustration, politics and visiting – he offers further judgment. First, despite statements to the contrary, ‘nobody really believed that [CHCs] constituted a real threat to the powerful management bodies of the reorganised NHS’.<sup>13: 544</sup> Professional and corporate interests remained impenetrable for the public. Second, although their ‘precise function’ remained ‘uncertain’, CHCs were ‘useful allies’ in running battles with the Department of Health and Social Security (DHSS) waged by DMTs.<sup>13: 545, 634</sup> Such utility was inextricable from their spatial and relational place within the reorganised NHS. Third, that because they were advocates of place, many CHCs were ‘over-tolerant of low standards’, preferring a *local service* to none.<sup>13: 776</sup>

Whilst a laudable intention, CHCs were hamstrung from the outset in providing a single voice to the plurality of patient experiences. This, within an NHS where authority, accountability and quality were fragmentary, diffuse and elusive in equal measure.

## LEADERSHIP AND MEMBERSHIP

Given ambiguity over their constitution and function, the place CHCs occupied in local health systems turned on their leadership, membership and organisational culture. Nationally, CHCs were a ‘distorting mirror’ of the wider population, being primarily male, middle-aged and middle-class, already active in other areas of public life, usually the NHS.<sup>14: 29</sup> The inaugural chairs of both SW and

SE Cumbria CHCs reflected this image. George Reginald Atkinson, Chair of SW Cumbria CHC until 1980, was a longstanding Labour councillor in Barrow (Mayor from 1964-65), formerly Chairman of their Health Committee, sat on the Hospital Management Committee, and ‘dedicated to the Health Establishment in this town and district’ as its elder statesman.<sup>15</sup> Sir David Arnold Solomon MBE, Chairman of SE Cumbria CHC until 1977, was a Liverpool stockbroker and the last Chairman of Liverpool Regional Hospital Board (RHB) from 1967-74 – where he was regarded as ineffectual<sup>16</sup> – only moving north on retirement.<sup>17</sup> Solomon’s successors as Chairman, James Winder (1977-80), and Councillors R. S. Harrison (1980-81) and Bill Stewart (1981-82) reflected similar backgrounds, albeit without NHS pedigrees.

Membership of the CHCs through local authority, voluntary and RHA representation reinforced the ‘distorting mirror’. Female membership was concentrated mainly in voluntary organisations, particularly local branches of national organisations associated with NHS activities such as the Samaritans, British Red Cross, Standing Conference of Women’s Organisations, the Women’s Royal Voluntary Service and Family Planning Association.<sup>18-21</sup> Voluntary organisation membership had a high turnover despite tenures being three years, meaning that other, smaller local organisations also came into the orbit of the CHC. Local authority membership derived from Barrow and South Lakeland for SW, and South Lakeland and Eden for SE Cumbria CHC, also being subject to turnover through elections and routine resignations. This left a core of regular and long-serving members in both SW and SE Cumbria CHCs; many of whom also led subcommittees and working groups.<sup>17, 22-23</sup>

This membership dynamic, of a stable core and floating periphery influenced the organisational cultures of both CHCs. This is reflected in vacancies and attendance, indicated in table 1 for SW Cumbria CHC. Moreover, whilst some CHCs, such as those in Liverpool and some London districts ‘conducted themselves like confraternities of the French Revolution’, both SE and SW Cumbria were firmly embedded in advancing community rather than partisan local government or sectional politics.<sup>13: 634</sup> The secretariat was small, with no ability to undertake independent research until the merger in 1982. This left both CHCs as reactive rather than proactive. The only exception was a 1979 survey of patient life in North Lonsdale Hospital commissioned by SW Cumbria CHC and undertaken by Susan Clayton of the Department of Social Administration at Lancaster University.<sup>15</sup> Clayton had personal as well as professional interests,<sup>24</sup> also being on Lancaster CHC and the Royal College of General Practitioners (RCGP) Patient Liaison Group.<sup>25</sup> The results found evident deterioration, even from a starting point where North Lonsdale was dubbed ‘the worst hospital I’ve ever seen’ by the Labour Health Minister Roland Moyle in 1977.<sup>26</sup>

Year	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80	1980-81	1981-82
<b>Members (26 Total)</b>	26	25	25	26	23	25	25	25
<b>Attend (Possible)</b>	274	205	236	252	245	260	253	197
<b>Attend (Actual)</b>	199	148	174	148	154	161	182	141

<b>Attend (Percent)</b>	72.6	72.2	73.7	58.7	62.9	61.9	71.9	71.6
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Table 1: SW Cumbria CHC members and their attendance record, 1974-82.

The sentiments of SW Cumbria CHC Chair George R. Atkinson for his 1978 annual report introduction capture the interplay of leadership, membership and organisational culture in representing patients and communities: ‘The NHS perhaps more than any other organisation depends heavily, if not entirely, on the goodwill and sense of those engaged in running it’.<sup>15:i</sup> CHCs relied upon recognised health service figures to chair, representative members to take the initiative or leave, resulting in a responsive organisational culture which did not engender wider participation.

### SYSTEM RELATIONSHIP

System relations were defined in relation to primary, secondary, and tertiary care. In relation to primary care, Cumbria Family Practitioner Committee (FPC) administered payments to GPs, pharmacists, opticians, and dentists. For secondary care Cumbria AHA, SW Cumbria and East Cumbria DMTs were responsible for local district services; the latter resulting from Kendal’s inclusion in the Carlisle district in the 1974 reorganisation of the NHS but securing a separate CHC for SE Cumbria to represent their interests given historic hospital links with Lancaster.

Nationally, the ability of CHCs to represent patient and community interests to FPCs was weak, with limited influence on provision, patterns of service and participation.<sup>27,28</sup> The two CHCs fared differently. The closure of the former Barrow Executive Council (EC) offices, the predecessor body to FPCs until 1974, occurred without consultation.<sup>22</sup> The opaque language of ‘substantial’ changes justifying consultation was widely used to subvert CHCs.<sup>29</sup> From its inception, the SW Cumbria CHC was prohibited by the FPC from visiting GP surgeries. They also failed to implement a 1977 DHSS circular allowing CHCs to be observers in FPC meetings.<sup>15</sup> Such poor local relations did not prevent SW Cumbria CHC from acting as a community watchdog. They reversed the 1975 decision of the Medical Practices Committee (MPC), the national body responsible for distributing GPs, to disband and merge Hawkshead on the retirement of its principal.<sup>22</sup> Whilst SE Cumbria CHC was likewise excluded from meetings, they influenced decision-making to develop health centres in Kendal and Ambleside. The CHC served as a conduit for received professional opinion to close branch surgeries with limited opening hours and patient lists – including Chapel Stile in 1975 and Grasmere in 1979, both served by Ambleside – which the FPC believed would attract young doctors, especially future principals.<sup>17,23</sup> Although contested, it slowly improved the longstanding workforce shortages.

Both CHCs were engaged in skirmishes with Cumbria AHA and Northern RHA, headquartered in distant Carlisle and Newcastle respectively. There were persistent complaints about representation, particularly from SW Cumbria which had 2/17 local authority members on the AHA despite having 23% of its population. The proposed closure of Ulverston hospital maternity unit in 1978, initially without consultation, provoked a battle between the wider community, the AHA and RHA in turn, which led to their temporary retreat.<sup>15:8</sup> Both CHCs were, however, unsuccessful in their opposition to AHA centralisation of ambulance stations in 1979.<sup>15:9</sup> Access to specialist tertiary services located in Newcastle was a perennial grievance. SW Cumbria CHC petitioned the RHA for closer dialysis services in 1976 owing to the experiences of a patient visiting Newcastle three days a week for treatment, entailing ‘an extremely inconvenient, exhausting, long and difficult journey’.<sup>15:10</sup>

Referral to Manchester until services were provided at Carlisle eventually elicited the desired response.<sup>22</sup>

Given that DMTs and CHCs, apart from SE Cumbria, shared territorial boundaries, they were the 'most common contact point' of the local health system.<sup>30: 31</sup> DMTs were executive bodies responsible for planning and delivering local community and hospital services. However, as was the case elsewhere, they 'had great difficult reconciling [their] role representing the community whilst remaining on sufficiently good terms with managers to be influential'.<sup>31: 138</sup> Moreover, the ability of CHCs to hold the DMT to account was undermined through an information imbalance, reinforcing trends towards cosy consensus.<sup>32: 228</sup> SW Cumbria CHC reported in 1979 that there was 'mutual tolerance, cooperation and goodwill' with the DMT, with most of its meetings including a talk by the senior management team.<sup>15: 18</sup> They organised their special interests groups around the planning units of the DMT: paediatrics, geriatrics, mental health, and later maternity.<sup>22</sup> SE Cumbria CHC had a different relation because its DMT worked with two CHCs; East Cumbria representing Carlisle and Penrith. The South East sector had a separate planning team but limited executive independence. Accordingly, the CHC articulated the demands of professionals and the sector planners as much as patients to the DMT, ensuring that viable hospital services remained in Kendal given the lack of its own district upon which to rationalise provision.

## HOSPITAL RATIONALISATION

Comparing the responses of SE and SW Cumbria CHCs to the centralisation and rationalisation of hospitals reveals much about their outlook and priorities in terms of representing patients and communities. Folding inherited hospitals and their services into one District General Hospital was 'policy by default' even before the 1962 Hospital Plan and 1969 Bonham-Carter Report which formalised this process.<sup>33: 168</sup> Preventing closure or returning services, particularly to more affluent areas, was a hallmark of CHC community advocacy along with other interest groups.

SW Cumbria CHC was hand-in-glove with the DMT in agitating for a new DGH to replace ageing and outdated stock. Recommendations of centralisation dated to the wartime Domesday Surveys of 1945 by the Ministry of Health and Nuffield Provincial Hospital Trust.<sup>34, 35</sup> This was finally recommended in the 1962 Hospital Plan, with Barrow and District HMC reporting that it 'will solve most if not all problems, and will at the same time give the modern hospital services which the residents of this area... most surely deserve'.<sup>36: 13</sup> The hospital was not given priority by Manchester RHB, and it was repeatedly delayed at the expense of other districts. One of the first actions of the CHC was to organise a petition to Northern RHA, securing 49,566 signatures and lobbying local Members of Parliament Alfred Hall-Davis (Conservative, Morecambe and Lonsdale) and Albert Booth (Labour, Barrow and Furness) in 1975. It was this which prompted the visit by the Health Minister in 1976. Ministerial intervention secured a new DGH, leaving the CHC to back unpopular early hospital closures and justify the running down of long-stay institutions, community services, and mental health care by the DMT in the name of financial savings and modernisation.<sup>15</sup> Here, community representation conflicted with that of patients, particularly those using so-called Cinderella services.

For SE Cumbria CHC pressure to retain services by any means shaped their outlook. Unlike SW Cumbria, they were omitted from the 1962 Hospital Plan, being subsumed as a district into Lancaster's future. The 1974 reorganisation severed this link from a planning perspective, and Westmorland County Hospital subsequently suspended its casualty department owing to the attendant staffing problems, particularly in anaesthetics. Initially for three years, the lack of

accreditation from the Royal College of Surgeons (RCS) left reliance on clinical assistants and hospital practitioners for coverage as a permanent feature.<sup>17, 23</sup> Patients and specialist consultant coverage flowed south to Lancaster. The CHC were mindful of what a loss of service meant for closures, with many of its members being veterans of the unsuccessful campaign to retain Ethel Hedley Hospital at Windermere from 1968 to 1970.<sup>37, 38</sup> The fate of services was rendered even more vulnerable following the announcement of a new DGH for Barrow alongside creeping bed closures at Kendal Green and Meathop Hospitals owing to a clinical workforce recruitment and retention difficulties. As with SW Cumbria, a new DGH became the panacea for the underlying issues, and the CHC vociferously supported these plans. However, unlike SW Cumbria due attention was paid to geriatric, psychiatric and other Cinderella services, along with chiropody and community care.<sup>23</sup> Although this attention came at the expense of health prevention and promotion and emergent needs, which were the bread and butter of CHCs nationally.<sup>13:770</sup>

Ultimately, the merger of SW and SE Cumbria CHCs with the creation of South Cumbria District Health Authority (DHA) in 1982 was a reluctant marriage of convenience given the range of alternatives. The announcement of this reform in 1980 with Patients First, which also threatened the existence of CHCs, combined with concurrent social, economic and political turmoil meant that both CHCs struggled to secure a role given the prevailing 'atmosphere of crisis' which gripped the NHS during the 1970s.<sup>13:770</sup>

## CONCLUSION

Created in 2023, Healthwatch Westmorland and Furness shares virtually the same territorial boundaries with South Cumbria CHC 41 years earlier following the merger of SW and SE Cumbria. Beyond geography, it shares many of the same longstanding problems of patient and community representation in the NHS first introduced in 1974; namely geography, relationships to the local, regional and national NHS system – including overlapping and competing functions – and the responsibility of holding services to account for their diverse users. In a context of wider problems with CHCs in the NHS, the ability of both SW and SE Cumbria CHCs to influence the NHS was shaped by their leadership and membership, and the tension of creating and maintaining relations with other organisations given that criticisms often impacted the fate of local services. This can be seen in CHC responses to hospital rationalisation which, by different routes, saw both SE and SW Cumbria CHCs support controversial proposals pushed by the DMT, AHA and RHA. Fundamentally, patients and communities are not singular but plural. What and where these are located changes over time, depending on the relational and spatial framework of public engagement within the NHS. Advancing the interests of either patient or community frequently, if unintentionally, comes at the expense of another when resources are restricted, demands compete, expectations rise, and clinical care becomes more complex, specialised, and costly.

Crucially, the 'participatory initiatives embodied in the CHCs did not, for the most part, actually change the modes in which most of the public actually experienced the NHS'.<sup>39:303</sup> Issues of quality were secondary to CHCs, who were willing to overlook shortcomings and empathise with the constraints of managers. As SW Cumbria CHC reported in 1978:

When visiting hospitals, [CHC] members very quickly find that the [DMT] and senior staff know only too well of the physical imperfection of the facilities and are constantly struggling to attract enough money to long-term care to enable something to be done.<sup>15:17</sup>

The CHC refused to act as a 'prosecuting counsel' for patients, dismissing most patient grievances as either 'misunderstandings' or due to 'lack of communication'.<sup>15:7</sup> Tellingly, such hospital visits – occupying inordinate time and energy – reported more on the integrity of buildings and their suitability for staff rather than patient problems. This reluctance stemmed, in part, from overlapping jurisdictions with the Health Service Commissioner (HSC) and FPCs to handle complaints.<sup>40</sup> However, reluctance stemmed from a larger cause. Whether a lapdog, watchdog or sheepdog – all of which both SW and SE Cumbria CHCs served at some stage in their existence – institutional paternalism and preserving professional power remained the order of the day. Patients may have been given a voice for the first time as consumers of health services, but this voice was, as Mike Gerrard notes, ignored when difficult, muted when troublesome and ultimately *stifled*.<sup>41</sup>

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