Organisational change and resistance : an oral history of the rundown of a long-stay institution for people with learning difficulties

Thesis

Organisational Change and Resistance

An Oral History of the Rundown of a Long-Stay Institution for People with Learning Difficulties

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Abstract

The thesis explores the rundown process of one large long-stay hospital for people with learning difficulties in the north west of England during the later years of the twentieth century. It does this through a multi-voiced account which draws on oral history interview and documentary data relating to managers, staff and relatives. This polyphonic approach, focused upon those who had agency in the rundown of the institution, enables an in-depth examination of the processes and meanings of such an immense organisational change.

The research found that the contraction of the Royal Albert Hospital, Lancaster was a complex process, involving *high* levels of managerial acumen, compassion and enthusiasm. However, although presented by those implementing change as being predicated upon sound ethical and ideological principles, the study also indicated that this institutional rundown was shaped significantly by a neo-liberal agenda bound up with imperatives of logistics and cost. Tensions and contradictions associated with the latter were partly reflected in the viewpoints of staff and families who were critical of elements of the policy and practice of organisational downsizing. The oral history data in particular suggests, however, that these oppositional perspectives were discredited and distanced within the constraints of a dominant organisational narrative which espoused the absolute rightness of institutional closure. Furthermore, this ethically infused rhetoric underplayed the negative impact of the rundown on employees as they experienced insecurities associated with the loss of a meaningful and, in many instances, long-standing workplace.

The research contributes to the literature on the social history of learning disability, especially pertaining to institutional closures and deinstitutionalisation; organisational studies (the management of change); deindustrialisation; and oral history methodology.

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Contents

CHAPTER ONE

INTRODUCTION

This study examines the rundown process of a large long-stay hospital for people with learning difficulties in the north west of England during the late twentieth century. The twin aims of the research were: to reconstruct how the contraction occurred; and to identify what institutional rundown meant for those involved. Underpinning these objectives, and the study overall, was a rationale rooted in a fusion of personal and historical interests.

1.1 Research Rationale

Having studied institutional histories as a community oral historian, mainly through the recorded testimonies of people with learning difficulties, I concluded that a closer examination of the ways in which these monolithic establishments closed represented a logical next step. The choice of the Royal Albert Hospital, Lancaster as the locus for the research reflected a personal connection. During the 1980s, both on-site and at the nearby college, I had worked as an adult educator with individuals with learning difficulties who resided at the hospital. Starting in 1981 this involvement, under the umbrella of the local authority adult education college, had taken myriad forms. Initially, in the role of adult literacy volunteer, I worked closely with a man who resided in one of the hospital's smaller and more independent living units. Then in 1985, for a year, I was a member of an educational team which carried out 1:1 assessments with *all* the

hospital residents. Working in ward settings brought me into direct contact with most areas of the hospital, including the 'back wards' and ones which were permanently locked. Coming from a non-nursing background, the job constituted one of the most powerful, and, at times, moving, experiences of my life. I was impelled to adjust to a world, which, with its congregate, regimented patterns of living, was radically unlike anything I had previously encountered. Around the same time I became a college-based adult education tutor, teaching students with learning difficulties, many of whom either resided at, or had recently moved out from, the Royal Albert. By the end of the 1980s my own employment narrative had been entwined with that of the Albert[1] for nearly ten years.

My own interest in the lives of those resident at the Royal Albert was enhanced by having the opportunity to record their life stories during my tenure at the adult education college in Lancaster. Collaborating with a hospital social worker and charge nurse, itself a sign of the increasing links between the 'asylum' and those outside its walls, I led reminiscence sessions with hospital residents. Having been away for ten years, I returned to the area in the early 2000s, at which point I set up an on-line archive comprising the audio tapes from these sessions, along with fresh recordings (Ingham 2006). Largely absent from these archival accounts were any in-depth testimonies which dealt with the final period of the hospital's existence. These had been years, as already pinpointed, which carried a personal resonance for me. Furthermore, the individual testimonies of institutional life were weighted, quite appropriately, towards those voices which could be construed as 'forgotten lives' (Atkinson, Jackson et al. 1997). Lacking were accounts providing insights into how hospital closure was enacted by those who exercised agency in relationship to people with learning difficulties. The narratives of managers, staff and families were generally missing from this institutional

[1] The Royal Albert Hospital was referred to locally as 'the Albert' as well as 'the Royal Albert'. Both epithets will be used throughout the thesis.

story. I was motivated to rectify this state of affairs and, given my contacts and residency in Lancaster, was in a position to do so.

Researching the rundown of a large long-stay institution for people with learning difficulties, however, went beyond self-interest. Institutional closure was, and still is in part, a phenomenon which has swept through the United Kingdom, North America, Australia, New Zealand, Scandinavia and other European countries during the past forty years. During this period it has been an integral element in the shift to community care which arguably has dominated the landscape of learning disability social policy in the UK and in all the richer countries of the western world (Emerson 2004:187). Institutional closures have impacted on the lives of thousands of people. In England and Wales, for instance, in the 1970s there were nearly 70,000 people with learning difficulties resident in congregate NHS establishments (MIND 1977; Ryan and Thomas 1998). Well over half of these hospitals, of which there were around eighty, had in excess of 500 residents, with a significant number housing a thousand or more people with learning difficulties (Morris 1969; Ryan and Thomas 1998). Moreover, inextricably linked to these huge, and in many cases architecturally imposing, institutions were considerable numbers of staff, families and members of local communities (DHSS 1976; DHSS 1985). Starting in 1986, however, with the demise of Starcross in Exeter (Radford and Tipper 1988), twenty years later almost all of these NHS organisations had ceased to exist – in some cases literally as bulldozers had cleared the sites. Even though 'people had said they would never do it' (Mitchell and Chapman 2008) within a relatively short space of time one after another of these apparently unassailable embodiments of social policy had closed.

Cited in Chapter Two are studies which indicate that processes of institutional rundown, in the UK and internationally, were protracted affairs involving high levels of complexity,

challenge, emotion and negotiation, as well as logistical and financial entanglements. At the core of this globally experienced downsizing was the displacement of thousands of people whose lives, rightly or wrongly, had become anchored in a discredited form of care. However, although significant pieces of research have been carried out into the manner in which some of these organisations contracted, there are salient gaps in the literature. Particularly lacking are studies which offer in-depth insider accounts of the micro-politics of these organisations as they underwent such a colossal and, for some stakeholders, painful transition. Similarly under-researched are the multiple meanings which rundown had for those charged with supporting people with learning difficulties through such a transition. Both in the UK and internationally, the depiction of hospital rundown is patchy, with the lack of detailed case studies frustrating attempts to develop a better understanding of this seminal feature of learning disability policy and practice. Researching elements of the nuts and bolts of this dramatic change with reference to *one* large, long-stay institution seemed both timely and expedient, while it still resided within living memory. Furthermore, eliciting a range of viewpoints, gleaned from oral history and documentary data, offered the promise of both reconstructing the event itself and embracing the *diversity* of meanings it had for key stakeholders.

Regardless of personal associations, the Royal Albert Hospital as a choice of case study fulfilled important historical criteria. It exemplified the contraction of a *large* long-stay NHS hospital for people with learning difficulties, having a thousand residents in the 1970s with almost equal numbers of staff. It was run by the North West Regional Health Authority (NWRHA) which, as referenced in Chapter Two, prided itself on the progressive manner in which it pursued a policy of deinstitutionalisation. However, of its three main NHS hospitals for people with learning difficulties, this institution was the only one to close by resettling all its residents to community settings: Brockhall transferred nearly half its residents to Calderstones, another institution, which still

retained a degree of on-site provision at the time of writing. The exploration of the blurred edges between learning disability social policy and implementation could be particularly revealing in a context in which there was such a powerful rhetoric espousing the progressive principles of the day.

Idealism was also evident in the institution's inception in 1870, when it opened as the Royal Albert Asylum for Idiots and Imbeciles of the Northern Counties (Roberts 1992). It was one of five 'voluntary idiot asylums' set up nationally during the middle years of the nineteenth century, four of which, including the Royal Albert, had regional remits (Gladstone 1996). All these institutions focussed primarily upon children and young people with learning difficulties, offering training and education lasting between five and seven years, after which time they were able to leave as 'economically independent and morally competent individuals' (Roberts 1992; Gladstone 1996:138, 141-2; Jackson 1996). Although, as with other institutions, the Royal Albert became a long-stay adult residence for many people with learning difficulties during the twentieth century, this was not its original remit. As argued by Gladstone, these voluntary asylums were pervaded by a 'positive optimism', expressed in the idea that 'the idiot may be educated' (Gladstone 1996:138). Funding the pursuit of this notion was Victorian 'philanthropic endeavour' with all five establishments being funded by public, not state, moneys (Roberts 1992; Gladstone 1996:140-1). These charitable roots provide the Royal Albert Hospital, Lancaster with a significant place in the history of learning disability institutions in the UK. Privileging a study of its closure recognised its particular contribution to the social history of learning disability.

Driving this study, however, was a political desire to reposition, albeit in a modest way, learning disability research itself. People with learning difficulties, and their history, and arguably those who have supported them (Mitchell 2000), have traditionally been

marginalised and stigmatised. This research presented the opportunity to challenge this ghettoisation and place the rundown of the Royal Albert in a wider context both historically and academically. The latter was attempted by being open to insights from organisational and political studies, as well as giving credence to a perspective that saw the hospital not just as a therapeutic environment but as a workplace. Historically I aimed to explore the idea that institutional rundown was an *integral* facet of national and local political shifts occurring during the latter part of the twentieth century. Expanding the gaze of the study was fuelled by the belief that this would enrich the research topic itself, the social history of learning disability and potentially other academic disciplines.

1.2 Thesis Structure

Informed by the research rationale and a review of pertinent literature, the study pursued two overarching lines of enquiry:

1. *How did the Royal Albert contract?*
2. *What did the rundown of the Royal Albert Hospital mean for key stakeholders?*

Discussed in Chapter Two are the ways in which these overarching questions were adapted and broken down into manageable sub-questions. These avenues of interrogation are explored within the structure of the thesis which consists of ten chapters:

Chapter 1 ***Introduction***

Chapter 2 ***Literature Review*** examines the literature pertinent to the research. In particular it looks at deinstitutionalisation policy, as well as specific studies focussing upon the practice of institutional closure. Through highlighting gaps in the literature the chapter references the specific questions addressed by the research.

Chapter 3 ***Research Methods: Theory and Practice*** reviews the qualitative research literature informing the approaches adopted by the study. The chapter then describes

and evaluates the processes of data collection and analysis, especially relating to the study's oral history interviews.

Chapter 4 ***Pressures of Change*** explores the often contradictory pressures applied by external bodies to the process of contracting the Royal Albert. Although drawing upon various policy documents, especially those issued by the Regional Health Authority, the chapter's insights hinge upon the oral testimonies of former managers at the institution.

Chapter 5 ***Agents of Change: A Hegemonic Approach*** argues that a dominant strand in the managers' implementation of rundown at the Royal Albert was the application of a hegemonic approach. Through a combination of rhetoric and coercion, attempts were made to engender the consent of staff, families and people with learning difficulties to a deinstitutionalisation agenda.

Chapter 6 ***Agents of Change: Personalities and Providence*** discusses both the impact of managerial personalities and good fortune upon the shape and pace of Royal Albert contraction.

Chapter 7 ***Voices of Resistance*** explicates the viewpoints of those who were critical of dominant facets of the policy and practice of Royal Albert rundown.

Chapter 8 ***Acts of Resistance*** draws heavily upon oral testimony and internal hospital documents to highlight how disquiet with elements of the Royal Albert closure processes was expressed in tangible ways.

Chapter 9 ***Meanings of Change*** focuses upon the multiple and contrasting meanings the rundown of the Royal Albert had for key organisational stakeholders. In particular, the chapter discusses the dichotomy between proponents and resisters of institutional contraction.

Chapter 10 ***Conclusion*** brings together the main findings of the thesis and points out avenues worthy of further research.

1.3 A Note on Terminology

Historically many labels have been ascribed to those individuals who, in the UK at least, seem to be generally known as 'people with learning difficulties' or 'people with learning disabilities' or 'learning disabled people' (Walmsley and Johnson 2003; Rolph, Atkinson et al. 2005; Johnson and Traustadâottir 2005a; Welshman and Walmsley 2006; McClimens 2007; Humber 2008). Internationally, however, the term 'people with intellectual disabilities' has an increasing currency (Johnson and Traustadâottir 2005a; Johnson and Walmsley 2010). However, my chosen contemporary phrase is 'people with learning difficulties' and in so doing the study aligns itself politically with the terminology favoured by advocacy groups, such as People First.[2] The use of such terminology does not imply a relationship with any sort of 'measurable' criteria of what is a 'learning difficulty' or 'intellectual disability', about which there appears to be little consensus anyway (Welshman and Walmsley 2006:5-6). The historic labels used in the thesis reflect a desire as a historian to be as authentic as possible.

1.4 Conclusion

This introductory chapter has set the scene for the thesis by outlining its aims, rationale and structure. It has suggested that a mixture of personal and broader historical imperatives lay at the heart of the research. Chapter Two considers the wider literature which helped inform this study of institutional rundown.

[2] www.peoplefirstltd.com

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature on the history of deinstitutionalisation of people with learning difficulties in the late twentieth and early twenty first centuries, with a particular focus on institutional closure. It draws on developments in the UK and further afield, especially Australia, New Zealand, Scandinavia and North America. The chapter

identifies gaps in the literature, and emerging themes which are examined throughout the thesis.

Writers make important distinctions between the interconnected concepts of deinstitutionalisation and institutional closure (Atkinson 2000; Bigby and Fyffe 2006). The former's focus is the 'process of resettling people from hospital into the community' (Atkinson 2000:87). The success of deinstitutionalisation is predicated on ensuring that people with learning difficulties are able 'to take their place in society as ordinary citizens' (Atkinson 2000:87). This in turn requires 'significant support to people with intellectual disabilities as well as societal change' (Bigby and Fyffe 2006:569). However, as explained later in the chapter, the ideological and fiscal climate of the late twentieth century discredited hospitals as a suitable place of care. Within this context the closing of institutions formed a lynch pin of a deinstitutionalisation strategy. Institutional closure is summarised by Bigby and Fyffe as constituting

> the progressive reduction in the number of people with disabilities living in a large residential facility or the cessation of a facilities operation (Bigby and Fyffe 2006:569).

Framed within a conceptual framework of deinstitutionalisation, such a definition enables the focus, as in this study, to rest firmly upon the changes *within* the institution itself.

2.2 Deinstitutionalisation

This section provides firstly an outline of the literature on deinstitutionalisation policy, particularly pertaining to the UK in the twentieth century. It then proceeds to analyse the main drivers behind the move away from institutionalised care for people with learning difficulties. Overall the section highlights the context in which institutional closure was conceived, as well as identifying themes of particular relevance to this study.

2.2.1 Policy Framework

The second half of the twentieth century witnessed the creation of a national legislative and policy infrastructure in the UK making *possible* the demise of large long-stay institutions for people with learning difficulties (Booth, Simons et al. 1990; Collins 1992; Stevens 2004; Walmsley 2006). Welshman, Nind and Rolph suggest that:

> a gradual transition is presented from predominantly institutionally based, medically provided and group-focused care through to the most recent *Valuing People* strategy where the emphasis is on person centred planning, with people with learning difficulties gaining control of service design and delivery (Welshman, Nind et al. 2005:18-19).

This is not to say that reality has always reflected this 'official history'. In the same publication the authors, and others, demonstrate that families experienced actual provision as patchy and varying considerably across time and place (Rolph, Atkinson et al. 2005). Similarly, as indicated elsewhere in this chapter, the implementation of institutional closure was often at odds with government rhetoric. All this notwithstanding, the policy statements represented in particular by the 1959 Mental Health Act (1960 Scotland), 1971 White Paper *Better Services for the Mentally Handicapped* (followed by the creation of the independent advisory bodies - the National Development Group and National Development Team), the Jay Report 1979, and the 1990 *NHS and Community Care Act*, emphasise an increasing drive, in rhetoric at least, towards community rather than institutional based care for people with learning difficulties (Ryan and Thomas 1998; Stevens 2004; Welshman and Walmsley 2006). It appears to be the third quarter of the twentieth century which laid the policy foundations for institutional closure (Radford and Tipper 1988:76; Welshman 2006:17-18). However, what seems less clear is the point at which the state proposed the closure of all long-stay institutions for people with learning difficulties. Stevens, for instance, contests what he describes as the 'common modern misinterpretation of the published policy' that institutional closure

was initiated by the 1971 White Paper *Better Services for the Mentally Handicapped* with the 1989 White Paper *Caring for People* merely confirming this commitment. He describes the statements in both papers as being 'more guarded' (Stevens 2004:237). Ryan and Thomas, however, do indicate that the 1971 White Paper pledges itself to halve the number of hospital places for people with learning difficulties by 1991, but not closing all institutions (Ryan and Thomas 1998:117). Hamlin and Oakes, in turn, assert that the 1971 White Paper 'set the agenda for deinstitutionalisation in the UK' (Hamlin and Oakes 2008:47). The crucial shift away from long-term institutional care, according to Stevens,

> can be more appropriately traced to the government review of services *Mental Handicap: Progress, Problems and Priorities* (DHSS 1987) (Stevens 2004:240).

Identifying the exact point at which total closure became government policy, rather than a general push towards reducing the institutions in size, appears to be a contested area requiring further investigation.

Ideologically this movement away from institutional care as the twentieth century unfolded seemed to be inextricably bound up with a shift in the definition of 'community care'. Welshman and Walmsley, for instance, accept the position of Andrews in stating that:

> throughout history, 'community care', if we include in that term care in families, has been the dominant mode of care provision for most people most of the time (Andrews 1996; Welshman and Walmsley 2006:8).

Such an argument fits easily with the concept of there being 'a continuum between institutional and community care' (Thomson 1998; Rolph 2000:25). Supervision, guardianship and licensing, for example were built into the mental deficiency legislation of the early twentieth century (Rolph 2000:20,24). These ideas contrast with those who see community care as the opposite of institutional care. According to this polarised

perspective the origins of community care reside in the findings of the 1954 Royal Commission and the subsequent 1959 Mental Health Act (Bulmer 1987; Rolph 2000:22). Welshman and Walmsley, however, stress that during the crucial mid-century period there was a radical transformation in the official perception of community care from it being viewed as a necessary adjunct to institutional care to being seen as a positive alternative (Welshman and Walmsley 2006:9). Examining the reasons underpinning such a shift in the thinking of social policy makers is the focus of the next section of the chapter.

2.2.2 Policy Drivers

Researchers, in disentangling the forces driving these policy developments towards deinstitutionalisation, and with it hospital closure *to whatever degree*, often define the second half of the twentieth century as a juxtaposition between factors which on the one hand discredited institutions, the institutional 'push', and on the other those which fomented an increasing movement towards community care, the community 'pull' (Collins 1992; Felce, Grant et al. 1998; Walmsley 2006a). Within these parameters it is possible to view the complementary and, at times, competing influences of hospital scandals, ideological changes, pressure groups, and the economics of institutional and community care (Welshman and Walmsley 2006:233-235). The chapter now considers each of these elements in turn. Although the geographical focus in exploring these areas, is mainly a UK one, I am aware that, as Lavalette and Mooney argue, any study of British welfare policies is illuminated by a consideration of European socio-economic developments (Lavalette and Mooney 2000). Their argument is that despite having governments of different political hues, similar welfare policy developments occurred across Europe especially post-1945 and from the early 1980s (Lavalette and Mooney 2000:3). Albeit worthy of investigation, such a broad sweep is beyond the scope of this thesis.

2.2.2.1 Hospital Scandals

During the 1960s and 1970s there were Committees of Inquiry into at least 19 learning disability and psychiatric hospitals in England (Martin 1984; Butler and Drakeford 2005). In assessing the impact of scandal on generic social policy Butler and Drakeford sound a note of caution suggesting that the relationship is complex, with scandal as much reflective of policy trends as their creator (Butler and Drakeford 2005:4-5). Evidencing a 'push' away from institutional care, the committee reports were highly critical of institutional living conditions and 'presented a catalogue of failures at all levels of service provision and management' (Korman and Glennerster 1990:15). Amongst inquiries focussed upon long-stay hospitals for people with learning difficulties, including South Ockendon (1974) and Normansfield (1978), the first and probably most influential dealt with Ely Hospital, Cardiff in 1969 (Butler and Drakeford 2005). Extremely poor living conditions were exposed by the News of the World in 1967. The report arising out of this scandal impacted nationally with Richard Crossman, Secretary of State for Social Services, insisting that the entire document was published, followed by a working party which eventually led to the establishment of the Hospital Advisory Service (Butler and Drakeford 2005:59). On the working party were not only Geoffrey Howe who chaired the Ely Inquiry but Peter Townsend and Pauline Morris, both involved in *Put Away* a landmark sociological report 'which provided a devastating picture of conditions in the larger institutions' (Morris 1969; Welshman 2006:35). Two years later the White Paper *Better Services for the Mentally Handicapped* acknowledged serious issues surrounding long-stay NHS institutions (Booth, Simons et al. 1990:2). However, the various policy documents, certainly arising out of the Ely Inquiry, while portraying a negative picture of institutions, did not appear to contemplate their demise, rather it was about improving their level of provision; the emphasis was one of reform not closure. A strong dissenting voice in this consensus appears to be Peter Townsend who, in reviewing Pauline Morris's research, asserts that:

> A structural change must be started... There must be a complete reorganisation of services – so that the subnormal persons are no longer isolated in hospitals remote from the community (Townsend 1969:xxxii).

2.2.2.2 Ideas and Ideology

In their overarching summary of community care developments during the second half of the twentieth century both Welshman and Walmsley identify changes in ideas and ideology. They, however, shy away from making unequivocal claims as to their impact upon policy (and practice): Welshman in analysing the period 1948 – 71 intimated that

> ideas alone do not drive change – although they can influence direction of changes (Welshman 2006:17).

Similarly, with respect to the last 30 years of the century, Walmsley asserted that:

> ideas alone did not drive change, (however) they did create mental frameworks within which change was conceptualised (Walmsley 2006:55).

Adding to this dialogue, admittedly with a focus upon institutions for those with mental illness (in England and America), Scull is highly sceptical of an analysis which emphasises the importance of ideas, arguing that:

> in general, social policy proves only mildly susceptible to the shifting intellectual fads and fashions of the day (Scull 1976:185).

He suggests that ideas critical of the asylum were prevalent in the 1860s and 70s, but similar assessments had far more impact in the 1950s and 1960s.

> The arguments had not changed, but the structural context in which they were advanced had (Scull 1976:194).

During the third quarter of the twentieth century fundamental critiques of institutions did surface, probably none more powerful than the sociological analysis offered by Goffman in *Asylums* in 1961 (Goffman 1961; Korman and Glennerster 1990:13-14; Welshman

2006:33). At around the same time Russell Barton, who was Physician Superintendent of Severalls Hospital in England, in similar fashion described dehumanising aspects of institutional life (Korman and Glennerster 1990:14; Welshman 2006:33-34). In their reflective study of deinstitutionalisation in the UK, Hamlin and Oates stress the key role played by the ideas of both Goffman and Barton in encouraging this movement away from the long-stay hospitals (Hamlin and Oakes 2008:47). Institutional closure in New York State around 1990, according to Castellani, was partly driven by the idea that 'large institutions were *de facto* inappropriate' (Castellani 1992:596). Further studies in the UK such as *Put Away* and Robb's *Sans Everything* in 1967 emerged during the 1960s, all discrediting the idea of institutional care (Robb 1967; Morris 1969; Welshman 2006:33-34). Concurrently during the fifties and sixties research was being done which took a critical but more reformist stance. Welshman charts the contribution of psychologists such as Jack Tizard and Neil O'Connor, amongst others, which challenged the perception of people with learning difficulties as needy and passive, requiring control either through families or in institutions (O'Connor and Tizard 1954; O'Connor and Tizard 1956). Regarding institutions, psychological research indicated that many residents were wrongly classified and should not be in long-stay institutional care (Brandon 1960). Furthermore, studies such as the 'Brooklands' experiment (Tizard 1960),[1] demonstrated that when given an appropriate alternative environment to that of an institution, people with learning difficulties could develop both psychologically and educationally. Overall, Welshman argues, the burgeoning psychological and sociological research literature of the 1950s and 1960s helped to inform the direction of social policy (Welshman 2006:25-33).

[1] Supervised by Jack Tizard, this project took 32 children with high support needs out of a large long-stay institution, and placed them in smaller community based units. These individuals, in contrast to a 'control group' remaining in hospital, showed considerable developments in mental abilities and independence.

Walmsley and Johnson suggest that 'it was but a small step' from the assertions of O'Connor and Tizard to the idea of normalisation (Johnson and Walmsley 2010:67). Initially formulated by Bank-Mikkelson, this concept was defined in the Danish 1959 Mental Retardation Act as:

> Making normal mentally retarded people's housing, education, working and leisure conditions. It means bringing them the legal and human rights of all other citizens (Bank-Mikkelson 1980:56).

What has become known as the Scandinavian strand of normalisation thinking was further developed in the 1960s in Sweden by Nirje (Emerson 1992; Mee 2005; Tilley 2006). He summarised it as:

> Making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life of society (Nirje 1980:33).

Both this definition and the earlier one of Bank-Mikkelson emphasise what Emerson calls:

> the basic rights of people with learning difficulties in an egalitarian society (Emerson 1992:33).

This approach was incorporated in the United Nations Declaration of the General and Specific Rights of the Mentally Retarded (United Nations 1971). Further developed in the 1980s, Mee suggests that in this vision of normalisation the individual had 'the right to choose'; it was not a 'life prescription' but rather about 'providing opportunities' for living like other people in the wider community (Mee 2005:46).

What Tilley describes as 'a more elaborate version of normalisation' was developed during the 1970s, and beyond, in North America by Wolf Wolfensberger (Emerson 1992; Tilley 2006:60). Unlike the Scandinavian model, this drew heavily upon a

conceptual framework related to sociological theories of deviance and labelling. In his early writings Wolfensberger defined normalisation as:

> Utilisation of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible (Wolfensberger 1972:28).

His concern was 'to reverse or prevent devaluing', a process which 'for the first time' hinged upon the presentation and interpretation of a person with a learning difficulty (Mee 2005:47). By 1983, reflecting its theoretical underpinnings, Wolfensberger had renamed his theory social role valorisation (SRV). He argued that

> ...the most explicit and highest goal of normalisation must be the creation, support and defence of *valued social roles* for people who are at risk of devaluation (Wolfensberger 1983:234).

Unlike the original Scandinavian version, Wolfensberger's perspective hinged on integration, not segregation: there was no place for separate congregate living as represented particularly by large long-stay institutions. In addition, again in contrast to the normalisation of Nirje and Bank-Mikkelson, it has been claimed that SRV

> was only tangentially concerned with the rights of people with a learning disability. Indeed the right to not be segregated is seen as a bigger issue than the right to choice... (Mee 2005:55).

A dominating emphasis on 'autonomy, empowerment, and self determination' (Wolfensberger 2002:253) is viewed by Wolfensberger as potentially dangerous for 'a person of limited, disturbed, or diminished mentality' (Wolfensberger 2002:257). The latter's welfare is *best* served, according to Wolfensberger (2002), by ensuring that she or he is regarded as a *valued* member of society.

Wolfensberger's normalisation/SRV has not been without its critics in the field of learning disability (Dalley 1992; Atkinson 1998; Mee 2005; Walmsley 2006). However,

although Race (1999) questions its impact, there is a general consensus among researchers, summarised by Walmsley, that these ideas:

> have been remarkably influential in the design and philosophy of learning disability services since the 1970s (Walmsley 2006:44; Philpot and Ward 1995; May 2000; Deeley 2002).

Deinstitutionalisation, it is claimed, has been a central feature of these service developments (Emerson 2004:187). The Jay Report with its critique of learning disability nursing, emphasised normal living in the community with support from non-medical professions and was, Walmsley argues, a clear example of SRV being adopted at a policy level (Jay 1979; Mitchell 2003; Walmsley 2006). Three years after this report, in 1982, the new syllabus for Registered Nurse in Mental Handicap (RNMH) was introduced. This it was claimed by the Royal College of Nursing was heavily influenced by normalisation, 'the prevailing philosophy of care' (RCN 1989:6), and

> reinforced the direction of mental handicap nursing away from being a speciality based on an illness-dominated medical model (RCN 1989:13).

During the 1980s as hospital closure programmes, including the Royal Albert, came into being many members of nursing staff attended Wolfensberger influenced PASS workshops, intended to 'spread the gospel' of normalisation and drive change (Wertheimer, Ineichen et al. 1985; Korman and Glennerster 1990:64; Emerson 1992; Wangermann 1992). Chapman highlights the 1983 All Wales Strategy as explicitly recognising its debt to normalisation (Chapman 2006). Similarly, the North West Regional Health Authority (NWRHA), overseer of the closure of the Royal Albert, seems to have been heavily influenced by the principles of normalisation, both the European and North American versions, especially in its 1983 nationally recognised guidance document, *A Model District Service* (NWRHA 1983; Wangermann 1992; Walker, Ryan et al. 1993; Chapman, Asbury et al. 2006). However, institutional studies indicate

(ironically) that the adoption of normalisation had a reforming influence in improving the living environment *within* institutions (Malster 1994; Godsell 2002; Ingham 2003).

2.2.2.3 Campaigning Groups

Significantly, both Morris's 1969 study and Tizard's Brooklands experiment were commissioned by a parents' group (the National Society for Mentally Handicapped Children and Adults) symbolising the influence of campaigning organisations, specifically parental but also others, in the dynamics of policy change (Morris 1969; Rolph 2006; Tilley 2006; Walmsley 2006; Welshman 2006; Welshman and Walmsley 2006). Members of the Open University Social History of Learning Disability Research Group, apparently alone amongst the other analyses, emphasise:

> the efforts of the families themselves, usually parents campaigning for improved services for their children, articulated through local voluntary societies from the early 1950s (Welshman and Walmsley 2006:234).

The same authors assert that while difficult to assess the impact of families vis-a-vis policy development 'there is no doubt that post World War Two they were an important force' (Welshman and Walmsley 2006:234). Rolph while recognising that the relationship of families to institutional care is complex, also stresses their role in influencing 'the shift from control to care to citizenship' (Rolph 2006:186). In addition, Welshman points out the contribution made by another campaigning group, the National Council for Civil Liberties. In 1951 they published *50,000 Outside the Law* - a report distinctly critical of unjust institutional detainment. The parental movement then joined forces with NCCL and pressurised the government into setting up the seminal 1954 – 57 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Welshman 2006:23-24). This in turn was key to the 1959 Mental Health Act espousing community care ideas and revoking the Mental Deficiency Acts of the early twentieth century.

Although recognising the crucial influence of Mencap[2] in influencing the shift *towards* deinstitutionalisation, another parental group, Rescare, is identified as extremely *critical* of the move away from segregated forms of care (Ryan and Thomas 1998:158; Stevens 2004:240-3). Set up in 1984, Rescare has become a firm advocate of so-called 'village and intentional communities' for people with learning difficulties (www.rescare.org.uk), such an idea becoming embodied in the 2001 White Paper *Valuing People* (Stevens 2004:243). However, the actual degree to which Rescare's resistance influenced the shape and pace of institutional closure, arriving fairly late on in the policy development landscape, requires further research.

Furthermore, as the century wore on the voice of user groups, such as People First, was increasingly heard, critical of institutions and campaigning for the rights of people with learning difficulties (Ryan and Thomas 1998:160-1; Stevens 2004; Rolph, Atkinson et al. 2005:23-4). Sympathetic to the positioning of such groups have been pressure groups such as the Campaign for the Mentally Handicapped (CMH), later renamed Values into Action. Stevens claims that its activities, like Mencap, were influential in policy gravitating towards institutional closure (Ryan and Thomas 1998:121-2; Stevens 2004:240).

2.2.2.4 Political Economic Imperatives

Many writers stress economic 'push' and 'pull' forces as prime drivers in the closing of long-stay institutions for people with learning difficulties. Korman and Glennerster (1990) argue that changing ideologies in themselves were not enough to impact upon national policy. Policy changes occurred in the 1960s and 70s when governments came to believe, in a climate of 'fiscal stress, that community care would be *cheaper* ' (Walker

[2] Formerly known as the National Society for Mentally Handicapped Children and Adults.

1982; Scull 1984; Korman and Glennerster 1990:18). Walmsley quotes Dalley (1989) in arguing that 'community care was expected to be less expensive' (Dalley 1989; Walmsley 2006a:82). Wright supported such a stance by citing a 1980 government paper which calculated that costs of community care were cheaper than the institutional option (Wright 1982:172). In addition, the Audit Commission (1986) claimed that the development of community services, and

> the reduction of long-stay hospital provision... is generally considered better in most situations. It is also more economical in many cases (Audit Commission 1986:1).

Against this 'pull' towards community care Walmsley positions the 'push' factor of poor funding leading to the hospital scandals of the late 1960s and 1970s, in the process tarnishing institutional care (Walmsley 2006a:82). Godsell, with reference to the UK, and Castellani, in discussing the closure of six institutions in New York State in the later part of the twentieth century, also highlight economic factors as dominant drivers in deinstitutionalisation: community care was perceived as a cheaper option; and institutional care costs were rising (Audit Commission 1986; Korman and Glennerster 1990; Castellani 1992; Godsell 2002). The hospitals were not only in need of upgrading but by the mid-1980s increased staffing levels had meant that they were 'costing considerably more to run than they were a decade ago' (Audit Commission 1986:62). However, their sale would release substantial capital revenues (CMH, MIND et al. 1975; Korman and Glennerster 1990:18). Furthermore, as Welshman points out, pivotal policy documents of the late 1950s and early 1960s (1959 Mental Health Act, 1962 Hospital Plan) were produced by Conservative Governments pursuing an agenda of expenditure cuts in public services (Welshman 2006a:66-67).

Other authors have presented an economic analysis within a broader political critique. Langan (1998) and Lewis (1998) both argue that although reducing the cost of the

welfare state had been a concern of the 1970s Labour Government, it was under the government of Thatcher in the 1980s 'that this (the cost-cutting) argument was honed and deployed with great effect' (Lewis 1998:48). In the public sector, including the NHS, the emphasis was on shifting the burden of social care away from the government, as an integral expression of a New Right, neo-liberal, ideology which espoused the virtues of private enterprise and the market (Langan 1998; Lewis 1998). This constituted an ideological underpinning to a government drive to close state-run institutions and shift the financial responsibility for learning disability services to other providers. A more Foucauldian analysis is presented by Scull (1976; 1984). He argued, in relationship to people with mental illness, that the social control of those seen as 'deviant' was better accomplished, in the light of a fiscal crisis in the second half of the twentieth century, through 'decarceration' and reliance upon cheaper welfare programmes. This provided a context in which institutional critiques had a currency, in influencing social policy, in the 1960s and 1970s which they had failed to have in the 19th century (Scull 1976; Scull 1984). Lavelette and Mooney taking a Marxist overview of drivers in social welfare developments argue eloquently that the latter can only be understood with reference to class, because this

> provides the context within which policies are developed, welfare states reorganised and in which groups get access or are denied access to welfare (Lavalette and Mooney 2000:9).

Their definition of 'working class' is positioned in relation to the means of production, and embraces many 'oppressed' groups including people with learning difficulties. Other commentators also claim that economic considerations played a significant part in driving policy change (Welshman and Walmsley 2006), not only in the UK but European wide (Means, Richards et al. 2008:223-27).

2.2.3 Research Implications

The literature on the history of deinstitutionalisation, as depicted here, suggests an intricate web of policies, initiatives, influences and perspectives. In the midst of this complexity it is possible to identify a central and contested theme. This relates to the degree to which the drive to close large long-stay hospitals, and develop community care, reflected the needs, desires and rights of people with learning difficulties or was driven by imperatives of cost, convenience and neo-liberal ideology. To help unpick this conundrum my research asked:

> *What were the external pressures shaping the rundown of the Royal Albert Hospital, Lancaster in the late twentieth century?*

An examination of this question constitutes the focus of Chapter Four of the thesis.

2.3 Institutional Closure

Having discussed deinstitutionalisation as an overarching framework, this section examines the literature on aspects of institutional closure itself. Firstly there is an outline of the extent to which deinstitutionalisation policies translated into actual institutional closures in the UK during the late twentieth century. Then the section considers the type of studies, both in the UK and internationally, which have been undertaken in this field. This is followed by a consideration of key themes which have emerged from the research into the closures of institutions. Finally, the implications of this review for my own study are summarised.

2.3.1 Overview of Institutional Closures in the United Kingdom

Despite the rhetoric of community care being heightened with the 1959 Mental Health Act and the 1962 Hospital Plan, hospitals for people with learning difficulties were still being built in England during the 1950s and 60s; in fact the total number of hospital residents peaked in 1969 (Stevens 2004; Welshman and Walmsley 2006). The

significant 1971 White Paper, *Better Services*, as already indicated, was not promoting the closure of all hospitals (Ryan and Thomas 1998; Stevens 2004) and during the following decade numbers hardly reduced, with any decrease largely explained by a dramatic fall in the number of children admitted combined with the deaths of long-stay residents (Booth, Simons et al. 1990:1; Emerson and Hatton 1994:1-2). Investment in institutional infrastructure continued well into the eighties in some cases: both the Royal Albert and Normansfield, for example, put substantial resources into new on-site units as a response to critical reports (Alston and Roberts 1992); and the head of Cambridge Priority Services Unit making it clear, with respect to Ida Darwin Hospital, that as late as 1985 if 'we had spare cash we had to invest it in the institution'[3]. Tyne, at that time a researcher with CMH, writing in the early 1980s, argued firstly that: the 1981 *Care in the Community* paper was 'based firmly on the White Paper (1971) supposition that there will always be those who need hospital care' (Tyne 1982:149); and secondly,

> it seems almost inevitable that, with increased pressure from the community, hospitals will once again begin to open their doors to new admissions, and that the hospital population will cease to fall or even begin to grow again (Tyne 1982:157).

What appeared to shake up this institutional inertia was the 1983 *Health and Social Security Adjustments Act* which allowed DHSS benefits to finance former hospital residents in private and voluntary residential community accommodation (Korman and Glennerster 1990; Godsell 2002; Walmsley 2006a). In addition, this act introduced 'the dowry' system, an annual payment made by the district health authorities to local authorities to provide financial support for each individual who moved out of hospital into the wider community (Hudson 1991). Impetus was given to resettlement from the Royal Albert by this legislation (Wangermann 1992). Nationally the 1980s, leading into the early 1990s, witnessed a rapid reduction in the hospital population, and by 1992 it

[3] Stephen Thornton, interview with Jan Walmsley, March 2005

was 44% of its 1980 level (Emerson and Hatton 1994). This changing demographic, combined with the prediction that most institutions of this nature would have closed in England by the end of the century, led two academics to confidently assert that 'hospital closure or deinstitutionalisation' is a 'specific task nearing completion' (Emerson and Hatton 1994:2).

Although taking a while to get started it seems, therefore, that by the 1990s the closure programme was finally well on track. However, such a view was challenged strongly at the time, particularly by Collins but also by other commentators. The new financial arrangements introduced by the 1990 *NHS and Community Care Act*, combined with a lack of earmarked funding, were seen as detrimental to the momentum of resettlement which had been built up in the preceding years.

> Much of the energy and purpose of the closure programme has been dissipated... while it cannot be said that community care has been cancelled it is clear that, for at least some people with learning difficulties, it is being indefinitely postponed (Collins 1992:10).

Practitioners and researchers, both at the time and since, have emphasised the impact of the new funding regime introduced by the 1990 Act (Korman and Glennerster 1990; Wangermann 1992; Walmsley 2006a). Prior to this legislation community care, in many instances, had been effectively financed from a national pot via the DHSS. Now with new assessment procedures money was to come via a more restricted locally controlled budget. The effect of this altered funding environment on the quality of deinstitutionalisation was summed up by Pamela Charlwood, Chief Executive of Avon Area Health Authority in 1997, saying that they have had to compromise their ideals regarding the quality of community accommodation for residents moving out of Stoke Park:

> There is no way now with the changes. That (the ideal of 4 or 5 bedroom houses) was when we were drawing on Social Security money flowing like an ever-open tap. The tap has been shut off now (Godsell 2002:163).

Also impacting during this period were a range of other factors. Economies of scale in a large hospital, for instance, militated against resettling residents as it cost as much to run a half-empty ward as a full one (Wright 1982:172; Walmsley 2006a:83). Moreover, Collins criticised the lack of strategic leadership from the Conservative Government, placing undue emphasis on the goodwill and determination of personnel at a local and regional level (Collins 1992). Outside England, the lack of a coherent strategy to facilitate deinstitutionalisation was highlighted in a review of the All Wales Strategy, which is generally seen as a model of community care implementation. In the mid-to-late 1990s researchers argued that: 'No large hospital in Wales has closed and there is doubt as to whether complete institutional closure will be achieved' (Felce, Grant et al. 1998:94). Crucial reasons for this state of affairs were that county planning was neither sufficiently strategic nor linked to hospital resettlement.

Running counter to the push towards deinstitutionalisation during the late twentieth century was the contention that these monolithic structures would not close entirely, with residual residential services remaining on site. In *Making a reality of community care*, the Audit Commission in 1986 stated that, alongside community provision:

> there will *always* remain a very important role for hospitals (although on a reduced scale) in caring for a small number of very severely handicapped people; and residential care will continue to play an important role in the spectrum of care (Audit Commission 1986:1).[4]

[4] My italics.

Almost a quarter of a century later there were 753 former hospital residents still living on NHS campuses in England suggesting that the report's prediction has been realised (DH 2010). Calderstones, one of three former hospitals in Lancashire, continued to have, according to one well informed source, 150 residents in 2008.[5] Emerson and Hatton summarise the argument, prevalent in the 1990s, that while few would assert the need to retain institutional care in its current form, there are those who argue that there is a 'need for some sort of institutional provision for people with more complex needs' (Emerson and Hatton 1994:2). Underlying such a position was the suggestion that care for these individuals would be cheaper in an institutional rather than in a community setting: 'Good community care is costly' (Korman and Glennerster 1990). Furthermore, embracing the views of those critical and supportive of deinstitutionalisation, a lively debate about the wisdom of segregated communities of people with learning difficulties continued into the twenty first century (Cox and Pearson 1995; Cummins and Lau 2004; Emerson 2004). However, assessing the extent to which these arguments in favour of some form of institutional care impacted upon institutional closures remains problematic.

2.3.2 Institutional Closure Research Perspectives

Presented here is an outline of the research landscape associated with the mechanics of institutional closures; this will be further illuminated, later in the chapter, with an examination of key themes which emerged from the literature.

In life stories research, nationally and internationally, former hospital residents refer to the moving within and out of long-stay establishments (Atkinson, Jackson et al. 1997; Cooper 1997; Johnson and Traustadâottir 2005). Indeed some of this work has touched upon migration between institutional environments (Rolph 1999). These studies, by

[5] Tom McLean, Interview September 8th 2008.

their very nature, have a strong historical dimension. This contrasts with other contemporaneous research, which often had the express purpose of either impacting on the policy or practice of deinstitutionalisation or being seen as the final chapter in an institutional history (see below). Much of this research in England – including psychiatric hospital closure – written primarily from a policy perspective was carried out around the late 1980s and early 1990s. Policy studies at this time include a review document of the closure of Brockhall, the first large long-stay institution in the north west to close (Peters and Freeman 1992), as well as accounts of the closure process of long-stay institutions for people with learning difficulties in South East (Korman and Glennerster 1990) and South West England (King 1991). In addition there is a piece of research embracing a number of case studies nationally to analyse why institutional closure appeared to be floundering and to offer ways forward (Collins 1992; Collins 1993; Collins 1994). Internationally, and straddling the onset of the twenty first century, are pertinent pieces of American and Australian research (Castellani 1992; Bigby 2005; Bigby and Fyffe 2006).

All of these studies, written at the time, are of interest in providing insights into the political and economic dynamics of closure, although the voices of those at its heart are given little direct expression. Addressing this imbalance in relation to people with learning difficulties has been the focus of some later work, prominent amongst which has been an international compilation written and collated by Johnson and Traustadottir, who wanted to produce 'an account that brought together the lived experiences of people with intellectual disabilities and their families with reflections on deinstitutionalisation' (Johnson and Traustadâottir 2005a:17). They do this through the medium of life stories, and case studies showing how policy played out in the lives of those who moved out of the institution. Interestingly, and as with a London based piece of work carried out in the early part of the twenty first century (Owen 2004), Johnson in

her own study represents the process of closure from the perspective of those who are seen as being the most challenging, those who are on 'the back wards' of the large long-stay institutions (Jones 1975:96; Johnson 1998; Johnson 2005). In a study of Stoke Park learning disability institution, in Bristol, reference is also made to the particular issues in hospital closure encountered by those with 'a history of severe mental illness, psychotic or anti-social behaviour' (Godsell 2002:182).

Embracing the perspectives of not only people with learning difficulties, but also their relatives and staff are a number of UK, Australian and New Zealand studies (Johnson 1998; Godsell 2002; Gates 2008; Milner 2008; Stewart and Mirfin-Veitch 2008; Gleeson 2010). Echoing such an emphasis are two pieces of research executed in the late 1980s and 90s in Northern England (Booth, Simons et al. 1990; Walker, Ryan et al. 1993). One of these evaluates the North West Regional Health Authority's resettlement policy, focussing upon

> the experience of a group of people resettled from the three largest mental handicap hospitals in the region, and ... their progress towards the 'five accomplishments' that underpin the principle of normalisation... (Walker, Ryan et al. 1993:i).

This research drew upon the viewpoints of families, staff and service users presenting insights into aspects of deinstitutionalisation policy and practice in North West England. In a similar vein, the other north of England study, located in Kirklees, Yorkshire, while referencing policy was more concerned to evaluate 'the process of relocation itself, and of its effect on the lives of the movers and their families', as well as reflecting upon staff perspectives (Booth, Simons et al. 1990:22). This latter focus was at the core of Godsell's study of Stoke Park, concentrating upon

> the ways in which the closure of the hospital, and the movement between hospital and the community, have influenced staff's perception of the services and the roles they perform within them (Godsell 2002:194).

In analysing seminal facets of the relocation process, as well as the closing of the hospital over a period of time, Godsell gives considerable prominence to the voices of direct care staff. Unlike work on staff reflections on resettlement in the North West England (Mitchell and Chapman 2008), the perspectives in Godsell's work were gathered at the time of relocation. Both studies, however, focus primarily upon staff who took up posts in community learning disability services.

Institutional histories in the UK, including the Royal Albert, and further afield, sometimes contain a concluding chapter dealing with closure, often because the work has been commissioned as the hospital runs down. Some of these reference policy and embrace the voices of residents, staff and, in some instances, families, although as 'the last word' they do not present detailed analyses of the hospital closure process (Radford and Tipper 1988; Malster 1994; Hutchings 1998; Ingham 2003; Manning 2008).

2.3.3 Themes of Institutional Closure

A core theme of the literature on institutional closure, as already indicated, is that it was a highly *complex* process, whether at a micro or macro level, embracing an intricate web of relationships between different stakeholders, along with profoundly demanding logistical, administrative and resource issues.

In the face of such labyrinthine organisational challenges, strong and expert leadership is emphasised as a key factor in the implementation of institutional rundown (Korman and Glennerster 1990; King 1991; Castellani 1992; Collins 1992). In the case of the closure of Darenth Park, Kent, the researchers argue that:

> The central lesson to be learned is that top-class managerial skills are required to achieve this apparently unglamorous task (Korman and Glennerster 1990:123).

Such a sentiment is echoed by Castellani who, in his study of institutional contraction in New York State in the 1980s and 1990s, emphasises that those responsible for implementation needed 'problem solving, negotiation and conflict resolution' skills, more than 'routine management capacity and technical competence' usually associated with what he describes as 'middle management' (Castellani 1992:208). Moreover, in her nationwide English research in the 1990s, Collins pointed out that where clear and determined leadership existed financial difficulties merely slowed down the pace of institutional closure (Collins 1992).

Following the Griffiths review of 1983, general management replaced the tripartite consensus management structure.[6] This innovative shift was introduced across the NHS at regional, district and unit levels (Klein 2001; Webster 2002). It is suggested that this was all part of the business of targets and cost cutting particularly attractive to the Thatcher government as it reduced expenditure in public services (Booth, Simons et al. 1990:6). Moreover, general management can be viewed as a dominant strand in a managerial onslaught on public services in the UK during the 1980s (Newman 1998). However, regardless of the motivating forces, Korman and Glennerster argue that in learning disability services:

> general management did prove an important contributory factor in speeding up the process of hospital closure and in many areas unit general managers became key figures (Korman and Glennerster 1990:27).

In contrast to the previous management structure, now:

[6] In its re-organisation of 1974, the National Health Service introduced consensus management. It came to permeate the NHS, and was defined by its emphasis on collective decision-making, made by multi-disciplinary teams comprising doctors, nurses and administrators (Harrison 1982; Small 1989; Adams 2009).

> a single person could be given charge of the complex process of running down a large institution (Korman and Glennerster 1990:27).

These researchers assert that this clarity provided scope for manoeuvre in the implementation of hospital closure.

Although studies, such as the one on Darenth Park, emphasise the importance of leadership in implementing institutional closure, *first hand* managerial accounts although touched upon internationally (Johnson 1998; Enbar, Morris et al. 2004; Manning 2008) are lacking or under-represented. One of the exceptions to this is the memoir of the Chief Executive of Exeter Area Health Authority charting deinstitutionalisation policy and practice in South West England during the 1970s and 80s (King 1991). However, this is purely, as he acknowledges, *one* managerial perspective amongst many who were involved in that process, as well as presenting a broad regional sweep. Although Korman and Glennerster (1990) emphasise the vital role of general management in the context of institutional closures across the UK, they present insubstantial evidence to support such a claim. In addition, there are those who questioned the radical impact of the introduction of general management in the NHS during the 1980s (Hunter 1994; Langan 1998; Webster 2002:174). Furthermore, there is very little material which provides insights into *who* the general managers and other members of middle management were: their beliefs, values, feelings, the meanings implementation had for them, beyond an allusion to career advancement (Korman and Glennerster 1990:27). Such a lack of focus makes it difficult to assess the impact of the agency, or 'capacity', of specific individuals upon the implementation process (Korman and Glennerster 1990:27). This is in contrast, for instance, to a broader literature relating to deinstitutionalisation which is littered with the names of influential people (Butler and Drakeford 2005; Welshman and Walmsley 2006). Moreover, accounts such as those presented by Korman and Glennerster (1990), King (1991) and Collins (1992,

1993, 1994) in which administrative and managerial issues are pinpointed, tend to adopt a macro-focus, with issues such as financing, logistics and inter-agency relationships dominating their viewpoint. There is far less on the micro-political and *ethical* entanglements which occurred *within* an organisation as management attempted to implement its contraction.

Integral to the complex human dimension of institutional closure, both in the UK and internationally, was the theme of resistance. In her Australian study, for instance, Johnson argues that:

> The announcement of the decision to close Hilltop immediately divided staff, families and people living at the institution into those supporting its closure and those resisting it (Johnson 1998:84).

This dichotomy is replicated in other studies (Radford and Phillips 1985; Collins 1993; Godsell 2002; Gleeson 2010). Although public opposition to closure is pinpointed, the primary focus is upon resistance by families and by institutional employees (Radford and Phillips 1985; Enbar, Morris et al. 2004; Malacrida 2008; Manning 2008; Stewart and Mirfin-Veitch 2008; Gleeson 2010). According to the research the nature of opposition, where it occurred, was predominantly of a *collective* nature, whether through family groups or, in the case of hospital staff, trade unions (Johnson 1998; Manning 2008). On occasions, as referenced in North America, alliances were formed between employees and relatives, sometimes with public bodies, to oppose closure (Enbar, Morris et al. 2004; Malacrida 2008). However, although less prominent, studies do highlight instances of *individualised* actions by staff which could be construed as undermining resettlement (Collins 1993; Johnson 1998; Godsell 2002). These, as with a selection of collective actions, are viewed as having slowed down implementation processes (Radford and Phillips 1985; Collins 1993; Tøssebro 1993; Tøssebro and Lundeby 2006). There were instances in North America where an alliance of families,

staff and the public prevented closure happening at all (Enbar, Morris et al. 2004; Malacrida 2008). Mostly, though, the studies reveal that resistance was overcome and institutional rundown was implemented. With possible parallels for staff attitudes in learning disability institutions, one researcher argues that in the case of a London based psychiatric hospital closure:

> Negative attitudes tended to be seen as a kind of inevitable fighting against the dying of the light (Tomlinson 1992:66).

Occasionally, particularly in the United States, resistance was defeated in legal arenas (Enbar, Morris et al. 2004). Acceptable settlements or guarantees regarding continuity of employment are indicated as being crucial in overcoming potential and real opposition from hospital staff (Audit Commission 1986; Korman and Glennerster 1990; King 1991; Enbar, Morris et al. 2004). One study also argues that a *rapid* implementation programme was devised to prevent the development of an effective opposition (Johnson 1998). For families, however, the research consensus is that opposition withered away as resettlements proceeded. Relatives were initially anxious, and resistant to closure, but became re-assured and supportive of the process as former hospital residents settled into houses in the community (Tøssebro and Lundeby 2006; Stewart and Mirfin-Veitch 2008; Lemay 2009). Moreover, one North America study suggests that an institution's family group was a prime driving force *for* the adoption of deinstitutionalisation (Shumway 1996).

Lacking overall in the studies which reference resistance by staff or families is a detailed examination of their point of view. The oppositional perspective tends to be seen as reflecting self interest, in terms of job losses, or, for relatives, anxieties about *their own* family member safely in an institution for life. Moreover, those reacting adversely to institutional closure were merely a management problem. Korman and

Glennerster, for instance, while expressing some sympathy towards the predicament of staff, assert that:

> The longest-serving staff were often *the most difficult to deal with.*[7] Quite a number of people did not take up the posts that were reserved for them – they simply did not want to move, and were often unable to give a reason why. They resented the hospital closing and were not willing to give the new jobs a go. The hospital had had a very stable core of staff, and no matter how many warnings were given, they refused to move (Korman and Glennerster 1990:120).

The implication here is that management had kindly *reserved* jobs for members of staff, had given sufficient *warnings,* but bizarrely and obstinately these individuals refused to give the '*new* jobs a go'. In other words they were stuck in their *old* and irrational ways. The position of these employees is framed purely in terms of the management agenda, which they were obstructing. There is little attempt to understand, or *legitimise*, this alternative perspective. To say that they '*simply*' did not want to leave understates the complexity of the situation of staff in terms of meanings, emotion and their relationships with people with learning difficulties (Godsell 2002; O'Driscoll 2006; Gates 2008). One exception to those studies which collude in this community care research narrative is written by Gleeson (2010). He argues that the division, highlighted earlier, between those for or against closure reflected positions either side of an ethical faultline. There was a 'moral schism' between 'righteous reformers' and 'fearful reactionaries', and anyone questioning deinstitutionalisation was perceived as engaging in 'acts of moral failure' (Gleeson 2010). Drawing upon a comparative analysis of the closure of two Australian institutions, Gleeson argues that this dismissive attitude belies the point that opposition towards closure had a validity; it was *resistance*. Using the parents' group at Kew Cottages as his exemplar he asserts that their institutional rundown critique was rooted both in genuine caring, as an 'affective community', and credible concerns over

[7] My emphasis.

the implementation of features associated with a neo-liberal agenda. Such an argument reinforces Gleeson's overarching claim that:

> periods of intense transition in the ideology and mode of care are reflective of wider social transformations not merely of therapeutic or institutional shifts (Gleeson 2010:5).

In terms of highlighting the negative impact of a business, and management, culture upon closure processes other researchers can be construed as having sympathy with such a standpoint (Radford and Phillips 1985; Walker, Ryan et al. 1993; Johnson 1998; Godsell 2002; Bigby 2005). However under-represented, arguably because these perspectives are viewed as 'wrong', are studies which examine institutional contractions from the *critical* stance of staff, families, and indeed hospital residents.

Issues associated with resourcing the move from hospital, including the development of community provision, were, as illustrated below, examined in the different studies. In some cases deinstitutionalisation appeared relatively straightforward: monies realised by the closure of Starcross (King 1991), for example, financed the cost of relocating its residents; and almost 20 years later, across the other side of the world, the closure of Kew Cottages in Australia, similarly, helped to fund community residences (Manning 2008). Furthermore, the decision to close Darenth Park, in Kent, was triggered by the promise that this would finance deinstitutionalisation (Korman and Glennerster 1990). However, in North West England increasing financial pressures seemed to impact on the process of institutional closure and resettlement (Walker, Ryan et al. 1993). There appeared to be a shift in policy, during the 1980s, by the Regional Health Authority from one based primarily on the resettlement needs of the clients to one determined by more bureaucratic imperatives. By the late 1980s researchers argued that,

> the programme and pace of resettlement had to be structured in the most cost efficient way which, in turn, was closely dependent on the rundown of the hospital (Walker, Ryan et al. 1993:17).

One expression of this was the introduction of ward closure programmes, including the shutting down of wards when they were judged to be no longer economically viable. As other studies reference, the economics of closure could easily become enmeshed in the politics intra and inter Health and Social Services (Booth, Simons et al. 1990; Korman and Glennerster 1990).

Institutional closure and reprovisioning resource issues could impact adversely on people with learning difficulties moving out of hospital; in other words, those it was meant to serve. Studies, both in England and internationally, emphasise how financial concerns resulted in inter-ward moves for residents, impacting negatively on the health of some individuals (Turnbull 1993; Stancliffe 1998). Other ways in which poor resourcing could play a crucial role in how people moved out of hospital are explored by Johnson in her study of women leaving Hilltop in Australia. She describes half of the residents being prevented from transferring into the community because the monies were not there (Johnson 2005). Bigby, in a separate Australian study, extends this argument to show how the business culture prevalent at the time of the resettlement of 58 long-stay residents impacted negatively on this process and indeed set the tone for their new life in the community (Bigby 2005). Overall the research studies mentioned reveal how the more negative features of institutionalisation played out in the actual relocation process. In reflecting on her own work and others, Johnson, for instance, pinpoints the lack of influence, lack of voice – either directly or indirectly - that residents had in resettling (Johnson 2005a). Such sentiments resonate with UK research. In North West England for instance Walker, Ryan and Walker in their study of resettlement from the three main hospitals in the early 1990s, including the Royal Albert, state that:

> Movers were inadequately involved not only in the choice but also in the preparation of their new home. In most cases they were simply presented with the completed package (Walker, Ryan et al. 1993:ix).

This sentiment resonates with other British studies (Booth, Simons et al. 1990; Ingham 2003). Matthew Godsell develops the theme further, suggesting that preferential treatment occurred in the relocation process during the 1980s at Stoke Park:

> While some of the people with less severe disabilities had moved into group homes in NHS and community care trusts the people that remained in hospital were put into groups with people that shared common characteristics e.g. their age, physical impairment or behaviour. Wards were also referred to as accommodation specifically for people with challenging behaviour, or multiple impairments (Godsell 2002:175-6).

Such streaming in turn suggests that medical model thinking, viewing people primarily in relation to a perceived impairment or 'problem', was still prevalent within the framework of a social change viewed by many as progressive. However, in the same study, Godsell indicates how normalisation/SRV had filtered down and 'encouraged nursing staff to create a more domestic setting for services' (Godsell 2002). In some ways this example of conflicting ideologies appears to be emblematic of the whole process of closure and relocation, whether at a national, regional, local or personal level: namely that it was highly complex and often encompassed contradictory and competing forces.

2.3.4 Research Implications

A review of the literature on institutional closure indicates that there are key weaknesses in our understanding of the ways these large long-stay hospitals were contracted during the late twentieth and early twenty first centuries. Under-researched are what Gleeson describes as 'the many small scenes of moral and political struggle

around processes of closure'(Gleeson 2010:12). Lacking also are insider accounts of institutional rundown, whether from the standpoint of managers, staff or families which could shed light on this struggle. Opposition to the closing of institutions was, in general, viewed as a managerial *problem*, rather than a valid informed voice. Infusing this perspective were ideological underpinnings, linked with normalisation/SRV, emphasising the rightness of the task to implement closure. This ethical framework both underplays the impact of a bureaucratic and cost agenda, and 'others' those individuals who were critical of the process and policy of institutional contraction. In this 'othering' the meanings that the institution had for staff, particularly those who left the institution or were not involved in direct care, are largely missing from studies. Equally, however, beyond references to the professional task and the ideological zeal of the times, studies pay little attention to the meaning change had for those charged with implementation. Although existing research emphasises the importance of organisational leadership, there is a lack of managerial perspectives on the enormity of the task faced by those implementing change *within* their respective organisations

In order to investigate these issues, this thesis asked a number of related questions about institutional contraction:

How did managers implement the rundown of the Royal Albert Hospital, Lancaster?
This constitutes the focus of Chapters Five and Six.

What were the viewpoints of those who resisted the closure of the Royal Albert? How did they express their resistance?
These interlinked questions are examined in Chapters Seven and Eight respectively.

What meanings did Royal Albert rundown have for implementers and resisters of change?

This is investigated in Chapter Nine.

2.4 Conclusion

This chapter has reviewed the literature on deinstitutionalisation and institutional closure which helped shape the thesis and identify key research questions. Chapter Three discusses the research methods which were employed in the study.

CHAPTER THREE

RESEARCH METHODS: THEORY AND PRACTICE

3.1 Introduction

This chapter examines the theory and practice of the methods employed in researching the contraction of the Royal Albert Hospital, Lancaster. The research questions outlined

in the previous chapter were distilled into two overarching, and entwined, methodological challenges: how to reconstruct a past event? How to establish what this event meant for those involved? Firstly the chapter reviews the literature which informed and justified the approaches taken to explore these research avenues. Then it highlights critical elements in the practical application of chosen methodologies for the data collection and analysis carried out in the study.

3.2 Research Theory: Literature Review

This section discusses the literature on qualitative research which shaped the development of the study. Initially an overview is presented, then more specific reviews of case study and microhistory, oral history, multi-voicedness or polyphony, reflexivity, concluding with a consideration of the politics of the research methodology.

3.2.1 Qualitative Enquiry

I used a qualitative research approach to investigate the research topic. Such a model of enquiry hinges upon inductive analysis, a multiplicity of variables or voices, and a focus upon the richness and the depth of topics rather than their representativeness (Merriam 1998 cited in Yow 2005:5; Ziebland 2009). Although some researchers problematise assumed differences between quantitative and qualitative approaches (Silverman 1997; Yow 2005), the latter is perceived as far less controlled than the former which examines 'researcher-controlled answers' (Yow 2005:5). Unregulated data are seen as essential facets of qualitative research (Patton 2002) which embraces, as exemplified by soft systems methodology (Checkland and Scholes 1999), the 'messiness' of both problematic human situations and of the research process (Law 2004).

Qualitative enquiry is viewed as recognising the subjectivity and ambiguity involved in researching complex human contexts. Although subjectivity is prevalent in quantitative methodology, in qualitative enquiry it is *acknowledged* as integral to the investigative process (Yow 2005; Ziebland 2009). Douglas (1976) suggests that:

> Rather than trying to eliminate the subjective effects, the goal must be to try to understand how they are interdependent, how different forms of subjective interaction with the people we are studying affect our conclusions about them (Douglas 1976:25 cited in Yow 2005:7).

This reflexivity on the part of the researcher is therefore seen as a crucial component of qualitative research. On this point the research was sympathetic towards Dey's position in recognising that researchers inevitably bring pre-existing knowledge to the study, suggesting that 'an open mind does not mean an empty head' (Dey 1993). To facilitate an 'open mind' the study adopted the qualitative position that the research was an iterative process, involving ongoing learning and reflection, moving between data collection and analysis, and a fluidity in decision-making about the shape of the research.

Briefly outlined, these tenets of qualitative enquiry are now exemplified with reference to specific research methodologies.

3.2.2 Microhistory and Case Study

Central to the research task was the reconstruction of salient features of the contraction of the Royal Albert Hospital. It was assumed based upon a literature review, discussed in Chapter Two, that this institutional rundown constituted a considerable labyrinthine process. A key methodological challenge was how to embrace such complexity: the multi-perspectives; the inter-relationships between people and organisations both within and without the walls of the asylum; the changing dynamic over time; and the inter-

connectedness with wider socio-economic, historical, political and cultural contexts. Oral history, explained later in the chapter, was chosen as a core methodology to unpick the interactive elements of this organisational change. A broader conceptual *framework*, however, was provided by the traditions of microhistory and case-study.

Microhistory focuses on what could be described as small scale studies (Ginzburg and Tedeschi 1993); classic examples of the genre include a medieval village and a medieval French peasant (Le Roy Ladurie 1980; Davis 1985). Importantly such an approach is not parochial but merely concerned to adjust the scale of analysis, based on:

> the unifying principle of all microhistorical research... that microscopic observation will reveal factors previously unobserved (Levi 2001:101).

These factors, these interpretations could relate to broader contexts, so for instance Levi claims:

> it becomes immediately obvious that even the minutest of actions, say, somebody going to buy a loaf of bread, actually encompasses the far wider system of the whole world's grain markets (Levi 2001:100).

This type of analysis resonates with the 'thick description' of Clifford Geertz, who argued that, 'Historians do not study villages... they study in villages' (Geertz 1973:22). Other researchers have built upon such ideas to set up what they describe as a micro-macro framework for their studies (Thomson 1996; Eaman 2001; Johns 2002). Similar to this study, Johns researched an institution, including its closure, and wanted to understand what occurred on the ground as well as a broader picture. He saw a micro-macro approach as offering

> alternative *perspectives* (for) examining the same phenomenon in different ways (Johns 2002:31).

Importantly this methodological framework allows attention to fall on the dynamic interconnections between wider and more local social forces. These, however, are not two separate entities, because:

> the macro appears no longer as a particular layer of social reality on top of micro-episodes... Rather it is seen to reside within these micro-episodes (Knorr-Cetina and Cicourel 1981:34).

In social history of learning disability research such approaches seem to accord with auto/biographical methods. Atkinson, for instance, emphasises that the individual story is told

> against the social and historical backcloth... Auto/biographical research has the capacity to combine the political document with the historical – to reflect the lives which have been lived, but to see beyond the individuals to a wider view of learning disability (Atkinson 1997:22).

The theoretical underpinnings of a microhistorical tradition, as outlined here, echoed my own research aim of situating an institutional closure within a wider world.

Tensions, however, between the micro and the macro are highlighted in the microhistorical literature and the closely related social scientific area of case study research. A leading proponent of the latter approach, for instance, describes studies in which the researcher is fundamentally interested in the particular case, as '*intrinsic* case study' (Stake 1995; Stake 2005:445). He suggests that the purpose of such research is 'not to come to understand some abstract construct or generic phenomenon' (Stake 2005:445). The focus is on making sense of the particular case, rather than creating theory. Stake contrasts this with an '*instrumental* case study' where:

> a particular case is examined mainly to provide insight into an issue or to redraw a generalisation. The case is of secondary importance (Stake 2005:445).

Nevertheless, he emphasises that an in-depth study is still carried out, but the purpose is ultimately to learn about some 'external interest'. Stake, however, does argue that the two conceptual frameworks of 'intrinsic' and 'instrumental' are not mutually exclusive, and, in practice, the research topic may lie somewhere on a spectrum between the two. This offered a clarification for this research, enabling a focus both on the closing of a particular institution and development of ideas which had a broader resonance in the social history of learning disability. In this case study research there *was likely* to be a tension between the 'instrumental' and 'intrinsic'; and so there was a need to be aware that 'damage' could occur if theory was created at the expense of focussing upon 'features important for understanding the case itself' (Stake 2005:448).

Concern about the micro-macro relationship resonates with microhistorical studies. Burke warns that:

> If the micro-historical movement is to escape the law of diminishing returns, its practitioners will need to say more about the wider culture, and to demonstrate the links between small communities and macrohistorical trends (Burke 1992:43).

In Burke's view the interplay between the micro and macro is integral to the value of microhistory, otherwise it

> might become a kind of escapism, an acceptance of a fragmented world rather than an attempt to make sense of it (Burke 2001:116-7).

Stake on the other hand argues that ultimately learning is shared between the researcher and the reader. In presenting the case the researcher, in the role of teacher, facilitates a process of discovery learning on the part of the reader (Stake 2005:454). The latter makes sense of the case by contextualising with their own experience, including knowledge of other cases and the subject.

Although such sentiments reflect authentic facets of an active dialogue between a researcher and their audience, they constitute a limited perspective. In this study the presumption was that connections with a wider world were intrinsic to understanding the institutional contraction of the Royal Albert. This interplay would add richness to the research and contribute to wider debates concerning deinstitutionalisation. Expression was given to this viewpoint in the research with the consistent contextualising of a broader literature. The relationship between the micro and the macro was a vital component in making the closure programme of the Albert such an interesting and exciting object of study.

3.2.3 Oral History

Oral history's emphasis on the in-depth interview, along with its recognition of the centrality of subjectivity and induction in the research process, means that it complements the qualitative research approaches already discussed. Although specifying the key attributes of oral history is not unproblematic (Yow 2005:3-4), the research drew upon helpful working definitions. Perks, for instance, suggests that in essence:

> Oral history is spoken history: it is the recording of people's unique memories and life stories (Perks 1992:5).

The 'recording' element implies the presence of another, or others. Such a state of affairs enriches and complicates the creation of historical data in that:

> someone else is involved who frames the topics and *inspires*[1] the narrator to begin the act of remembering, jogs memory, and records and presents the narrator's words (Thompson 1988; Yow 2005:4).

Above all oral history, according to one practitioner, can be revelatory in that it:

[1] My emphasis.

> is a powerful, indispensable source; it provides a depth of insight that can rarely be retrieved from other sources. It is unique in offering the opportunity for a subjective reconstruction of past lives (Hareven 1982:382).

Unpicking these brief observations about the nature of oral history provides a useful starting point from which to explain its relevance to the research topic.

One of the primary goals of this study was 'the reconstruction of past lives'; in this instance the lives of those individuals whose experiences constituted the event[2] of institutional contraction. The aim was to 'arrive at an approximate understanding of what happened', accepting that the reconstruction of an event 'in its entirety' is not possible (Yow 2005:21). One oral historian however argues that a vital *peculiarity* of the discipline 'is that it tells us less about events as such than their meaning' (Portelli 1981:99). In Portelli's polyphonic study of a Nazi massacre in Rome, although embracing an ontological position (which resonated with this research) that the 'event... actually happened' his focus was on its multiple meanings (Portelli 2003:15). He was not concerned with 'factual revelations or discoveries' choosing to rely upon 'the scepticism and conclusions of existing scholarship' (Portelli 2003:15). For this study the latter was thin on the ground, as were archival documents, many of which had either been shredded, put in skips or burnt;[3] failing that, material such as case notes of former residents in recent times proved hard to reach because of ethical considerations. In other words, a major historical source for the research was the oral testimony of former stakeholders. The problematic nature of such a position for historical reconstruction is further emphasised by Hareven who claims that:

[2] For the purposes of the research Royal Albert rundown was viewed as a single over-arching event, albeit comprised of a number of smaller 'events'.
[3] Conversation (April 17th 2008) with Phil Morgan, who was a custodian of Royal Albert archives held by the NHS.

> Beyond any doubt, oral history is a record of perceptions; it is *not* a re-creation of historical events (Hareven 1982:377).[4]

Hareven, however, does offer a proviso to the above assertion. She argues that oral history 'can be employed as a factual source only if corroborated', stressing that a historical account relies on 'the necessity of cross-checking information' (Hareven 1982:377). In the same vein Portelli's study relied upon the importance of documentary records 'to establish a problematic but plausible framework of events' (Portelli 2003:16). This regard for other sources was reflected in this study through, as itemised later in the chapter, the use of various policy documents, private correspondence, minutes and importantly the local newspaper. However this triangulation, as discussed below in relation to polyphony, also extended to an internal examination of the oral data. Further assistance in the reconstruction of the Royal Albert rundown was provided by the adoption of a conceptual framework created by Frisch (1979; 1990). The American oral historian coined the phrases 'more history' and 'anti history'[5] to define ways in which oral testimony can contribute to history (Frisch 1979; Frisch 1990). 'More history' relays the possibility that oral data can be used, like a traditional historical source, to enhance and enrich already known aspects of our history. It can

> swing the flashlight of history into a significant, much neglected, and previously unknowable corner of the attic (Frisch 1979:74).

However, Frisch also asserts that people's recorded memories can provide a way 'to communicate with the past more directly' (Frisch 1979:74). This 'anti-history' in the form of authentic first hand accounts, as Rolph and Walmsley demonstrate in learning disability social history, can by-pass and challenge 'the established record' (Rolph and Walmsley 2006:84). These ideas of Frisch, combined with a focus upon the

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[4] My emphasis.
[5] Originally called 'no-history' (Frisch, M. (1979). "Oral history and 'Hard Times': A review essay." The Oral History Review 7: 70-79.)

triangulation of sources, provided a useful oral historical framework for this research study.

Hareven (1982) suggests in her definition that oral history offers a *subjective* historical reconstruction. As oral history has matured into a confident academic discipline it has embraced this subjectivity as a central strength, rather than a problematic historical source (Thomson, Frisch et al. 1994; Portelli 2003). About oral sources, Portelli says:

> They tell us not just what people did, but what they wanted to do, what they believed they were doing, what they now think they did (Portelli 1981:99-100).

Oral historical enquiry perceives memory and the development of historical consciousness as subjects worthy of study in their own right (Bodnar 1989; Grele and Terkel 1991). At the same time Yow (2005) is careful to emphasise that memory has a value as an authentic record of past events. She suggests that, if viewed critically, 'autobiographical or individual memory' can be used 'as evidence' by oral historians (Yow 2005:51). Oral history however deals with 'narratives and memory as historical facts' in themselves (Portelli 2003:16). The approach can do this by differentiating between 'events and narrative, history and memory' (Portelli 2003:16). Bearing these dichotomies in mind, this dual emphasis on sense-making *and* what happened meant that oral history was an approach ideally suited to this research.

3.2.4 Polyphony

A central strand of the research was the gathering, creating and analysing of interview data gleaned from different perspectives. Oral testimony itself, as explained above, was potentially a rich and rewarding approach to assist in fulfilling this task. However, providing a dynamic thrust to data analysis was the adoption of a conceptual framework relating to viewpoints employed by oral historians, and academics from other disciplines (Schrager 1998; Rouverol 2000a; Portelli 2003; Smith and Nicolson 2007; Riessman

2008; Bornat, Henry et al. 2009). They have been inspired by the ideas of Mikhail Bahktin, a Russian literary critic, on *polyphony* or *multi-voicedness* (Bakhtin 1984; Dentith 1995). Drawing upon their commentaries, as well as Bakhtin himself, outlined below are strands of Bakhtin's thinking which were relevant to the research.

Bakhtin emphasises the social context of utterances; what people say, as Riessman explains, contains an 'I – thou', it implies a dialogue with other voices, with other contexts (Riessman 2008:105-107). This narrative-researcher claims that Bakhtin's thinking is the foundation for the dialogic analysis of narratives which, in contrast to the emphasis on 'what' by thematic analysis, the 'how' by structural analysis (as explained later in the chapter), looks at 'who' is speaking, and why and when i.e. the social context of their utterances. As Schrager, and other oral historians have aptly demonstrated, such an approach enables an interpretation of the multi-voices within single interviews, an 'inner dialogue':

> ... far from dealing only with ourselves when we tell about the past, we incorporate the experiences of a multitude of others along with our own; they appear in what we say through our marvellous capacity to express other perspectives (Schrager 1998: 285).

In addition, dialogic analysis enables meanings to emerge by comparing and contrasting viewpoints across interviews, between different narrators (Schrager 1998; Rouverol 2000a; Portelli 2003). Importantly this approach assumes as central the notion of 'dialogue', that what people say has both arisen out of, and relates to real or imagined interaction with social contexts. There is a strong egalitarian ethos underlying this notion of polyphony. Bakhtin, from studying Dostoevsky's *The Brothers Karamazov*, asserts that here is an example of a polyphonic novel, the narrative of which has emerged from a dialogue between characters, all of whom have 'fully valid voices', and have the status of 'subjects', rather than 'objects' of some authorial discourse (Bakhtin

1984; Dostoyevsky 2003). Riessman extends this dialogic idea to include that occurring between teller and listener, as well as writer and reader– the latter dialogue relating to Stake's view that the wider significance of any individual case study is dependent upon the engagement and knowledge of those reading the research (Stake 1995; Riessman 2008).

This polyphonic approach had two broad implications for the research. Firstly, it presented a way of investigating interview, and other, data which did not preclude thematic or structural analysis, and, moreover, connects with notions that lie at the core of oral history analysis – exploring contradictions, gaps, listening to voices, oppositional narratives, with their social contexts and making sense of stories (Thompson 1988; Riessman 2008). Secondly, for research involving a study of a multi-voiced event, it offered ways in which to engage diverse viewpoints within a framework of genuine dialogue, and to hear the different voices. Although approaching a study in this way can generate discomfort on the part of the researcher, polyphony offers the possibility of rich meanings to emerge. This was the case in an oral history study of Linda Lord, a worker in a chicken factory in the USA who lost her job when the plant closed (Rouverol 2000a). Rouverol argues that in attempting to draw together Linda's narrative in some sort of coherent fashion she and her co-author were excluding those voices in Linda's *inner* dilaogue which they, as reseachers, either found uncomfortable or did not agree with. It was only when they opened themselves up to the idea of multivoicedness, giving equal weight to all of Linda's voices, some apparently contradictory, that deeper understandings started to emerge. This polyphonic idea is embodied in Linda's describing her time at Penobscot Poultry as being one when, 'I was content and not content'. In some ways the researchers initially wanted it to be one or the other, whereas they came to realise that Linda embraced both these sentiments, these 'voices', equally and simultaneously; Michael Frisch defined this as a state of

'multivalence' as opposed to ambivalence, implying confusion (Frisch 2000). These insights, and similar ones, enabled the researchers, and Linda it appears, to see how this individual narrative had a resonance with a wider world, in particular touching upon the potentially complex dialogue between 'community' and 'industrialisation'. This approach resonates with the microhistory, case study and auto/biographical methodologies discussed earlier.

3.2.5 Reflexivity

Integral to a qualitative research paradigm, and adopted by this study, is the idea of reflexivity (Fontana 2004; Jootun, McGhee et al. 2009). An interpretation of this concept is that:

> Reflecting on the process of one's research and trying to understand how one's own values and views may influence findings adds credibility to the research and should be part of any method of qualitative enquiry (Jootun, McGhee et al. 2009:42)

Particularly informative for this research were the ways in which this approach has been examined in oral history and inclusive research literature (Gluck and Patai 1991; Walmsley and Johnson 2003; Rolph and Walmsley 2006).

Exploring the subtle way an interviewer's preconceptions can creep into and influence an oral history interview, Walmsley and Rolph (2006) pinpoint examples from each of their respective PhD studies. Their argument is that they held an orthodox viewpoint, in this case that institutional life was bad, which had a detrimental effect on how they heard, or in fact didn't hear, stories from former residents whose memories conflicted with this perspective (Walmsley 1995; Rolph 2000; Rolph and Walmsley 2006). In discussing issues of inclusive research with people with learning difficulties Walmsley and Johnson emphasise the need for reflexivity on the part of researcher, especially an

awareness of the impact that their values and beliefs can have upon research processes and outcomes (Walmsley and Johnson 2003:38-41). An argument for self-reflection is further developed by the authors as a way of increasing awareness of power relationships in a research study. They highlight that,

> part of the underpinning of both feminist and participatory action research (is to) stress the importance of the researcher 'standing with' those involved in the research and of breaking down the barriers between self and others (Walmsley and Johnson 2003:39).

Certainly some other researchers have embraced aspects of this reflective approach. Matthew Godsell and Howard Mitchell in their respective pieces of research into staff working with people with learning difficulties and Sharon Lambert in her study of Irish women emigrating to Lancashire all emphasise some of the positive aspects of being 'insider researchers' when interviewing (Mitchell 1998; Lambert 2001; Godsell 2002). Their positions all gave them easier access than would have been the case if they had been 'outsiders' but equally they all felt that being perceived as someone with shared values (and experiences) assisted in the quality of disclosures from those being interviewed. Godsell's interviews were carried out as Stoke Park Hospital, Bristol, was due to close, a time when:

> many people were anxious about the future and their jobs... In an atmosphere where there was a lot of anxiety and uncertainty it was an advantage to be perceived as an insider. Rather than suppressing my identity the interviews presented an opportunity to exploit it in order to gather more information (Godsell 2002:83).

Similarly, Mitchell claims that part of the 'rapport' that could be created was linked with a sense of solidarity against a world which either devalued or criticised learning disability nursing. As he says, 'People who worked there (Lennox Castle Hospital,

Glasgow) were touchy' (Mitchell 1998:30). However he goes on to explain that this trust had a downside to it, asking himself:

> What did they trust me to do and did I have a duty towards them because they had shown trust and friendliness towards me (Mitchell 1998:30)?

This can be interpreted as a potential issue, only slightly less so for 'outsiders', for all researchers who base much of their approach upon those sorts of sympathetic building blocks. Both of the former nurses, Godsell and Mitchell, highlighted another serious issue in that they felt their relationship with hospital residents was problematic because of their professional status. Godsell suggested that 'it may have had a detrimental effect on some of the residents I encountered' (Godsell 2002:85). Mitchell, being quite confident that he would have been seen 'as a representative of established authority', also implied that this would have influenced what was shared in the interviews. Part of his evidence for this assertion is:

> the fact that the most free and lurid criticism of the hospital and nurses that I recorded was from an ex-patient who did not seem to grasp that I had worked there myself (Mitchell 1998:32-3).

Not everyone, however, is an insider researcher, in the sense discussed above, and sometimes more conscious efforts have to be made to break down barriers between interview partners. Olson and Shopes, for instance, refer to their oral history interviews with working class women, and being aware that:

> as educated, academic women we have been afforded – at least in the eyes of the larger society – higher status, greater access to resources, and consequently more power than the working class women we interview (Olsen and Shopes 1991:193).

However, they made efforts to communicate biographical elements they held in common with the people they interviewed; all this helping in 'equalising the encounter'.

They believe that it was their *attitude* of solidarity with interviewees which was crucial in contributing towards 'a more egalitarian encounter' (Olsen and Shopes 1991). Olsen and Shopes describe how they communicated, to those they were interviewing, their

> own critique of the inequalities present in the larger social and political world that we all inhabit as citizens... At times we and the people we are interviewing become allies in a common critical endeavour (Olsen and Shopes 1991:196).

Such reflections are very similar to the above comments of Johnson and Walmsley in 'standing with' research participants.

3.2.6 Political Issues

In this chapter's preceding discussion there has been an implicit assumption that this research was owned by the researcher. Positioning of this nature is politically contentious and, as Rolph and Walmsley argue, has been challenged in various academic studies (Rolph and Walmsley 2006). Fine, for instance, highlights

> the way in which much qualitative research has continued a discourse of 'colonising the other', speaking for and about those with whom we research (Fine 1998 cited in Walmsley and Johnson 2003:38-41).

There is the view that:

> only people who have the experience of oppression have the right to write about it (Rolph and Walmsley 2006:85).

In the social history of learning disability research such a perspective is strongly held by Simone Aspis who challenges:

> The power relationship between non-disabled researchers and researchers who have been labelled by the education system as having learning difficulties... There are too many different researchers jumping on the bandwagon of learning disability research which includes providing their own

interpretations and solutions to our individual and collective experiences (Aspis 2000:2-3).

She goes on to argue that people with learning difficulties 'are being used as puppets' (Aspis 2000:3). Entwined with such a stance is the one, also deriving from the advocacy movement of the last 20 years or so, that the only, or certainly dominant, voices heard in learning disability history should be those of people with learning difficulties themselves (Walmsley and Atkinson 2000). The themes relayed here can be related to *both* the content and the process of research into the social history of learning disability. The latter is as much about whose voice dominates in the historical endeavour, as to whose voice is heard in its products.

Non-learning disabled researchers, as I am myself, have responded to some of the above issues, warning of the dangers of 'one-sided history' (Walmsley and Atkinson 2000). Mark Jackson also emphasised that 'the history of learning disability is not solely about people with learning disabilities.' Because it involves the lives of others 'it is a shared history' (Jackson 2000:xii). This was the case in my research which, like Rolph's study of hostels, had to take account of 'multiple discourses and constructions, the official view as well as the personal experience' (Rolph 2000:58). This is consistent with a postmodernist influenced perspective which questions the notion of 'over-arching truths' (Williams 1996:63) and propounds that 'the sum of voices will reflect more accurately the past in all its myriad ways' (Jenkins 1997:207; Rolph 2000). However, the danger in this is that the voices of the people with learning difficulties are underplayed and the official version once again dominates (Rolph 2000:75). Such a sentiment was a pertinent warning for this institutional oral history which was heavily weighted towards respondents who were *not* people with learning difficulties. Furthermore, the data collection and analysis process was firmly in the researcher's hands; it was neither inclusive research nor one embracing 'a shared authority' between

researcher and narrator (Frisch 1990; Walmsley and Johnson 2003). The research did not focus upon ownership issues but upon *whose voices* were heard in the closure of one long-stay institution for people with learning difficulties (Rolph and Walmsley 2006:98). A polyphony of former managers and staff, hitherto under-researched, enabled insights into the complexities and multiple-meanings of learning disability policy implementation.

3.3 Research Practice: Data Collection and Analysis

3.3.1 The Case Study

The case study was the late twentieth century contraction of the Royal Albert Hospital, Lancaster, a large long-stay institution for people with learning difficulties. As discussed in Chapter One, this choice reflected a personal interest. In this sense the research topic could be described, in line with a discussion earlier in the chapter, as an *intrinsic* case study (Stake 1995). Connections with the place represented a degree of insider knowledge which it was anticipated, quite correctly, would assist in identifying and accessing potential interviewees. Similar to Johnson, however, in her study of a locked ward in an Australian institution, this research focus also aimed to have an *instrumental* value (Stake 1995; Johnson 1998). In other words, research into the rundown of the Royal Albert had a potential resonance beyond the confines of any esoteric interest. As highlighted in the previous chapter, there are contested interpretations as to how NHS long-stay hospitals for people with learning difficulties contracted in the later part of the twentieth century. The UK picture of institutional closure appeared to be patchy; local case studies, such as this one, could assist therefore in creating a fuller picture of the implementation of deinstitutionalisation policies. The Royal Albert Hospital was of particular interest because it was run by the North West Regional Health Authority (NWRHA) which prided itself on being progressive in pursuing a policy of deinstitutionalisation (Wertheimer, Ineichen et al. 1985; Walker, Ryan et al. 1993). An

in-depth study of one north west institution promised important insights into the mechanics and meanings of institutional closure within a policy environment imbued with the powerful community care rhetoric of the time.

3.3.2 Archival Material

In addition to recording research interviews, in a limited way the study drew upon an existing archive of Royal Albert oral histories (Ingham 2006). I had previously recorded life histories, for instance, with four of the research participants. These interview data offered important contextual insights into the multiple personal meanings of Royal Albert contraction. There is a wide ranging debate about re-visiting data in oral history and social scientific research (Bornat 2003; Moore 2007). However, like Bornat (2003), the material used had been deposited in a public archive. Moreover, most of it was from earlier interviews with research participants, and importantly these and any other oral recordings were of interviews involving myself.

There was, as stated already in this chapter, a paucity of documentary material. However, it was possible to access a selection of documents for triangulation purposes, to provide 'more history' (Frisch 1979), and to help with the construction of a 'plausible framework of events' (Portelli 2003:16). In terms of the latter, they assisted with the charting of the sequences of hospital contraction – oral sources are notoriously unreliable for establishing dates. The core *public* documentary source was the weekly published local newspaper, the Lancaster Guardian: all the copies of this paper contained on micro-film, in the Lancaster Public Library, covering 1984 to 1996. In addition *private* individuals, some of them interviewees, lent copies of regional and hospital policy documents, internal reports, training materials, and the archive of the Royal Albert Hospital League of Friends (RAHLOF). The latter contained minutes and correspondence for this relatives' group and proved to be a rich source of data. Sadly,

from a historical perspective, I was told on numerous occasions that material had been discarded. As with the oral testimonies, these documentary data were scrutinised critically and contextually, and triangulated both with each other and the recordings of interview participants.

3.3.3 Interview Participants

The principles of purposeful, or purposive, sampling underpinned the choice of interviewees (Stake 1995; Patton 2002). As one analyst argues:

> The idea behind qualitative research is to purposefully select participants (who)... will best help the reseachers understand the problem and the research question (Creswell 2003:185).

In other words the interviewees were chosen because they each offered an 'opportunity to learn' about the research topic (Stake 1995:451). The latter required an interview sample which: represented multiple-perspectives on Royal Albert contraction, by virtue of role and/or attitude towards the event; and allowed for flexibility of selection as the study developed.

A core element of the study was the reconstruction of an event. Given the paucity of written accounts, the starting point therefore was to contact key informants who could provide an overview of the contraction of the Royal Albert. Early in the research interviews were carried out with members of senior and middle management, as well as a senior figure at the Regional Health Authority. My own insider knowledge, as well as other names provided by interviewees aided identification and access to these initial contacts (Patton 2002). These interviews assisted in drawing up a schema of potential perspectives on the rundown of the hospital.

However, and pertinently for the study, these early research interviews with managers provided insights into how those implementing change *narrated* their experience. These narratives both extolled the virtues of the closure programme of the Royal Albert, and at the same time highlighted and distanced themselves from oppositional voices. Similar to Adams' study (2009:71), the research was in danger of producing a homogenous selection of participants. So within the overarching research remit of engaging with a multiplicity of viewpoints, based predominantly upon role, I sought out those who may have held alternative perspectives to the one I was hearing (Adams 2009). The potential identities of such individuals were provided by the managerial interviews themselves, Royal Albert archival oral testimonies, and research documentary data. A mixture of further word-of-mouth contacts, personal acquaintances, and, on one or two occasions, cold calling then enriched the sample in terms of multiple viewpoints. Those interviewed, however, from whatever background, were individuals who had long standing involvement either in the Royal Albert itself, the contraction process, the NHS or learning disability services. *All* research participants (charted in Table 1) revealed a high level of emotional investment in their relationship to different facets of Royal Albert contraction.

3.3.4 Interview Processes

This section reviews the logistics, ethics and subjectivities of interview processes adopted and encountered during the research.

3.3.4.1 Interview Logistics

Thirty semi-structured in-depth interviews, all with differing degrees of life history content, were at the heart of the research (Yow 2005). These encounters were recorded on audio mini-disc and lasted between just under an hour to three hours. Information was also gathered in a more peripheral manner through a number of

Table 1: Research Sample of Oral History Interviewees[6]

Residents

Two women (anonymised) were interviewed.

Senior Management

David Jordison *(General Manager/Chief Executive of Priority Services Trust)*
Geoff Hopkinson *(Divisional Director of Nursing Services/General Manager)*
Phil Morgan *(Senior Nursing Officer/Acting General Manager)*

Middle Management

Steve Mee *(Nursing Process Co-ordinator/Resettlement Officer)*
Dave Spencer *(Resettlement Officer)*
Mary Lawrenson *(Nursing Officer)*

Staff: Nursing

Tony Dennison *(Charge Nurse)*
Malcolm Alston *(Charge Nurse/Manager of Independence Training Unit)*
Eric R. *(Staff/Charge Nurse)*
Mrs. Creed *(Staff Nurse)*
Anonymous 1 *(Nursing Officer - Male)*
Anonymous 2 *(Charge Nurse)*
Anonymous 3 *(Ward Manager - Male)*

Staff: Non-Nursing

Mr. S. Webb *(Chief Engineer)*
Brian Illingworth *(Porter)*
Jimmy Downham *(Painter and Decorator)*

Other Staff

Dr. Prasad *(Clinical Psychiatrist)*
Gudrun O'Hara *(Social Worker)*
Bernadette Hobson *(Clinical Psychology Administrator/Voluntary Services Co-ordinator)*
Bob Dewhirst *(Head of Learning Disability Nursing)*

Trade Union Representatives

M.J. Kiernan *(NHS Lancaster - Branch Secretary of NUPE/Joint Shop Stewards Committee Secretary)*
Nikki Riley *(COHSE Royal Albert Shop Steward)*

Non–Royal Albert Personnel

Mrs. Ann M. Wilson *(Secretary of RAHLOF/former RAH Deputy Administrator)*
Jenny Dunkeld *(Officer-in-Charge Riverview Hostel, Lancaster/former RAH Sister)*
Paul Whitfield *(Chief Executive of Lancaster Health Authority)*
Tom McLean *(NWRHA Advisor/Divisional Nursing Officer of Calderstones Hospital)*
Gordon Greenshields *(NWRHA Chief Executive/NHS Finance Director)*

[6] See: Appendix I for abbreviations; and Appendix ii for more detailed biographical and professional information.

informal conversations, whether on the telephone or face-to-face. Interviews occurred mainly in the homes of interviewees, others taking place in offices and a day centre, as well as my own home. Deciding upon the appropriate venue was the prerogative of the interviewee. This process, however, may have been compromised in relationship to the two research participants with learning difficulties, where arrangements were mediated through a third party gatekeeper. All but two of the interviews were locally based, occurring either in Lancaster or within a five to ten mile radius.

Interviewees were usually contacted by telephone, or occasionally via email. This initial contact allowed me to explain the purpose of the interview and the research. Sometimes, if a fuller explanation was needed, I sent them an information sheet.[7] However, as the research developed I became aware that this could prejudice the interview through creating prior expectations. It seemed, for instance, that one individual had rejected the opportunity of a recorded interview because of the emphasis on closure. His perspective, as with some others, was upon the Royal Albert itself not its rundown, which was resented. Also important was how respondents viewed the 'later years'; too much information regarding how I saw this period again may have prejudiced what was recounted. Therefore the information sheet was used in a more circumspect manner than originally planned, supplemented by discussion of aspects of the research at the time of the interview.

The aim of the oral history approach was to encourage respondents to tell their own stories, as far as this was possible given the collaborative nature of interview data creation (Gluck and Patai 1991). Often interviewees needed little encouragement, launching into their memories before there was time to set up the recording equipment. Stock interview questions, of which there were about six or seven, were open-ended,

[7] See Appendix vi.

designed to elicit the perspective and memories of the teller.[8] Additionally, in preparation for each interview consideration was given to the *individual* respondent (Bornat 2003). This meant distilling any information about either the particular person or their circumstances. In some instances this process of individual preparation resulted in one or two specific questions, or merely, as with the general questions, a number of personal reference points jotted down on an index card. This approach is based upon previous experience as a community oral historian. Invariably in the research interviews little reference was made to the notes, but the work beforehand helped orientate the focus on the individual being interviewed. It was an important precursor to the rapport essential for a rich, in-depth interview (Yow 2005).

At the end of the interview respondents were provided with the opportunity to engage in a consent procedure. The pro-forma used offered individuals a range of choices as to how their data were to be used.[9] Four of the narrators used the clearance form to specify their desire for discretion with regard to names of people they had mentioned. Also, in two instances interviewees stressed their wish for any critical comments, if used, to be contextualised. Three individuals wanted to view the transcript prior to completing a clearance form. Furthermore, expressed verbally or in writing, a number of people indicated that they desired total or partial anonymity.[10]

Complex and nuanced ethical issues regarding interviewing are prevalent in oral history, research into the social history of learning disability and qualitative research generally (Thomson, Frisch et al. 1994; Rolph 1998; Yow 2005; Tilley and Woodthorpe 2011). Although it is beyond the scope of this chapter, or thesis, to discuss this topic in any great depth, concerns regarding informed consent, anonymity and general

[8] See Appendix v.
[9] See Appendix vii.
[10] See Table 1.

sensitivities around the analysis and dissemination of data were integral to the research. The study was primarily guided by the need to embrace the specificity of the topic, to provide transparent evidence-based research, and to respect the wishes of those participants who wanted their names used (Tilley and Woodthorpe 2011). However, even if the latter was the case, this still posed dilemmas for myself as a researcher. The study, for instance, critiques stances passionately held by some of those interviewed; individuals, or sources, with whom I 'have personal relationships' (Thomson et al 1994: 35). Also I chose to anonymise extracts from interviews where I believed, taken out of context, the analysis may be construed as personally detrimental to the teller. Overall, however, as discussed earlier, the research process did not embrace 'a shared authority' (Frisch 1990). Interviewees were not given the option of either hearing, or participating to any degree in the analysis of their oral historical accounts. Although not water-tight (Thomson et al 1994), such circumstances would have provided the opportunity for research participants to make better informed choices about the use of their names. Ultimately much of the ethical discretion, albeit engendering a degree of discomfort, resided with myself as the researcher. The clearance procedure highlighted here, in combination with ongoing reflexivity, a rigorous iterative approach to interview data, and discussions with peers and supervisors were all employed to ensure that, as far as possible, exacting standards of ethical research practice were upheld.

3.3.4.2 Interview Subjectivities and Reflexivity

As discussed earlier, the principle of the researcher 'standing with' those interviewed can constitute a central feature of qualitative research. This implication of solidarity resonates with a dominating ethos of much oral history work which:

> has often been linked to grassroots and progressive politics, and to the democratic impulse to 'give voice' to historical subjects marginalised, oppressed

or forgotten by traditional documentary history (Thompson 1988; Hamilton 2008:35; Perks 2010).

Such a spirit reflected my own personal and professional background, which was embedded in a *self-defined* radical identity. Integral to the latter has been a commitment to oral history as an advocating and liberating force for people with learning difficulties, and others, who have so often been the objects rather than subjects of political and historical narratives. Similar to some of the commentators already quoted, such positioning on my behalf was reinforced by interviewing and working *directly* with the least powerful sections of society (Ingham 1997; Ingham 2003). From the onset, however, and in its development this PhD research severely challenged my radical 'comfort zone' (Hamilton 2008; Perks 2010). Potentially it appeared to require me as a researcher to 'stand with' managers, arguably the institutional 'elite' (Hoffman 1976; Harris, Kelly et al. 2008; Adams 2009). Traditionally, and I am deeply rooted in this tradition, barring the odd exceptions, British oral historians have been averse to researching 'history from above' (Berridge 2010; Perks 2010). However, interviewing 'the powerful' as one researcher asserts does not mean taking their side (Berridge 2010:98). Similarly, in terms of my own unease, a commitment to a polyphonic account of closure brought me into contact with members of staff with whom I had strong conflicting ideological and political viewpoints. Hamilton (2008) suggests that in these situations it is crucial to separate the idea of empathy, critical for a 'good' interview, from that of solidarity. The latter she suggests is about political analysis and action while:

> establishing empathy in an interview does not imply support for the narrator's political position. To the contrary the ethical interview may depend upon a willingness to distinguish between empathy and solidarity, and to allow emotional discomfort to lead to a questioning of political pieties, both those of narrator and of the interviewer (Hamilton 2008:42).

This position demands a high degree of sensitivity, and reflexivity, on the part of the researcher. However like Berridge, with elite interviews, it is emphasising an awareness of political, ideological and professional boundaries.

With reference to the reflexive areas touched upon above, the focus now shifts to look more closely at how these issues played out in this study. Predicated upon the belief that an oral history interview is a *collaborative* venture between the teller and the interviewer (Thompson 1988; Bornat 2003), three facets of the research interview process were brought into sharp relief: relationships with 'like-minded' narrators; empathy with oppositional perspectives; and interviewing managers. These are now considered in turn.

Interviewing 'like-minded' people

One of the interviewees, in describing the fervent atmosphere of change at the Royal Albert during the 1980s, recalled that:

> *we somehow had a group of like-minded people who were together at the same time.*[11]

With at least four of the respondents I sensed that I was included as one of these 'like-minded people'. This was not an unproblematic position. In his institutional oral history, for instance, Adams implies that because of a degree of insider status

> it was necessary to maintain *constant vigilance* in order to preserve an appropriate sense of emotional distance from my topic (Adams 2009:77).[12]

Underpinning this stance was a concern that he would collude in a hospital history, similar to others elsewhere carried out by former staff, which emphasised 'the positive aspects of the regime' (Adams 2009:77). Adams, similar to Godsell and Mitchell (mentioned earlier), was a former member of health care staff. Although not falling into

[11] Mary Lawrenson, Interview September 9th 2009.
[12] My emphasis.

this professional category, my background is in adult education and oral history work with people with learning difficulties, including those associated with the Royal Albert. Part of this involvement, at different times (including the 1980s), had meant collaborating *directly* with two key interviewees[13] in promoting reminiscence work as a tool for advocacy (Bornat 1989; Walmsley and Atkinson 2000). Based on the work itself, and informal discussions over a number of years, the over-riding impression was that *we*, myself and these other professionals were on 'the same side' (Berridge 2010). In essence, this 'side' encompassed a viewpoint critical of institutions and the medical model, but which at the same time espoused the rights of people with learning difficulties. Unlike Adams, the danger for the researcher here was collusion in a narrative eulogising regime change, rather than the regime itself. The 'constant vigilance' required that the researcher did not 'go native' (Berridge 2010:97). In her discussion of related issues in interviewing policy makers, Berridge argues that historians have a different agenda. The former she asserts can see 'matters only in terms of taking sides.' A historian on the other hand needs to 'withdraw into objectivity' (Berridge 2010:97). These comments had a powerful resonance to this study.

The presumed solidarity with these 'like-minded' interviewees was experienced in myriad nuanced ways. In one interview, for instance, the narrator recalled his early memories of a mutual acquaintance (another research participant):

> *The place he came to was Bungalow One. I was the staff nurse at the time...* And we had the kind of conversations that you and I are having now, *from day one. What is this place? What's going on here? What's this all about? What's going to happen in the future?*[14]

In a narration which emphasised active involvement in the deinstitutionalisation agendas of the day, this extract positioned myself as a researcher, the interview, and

[13] Dave Spencer and Steve Mee.
[14] Eric R., Interview August 11th 2009. My emphasis.

the past in a continuum of solidarity. Trust in my discretion was exercised by another narrator. In an impassioned interview teeming with names of individuals, including family members, the teller was adamant that she did not want any names to appear in published form. Other interviewees were more circumspect about the use of names. A number of those I interviewed at the time of the research were occupying 'elite' positions in learning disability services, and agreed to be interviewed during their working day. However, although, given their busy schedules, arranging an interview often took a little time, when we did meet time was not an issue. One individual arrived at my house in the morning and told me he had 'all day'. Another, a senior manager, was insistent she had all morning, and during the interview when I checked how we were for time, she insisted that we continue. These interviews, as did another, lasted for up to three hours and proved to be extremely rich sources of data. In all these instances the generosity regarding time was completely unexpected; in pre-interview arrangements the explicit agreement was that they may last an hour at the most. Such experiences ran counter to one or two of those experienced by other researchers (Harris, Kelly et al. 2008; Adams 2009). I did wonder whether such magnanimity would have been afforded a researcher viewed as unsympathetic to 'the cause'. These narrators shared tales of earlier collusion in the institutional regime, mistakes they had made, as well as, at times, revelations about their lack of expertise in certain areas. Again I reflected as to whether this indicated a degree of trust in my discretion borne out of a notion of solidarity. Furthermore, as highlighted earlier, like an *insider* researcher I asked myself if the generosity of time and spirit carried expectations of the account I was to deliver of those years of intensely felt change (Mitchell 1998).

Interviewing 'non-like-minded' people

As already discussed, the study actively sought out, and wanted to hear, viewpoints which ran counter to those enthusiastically implementing changes linked to

deinstitutionalisation. However, such a research agenda posed challenges. Encountered in the research were individuals who were steeped in discourses of learning disability with which I did not agree. There was a resonance with the question articulated by Hamilton:

> What happens when the narrator is not an 'ideological hero', and is instead someone whose political views the interviewer does not share (Hamilton 2008:36)?

Tellers, for example, used medical terminology to describe people in their care, as well as the institutional language of 'higher' and 'lower grade'. In one instance, moreover, based on a number of testimonies of former staff and residents, I was reasonably sure that a former nurse (anonymised) had physically and verbally abused people with learning difficulties. These interviews generated a degree of discomfort on my part as a researcher. An important underpinning to this disquiet was a presumption that during the 1980s, I would have dismissed some of these individuals as 'fearful reactionaries' with myself firmly positioned in the 'righteous reformer' camp (Gleeson 2010).[15]

However, for the purposes of the study, and what Hamilton (2008) describes as an 'ethical history', it was important to hear these voices and confront any unease. Although there was a qualitative difference between some of this study's respondents and the narrators described by Blee (1993) and Hamilton, their concerns echoed with this research. Part of the issue was the need for rapport, and establishing an empathetic relationship in an interview (Bornat 2003; Yow 2005). Blee in her interviews with members of the racist Klu Klux Klan suggested that she found this surprisingly 'easy to achieve' (Blee 1993:605). At the same time she felt that this was 'fraudulent'; based as it was on non-disclosure of her own far more liberal perspectives. Similarly, in my interviews, when I encountered the sort of institutional views described above, the

[15] See Chapter Two.

priority was to propel the interview along (Blee 1993; Hamilton 2008) rather than being adversarial; historical needs were paramount. I wanted to gather and understand 'interesting research material' (Hamilton 2008:37). In fact on one occasion (and it did only happen once) I inadvertently used the term 'high grade', reflecting the language of my narrator, in an attempt to draw out a point. Both Blee and Hamilton emphasise that although they encountered viewpoints with which they disagreed, nevertheless they could not help liking some of the people they interviewed. Additionally, and important from a research perspective, by embracing their own discomfort and temporarily abandoning their own political posturing, a complex history started to emerge (Blee 1993; Hamilton 2008). Blee observes that:

> Oral histories of Klan women reveal that many held complicated attitudes towards gender, race, economics and nationalism, attitudes that did not fit traditional political categories, such as reactionary or progressive (Blee 1993:600).

My research experience echoed such complexity with regard to one or two interviewees. Although Blee warns about being 'deceived' by the narrator's subjective presentation, I found, like Hamilton, it was more complicated than that. Seven of the interviewees in particular, although holding certain viewpoints contrary to my own, conveyed *believable* narratives of human endeavour and caring. There were occasions when I was 'deeply moved' by the interviewee's account (Hamilton 2008:38). Their narratives, moreover, challenged the dominating viewpoints, including that held by this researcher, on institutional closure. By choosing to interview 'non like-minded people' the research invited the possibility of a richer level of understanding.

Interviews with senior personnel

Nine individuals were interviewed who had held key middle and senior management positions, both at the Royal Albert and at a district, regional and national level in the

NHS, during the period of study. Whether at the micro-institutional level or further afield these individuals could be described as 'powerful (in terms of position, knowledge and influence)' with 'considerable authority' (Harris, Kelly et al. 2008:237). Furthermore, at the time of interview although four had retired, at least two had assumed greater managerial responsibilities in regional learning disability services. Overall within the context of the study this interview sample could be construed as comprising *elite* members (Hoffman 1976; Harris, Kelly et al. 2008; Adams 2009). Some researchers suggest that elite interviews have characteristics different to the more traditional oral history, and social scientific, encounters (Harris, Kelly et al. 2008; Adams 2009; Berridge 2010). This assertion had a qualified resonance with the experience of this research.

In order to tap into the knowledge, the insights and narratives of senior personnel, like Adams this study adopted the default setting of 'an interested but essentially naïve researcher' (Adams 2009:78). This provided data-rich initial interviews. However, the most senior Royal Albert managers were re-interviewed in order to gather contextual life history data and to explore one or two questions which had emerged as the research developed. In these interviews research findings were used to probe a little deeper, provoking slightly defensive responses, which were revealing in themselves. Based on her research into health policy makers, Berridge intimates that 'elite interviewees':

> can be too well read, too knowledgeable and too canny, I would suspect that this is less the case for 'history from below' (Berridge 2010:94).

In this research this canniness was evident with one individual who had stories about people with learning difficulties at the Royal Albert which politically could be misconstrued. These were deliberately shared off-tape, because of concerns that they could be used to support a less than progressive learning disability discourse. I

experienced a wariness on the part of another narrator who was concerned as to how the interview data might be used. The roots of this anxiety, again spoken off-tape, lay in the fact that this individual had dismissed people in the past and they would be 'out to get me'. In both the instances cited here there was an acute awareness of a public dimension to the interview encounters. Berridge also intimates that the status of the *interviewer* is important in these sorts of interviews. Although difficult to be unequivocal about this, I felt that being a PhD researcher provided authority. This contrasted greatly with a previous life as a community oral historian in the voluntary sector. In one of the interviews, for instance, the respondent seemed concerned to illuminate all his academic achievements, including the possibility that 'like me' he could have gone on to do a PhD. However, one of the surprises these interviews threw up was the notion of those who were in power being vulnerable. Two of the respondents presented essentially tragic narratives which included themselves as victims, while another couple of senior figures emphasised stories of resistance to those above them. Finally, similar to most interviews I have conducted over the years, regardless of past or present status the respondents seemed very willing to talk, and were pleasantly surprised as to how much they recalled.

3.3.5 Data Analysis

To interpret the study data analytical tools were chosen which enabled the generation of ideas, the teasing out of the meanings in stories, the identification of emergent themes, an openness to surprises, and making sense of the complex human interactions endemic in the organisational change of the Royal Albert contraction. In addition, and already touched upon, I aimed to be a reflexive researcher. More specifically these elements, encompassed within a micro-macro framework, translated into an oral historical approach aided and abetted by a mixture of dialogic, narrative and thematic analysis. These complementary qualitative research methods enabled a

rigorous interrogation of the research data, both oral and documentary. Here I *outline* salient features of this process.

A core interpretative act of the research was to turn the oral history recording, the source data, into a transcription (Portelli 1981; Adams 2009). There are debates regarding the degree to which the researcher attempts to include all the pauses and hesitations of speech into the written document (Perks and Thomson 2006). Although one or two transcriptions were fuller versions than others, ultimately I adopted Portelli's (1981) perspective that they were always going to be imperfect representations of the spoken word; so the main criteria became readability. However, the link with the raw oral data was maintained by using a computer software package called Transana which enables a researcher to use the transcript to locate easily any point in the original recording. This digital tool proved invaluable in the retrieval of tellers' actual voices.

The research's oral history approach, as discussed earlier in the chapter, involved the use of triangulation as well as a dialogic analysis of data. The latter was complemented by the use of thematic and narrative (or structural) analysis. Thematic analysis, or grounded theory, was used in a partial way in the study, as a way of identifying themes in order to develop ideas which have 'the ability to predict or explain' (Glaser and Strauss 1999; Oreszczyn 1999:44; Rolph 2000; Charmaz 2006; Ziebland 2009). This approach was used in the spirit exemplified by one researcher in her study, who suggests that the 'process was a *creative* rather than simply a mechanical one allowing for many links to be made and further categories to emerge' (Rolph 2000:140). Combined with dialogic analysis, a thematic approach was particularly useful when analysing data, both oral and written, pertaining to the respective viewpoints of implementers and resisters of institutional contraction.[16] Such a process, and others

[16] See Chapters Five and Seven.

carried out in the research, were assisted by the use of the qualitative data analysis software package Hyper Research[17] which facilitated both coding and retrieval of data.

However there is a danger in thematic analysis that data are fractured. On this point Riessman quotes Charmaz, an advocate of grounded theory:

> We take segments of data apart, name them in concise terms, and propose an analytical handle to develop abstract ideas for interpreting each segment of data (Charmaz 2006; Riessman 2008:74).

In contrast, narrative analysts 'attempt to keep the story intact for interpretive purposes' and 'strive to preserve sequence and the wealth of detail preserved in long sequences' (Riessman 2008:74; Andrews, Squire et al. 2009). Crucially, for the research, as already discussed, narratives constituted an essential ingredient of oral historical testimonies. Pertinently, organisational studies are increasingly using narrative research to understand the life of organisations (Gabriel 2000; Reissner 2004; Reissner 2010). Narratives are viewed as a way of making sense of experience (Gabriel 2000). They provide insights into both meanings and events. Gabriel's insights in this field, involving his theories regarding the poetics of narrative creation, were particularly helpful for the development of the analysis of research data (Gabriel 2000).

The analytical tools highlighted here were used in a complementary and iterative manner. Initially former senior and middle managerial interview data were interrogated to enable an overview of the chronology of hospital rundown. Coding of these in-depth interviews also provided insights into their subjectivities. Themes of pride, idealism, conflict, risk-taking and ethical certitude, for instance, emerged from an embryonic application of a thematic approach. Much of the richness of these testimonies, however, was embedded in stories, infused with the way tellers voiced other people. Thematic

[17] http://www.researchware.com

coding failed to embrace adequately these twin elements of voice and narrative. These analytical limitations were re-inforced as further interviews were carried out with those critical of deinstitutionalisation. However, as the oral historical data were analysed, hand-in-hand with field work, the ideas of Bakhtin regarding polyphonic analysis became relevant (Bornat et al 2009; Smith 2009). Employing the notion of inner, and external dialogues, provided a dynamic thrust to the research analysis; dialogic analysis offered a way at looking at the relationships between voices. Doing this brought out the ethical content of the interview data, which was aided by an understanding of organisational narratives. Particularly helpful was the research of Gabriel (2000), especially his schema of classical narrative modes employed by members of organisations to make sense of their experience. Overall, this research process, although presented here in a linear fashion, was 'messy' and during the later stages of analysis encompassed the thematic, dialogic and narrative approaches in an iterative manner as the evidence was continually revisited. This analytical cocktail, as the thesis chapters reveal, enabled the richness of the contraction of the Royal Albert and its multiplicity of meanings to emerge from the oral and documentary data.

3.4 Conclusion

Explicated in this chapter have been the key facets of the qualitative approach employed in this research. Mirroring the complexity of the research topic itself, the methods chosen embraced an intricate web of relationships between researcher and researched, past and present, multiple viewpoints, event and meaning, as well as the micro and macro. These relationships were challenging, and, at times, uncomfortable but also intensely rewarding. Integral to the latter were the discoveries made during the course of the research; these findings are set out in the subsequent chapters of the thesis.

CHAPTER FOUR

PRESSURES OF CHANGE

4.1 Introduction

This is the first of the findings chapters. It addresses a key research question, posed in Chapter Two, which asked:

What were the external pressures shaping the rundown of the Royal Albert Hospital, Lancaster in the late twentieth century?

In reflecting upon the contraction of long-stay institutions in the north west, Gordon Greenshields, the first General Manager in 1984 of the North West Regional Health Authority (NWRHA), observed that:

> *There was a lot of pressure to make it (closure) happen, and it was a lot more difficult than people actually realised at the centre. It was more difficult than I realised. I think the guys at the sharp end probably were cursing everybody all the way up to the top. And I wouldn't blame them. You know the further you are from the sharp end the less you actually realise and I think you've got to understand that it's never as simple as you think it is.*[1]

This chapter explores the contraction of the Royal Albert in terms of this externally imposed 'pressure'. This was applied by what can be described as a 'change agency'. The latter is defined here as an 'external' organisation (Rogers 2003:27) having 'sufficient power over the system (or organisation[2]) to cause it to cease to exist' (Checkland and Scholes 1999). The core change agency in the case of the Royal Albert was the NWRHA, 'the centre', which was accountable to the Department of Health, and crucially was the employer of all the institutional staff. However on occasion, as discussed later in the chapter, bodies including the National Development Team, General Nursing Council and others could also be construed as change agencies.

The impact of these outside bodies upon Royal Albert rundown, it is argued in this chapter, can be distilled into dual competing agendas relating to 'cost' on the one hand and 'individual need' on the other. The former emphasised the primary role of organisational finance, logistics, and bureaucracy; while at the nub of the latter was concern for people with learning difficulties, with staff need constituting a secondary consideration. Such a dichotomy mirrored, as discussed in Chapter Two, tensions which existed nationally. Examination of the imperatives outlined here is based upon

[1] Gordon Greenshields, Interview December 16th 2009.
[2] My addition in parentheses.

data analysis of a combination of oral and documentary evidence. In particular, the perspective of former members of hospital management was instrumental to the formulation of a coherent research narrative.

4.2 Conflicting Pressures

The *tension* between pressures of 'cost' and 'needs' was evident, both implicitly and explicitly, in the oral testimonies of Royal Albert senior and middle management. The most senior figure in the institution during the contraction period was David Jordison. In 1986 he was appointed by the District Health Authority, as Unit General Manager. His arrival reflected the Griffiths Report of 1983, discussed in Chapter Two, and heralded the break with tripartite consensus management at the Royal Albert (Griffiths 1983; Harrison 1994). According to Jordison he was issued with a very clear remit:

> *My job description was... to resettle the residents of the Royal Albert Hospital and to close it. And my contract said I'd got three years to do it in.*[3]

Research data indicated that the twin priorities of resettlement and closure, highlighted here, were inextricably linked by financing considerations. A point developed later in the chapter, such a symbiotic relationship was suggested by another of the hospital senior managers, who asserted that:

> *(the Regional Health Authority) had this very simple equation that if money was transferred from the hospitals at a fast enough rate then they would have enough money to be able to fund community care as it was developing.*[4]

This managerial perspective is re-inforced by reference to a 1985 NWRHA policy document, which stated that:

> Provision of services for mentally handicapped people within the community is the statutory responsibility of local authorities... Given the present financial difficulties with which many local authorities are faced, the speed of provision of

[3] David Jordison, Interview February 15th 2008. My emphasis.
[4] Geoff Hopkinson, Interview May 1st 2008.

> care will be dependent on the speed with which the NHS is able to make available sufficient funds related to the number of residents to be discharged from hospital (NWRHA 1985:10).

Making 'available sufficient funds' was dependent upon the closure of wards as the Royal Albert contracted. It was in this arena that elements of the tension in the closure process are thrown into stark relief. Phil Morgan, for instance, who was responsible for implementing the gradual contraction of the institution's wards, asserted that he and his management colleagues had to:

> *be very mindful that at the centre of everything that we were doing were the clients, not us as the service.*[5]

At the same time his testimony highlighted decision-making predicated on whether hospital wards could be maintained as 'viable units of accommodation'.[6] David Jordison, in a frank recollection, pinpointed anomalies in implementing resettlement for all, based on individual need rather than cost:

> *The ward closure order... had to be based on the needs of the people that lived in it (the ward) ...but I have to say the people with the greatest needs tended to be the ones most difficult to resettle, and judging from what I've just said that shouldn't have been the case should it really? But it just took longer and there were so many blocks out there, and social services would be arguing they needed much more money to support them.*[7]

It was the testimony of a former middle manager who illuminated how these conflicting pressures of political economy and individual need were experienced at the cutting edge of resettlement implementation. Dave Spencer recognised that:

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[5] Phil Morgan, Interview March 20th 2008. My emphasis.
[6] Phil Morgan. Ibid.
[7] David Jordison, Interview June 12th 2009.

... there was this organisational logistical difficulty of, 'We have to close this ward'. There comes a point where you can only move so many people off a ward without it having any impact on staffing levels or anything else. Eventually financially it just doesn't stack up at all, so there does have to be some planning - 'Well let's concentrate on these wards.' And that was rubbing-up against this, 'We are doing it around individuals and who is most ready to go and friendships and compatible groupings and all that kind of stuff.' [8]

He then suggested, however, ways in which these conflicting agendas 'rubbing-up' against each other could translate into a challenging managerial dilemma. Reflecting on the intensification of hospital contraction during the later years, Spencer recalled that:

you would be up against a real tight timetable because the wards would be scheduled to close, engineers would be coming round to switch things off... I would know that and you would be saying (to families), 'There is no rush and - I don't know if we used the phrase at the time - we are being as person-centred in this and we would go at everybody's individual pace.' And you would be thinking, Well we can still but that would involve us doing this and closing that and we would have to move them from here to there and if this one conversation doesn't go right it is going to involve us in all sorts of work and undoing things we have already done - because by and large people were moving in groups so you were trying to coordinate three or four sets of these conversations as well, it wasn't all just about one individual. You would be saying one thing but you would be really hoping that they wouldn't take you at your word. I don't know that I ever actually told an outright lie in the sense of saying to people you know they can stay as long as they want when in fact that wasn't true, I think I did start to be honest with people and say this place is going to shut so we are talking about how and when not whether or not and those sorts of things. But I am sure

[8] Dave Spencer, Interview April 3rd 2009.

I sat in many a front room or many a meeting room thinking, I have just said we are going to take this slowly and steadily and not rush it knowing damn well that if they take me at my word too much then there is going to be hell to pay with Phil Morgan[9] or somebody else because we have got plans.[10]

This extract provides a flavour of how the pressures of economic viability were recalled as playing out. Although, echoing other Royal Albert management oral testimonies, it also touches upon the complexities of co-ordinating the interests and wishes of a range of individuals, not least people with learning difficulties.

Examining the relative impact of the twin imperatives of 'cost' and 'need' embodied in the rundown dialogue outlined here, and the complexities of their inter-connectedness, is the nub of this chapter. Such an analysis deals with the *structure* of organisational change, in particular how imperatives emanating from external change agencies shaped hospital contraction; the *agency* of specific individuals within the institution, and their mediation of these agendas, is the primary focus of subsequent chapters.

4.3 Pressures of Cost and Logistics

The rhetoric of the NWRHA's key policy document, the *Model District Service* (*MDS*), was that the reprovision of services for people with learning difficulties from hospital to community settings was affordable (NWRHA 1983). However, as will be argued below, this seemed to take little account of the economic complexities associated with the implementation of such a policy. Within the increasing restraints of regional and district health authority budgets, fuelled by the free market ideological zeal of a cost-cutting Thatcherite government, releasing funds from the contraction process of the Royal Albert, as with the other large Lancashire long stay hospitals, was problematic. Ironically, the neo-liberal agenda of the Thatcherite government had imposed rate

[9] Phil Morgan co-ordinated the ward closure programme.
[10] Dave Spencer, Interview April 3rd 2009.

capping on local authorities, limiting their ability to create funding streams (Wertheimer, Ineichen et al. 1985). The two *main* stumbling blocks were: rising revenue and capital costs of institutional care; and, financial resources tied up in wards rather than with individuals (NWRHA 1989). Although, as will be illustrated later in the analysis, managers attempted to overcome these obstacles, nevertheless they did impact on the rundown process. People with higher support needs, for instance, and seen as needing more resources, seemed to slip down the list of those for resettlement. More generally, reflecting the latter point, conflict over funding levels had a detrimental effect on transferring finances from health to local authority budgets. In accord with other regions, a key area of dispute was over the size of the dowry (explained in Chapter Two) which went with each resident as they left the institution (Hudson 1991). From the late 1980s onwards the imperative to resolve economic issues of rundown, diverging from the tone of the *Model District Service*, translated into an increasing pressure to close the wards, and the institution itself.

4.3.1 Affordable Organisational Change

There was a *rhetoric* in the early 1980s suggesting that the development of community based provision in the north west was an affordable option. In 1983 NWRHA adopted the *Model District Service (MDS)* as its blueprint for services for people with learning difficulties; a policy document heavily influenced by Wolfensberger's principles of normalisation/SRV (NWRHA 1983; Wolfensberger and Tullman 1989). Interwoven into its ideological vision *MDS*, crucially, makes assertions about the resourcing of service development. These claims make the case that, to the extent the authors of *MDS* could predict, the new services would be financially efficacious *for the NHS*, especially as other agencies would also provide essential funding.

The opening page of *MDS* asserts that:

> The presence of three large mental handicap hospitals in the north west poses particular problems. If the residents of all these hospitals are to be enabled to live within the community, substantial developments will be needed in community service provision. If properly redeployed, *the staff and finance now available could go a long way to meet the demands of re-organised services* (NWRHA 1983:1)[11]

However, the report recognises the difficulty of predicting accurately the costs of a new community service:

> It is not yet possible to identify with any degree of accuracy the likely costs of the full application of the policy recommended in this report (NWRHA 1983:23).

Having stated this, however, it then presents a number of resettlement case studies, in which all except one are cheaper to the NHS for each individual than hospital care. Importantly these examples only cost out what the health service would pay. The other sources of income are referenced but not costed; in other words the *total* costs to service providers per individual are not highlighted. Extrapolating from these data the report concludes that:

> It will be seen that in the long term it may be possible to re-provide services for the mentally handicapped in the community at no greater total cost than that which now exists in hospitals (NWRHA 1983:25).

In addition, it underplays two other elements which proved to be critically challenging in the transfer of services from hospital to community. Firstly, *MDS* claims that:

> The faster the development of district based services proceeds, the faster the savings will be achieved at the existing hospitals (NWRHA 1983:25).

Such a statement implies that community service developments will drive cost cutting in hospitals, whereas, as explained below, issues arose because of financial inertia within

[11] My emphasis.

the institutions. Secondly the report argues, without apparently anticipating any difficulties, that:

> The establishment of services for the mentally handicapped within the community will place demands on all the agencies involved in this provision, not least the local authorities (social services, education and housing). In the short term each provider of services must meet the additional costs incurred in the establishment of local services (NWRHA 1983:25).

What emerged within two or three years, and impacted upon Royal Albert rundown, was that these additional costs were not easily met. Overall, the dominant impression conveyed by the report was that the development of care in the community in the north west was both affordable and logistically achievable.

However, as already stated, there is an argument to be made for this being a powerful *rhetorical* policy document. The previous regional plan, in 1979, for service development in the north west had been, accordingly to CMH, 'cautious in the extreme' (Wertheimer, Ineichen et al. 1985:30). This earlier document bore few traces of normalisation/SRV thinking. It did not, for instance, envisage the contraction of the long-stay hospitals in the near future, and any new provision suggested units of between 30-120 residents (Wertheimer, Ineichen et al. 1985:30). A broad church of academics and senior professionals, convened by Tom McLean, at that time divisional Nursing Officer at Calderstones, and member of the National Development Team, reacted to this plan and produced the *Model District Service*, described by CMH as 'probably the most far-reaching and radical Regional plan in existence' (Wertheimer, Ineichen et al. 1985:31). Given that this was aimed at 'the newly appointed District Health Authorities', and needed adoption by the Regional Health Authority, as well as governmental approval, it is perhaps not surprising that it presents these innovative service suggestions as economically feasible. Also, the authors may have been mindful of another loud critical

voice: that of the trade unions. COHSE, the large health service union, had responded to the Jay Report of 1979 with claims that the implementation of deinstitutionalisation was impractical because of increased resourcing requirements (COHSE 1980). Nikki Riley, the shop steward at the Royal Albert, recalled that senior managers always said that 'it was not viable' for the hospital to remain open;[12] implying that other care choices were indeed financially realisable. This was the early 1980s when a cost cutting agenda was pervading all of the public services, not least the NHS (Langan 1998). A further hint of the rhetorical stance embodied in *MDS* was given by one of the former middle managers, who was a keen advocate of deinstitutionalisation. In considering whether the closure of institutions was economically motivated, this individual stated that,

> *There was not a cost cutting agenda I mean it cost us, not us (NHS), the tax payer more, I mean we used to deny this but we all knew that if anybody put two and two together they could point out that it cost more to do what we were doing.*[13]

The suggestion that 'we used to deny this' intimated, like the authors of *MDS*, that those in favour of policy change were perhaps willing to be economical with the truth when it was deemed necessary. Moreover, the suggestion that deinstitutionalisation was affordable underplayed the intricate logistical challenges which were faced by those who implemented Royal Albert contraction; *MDS* implied that 'the right values' were sufficient to drive through service change.

4.3.2 Financial Imperatives

4.3.2.1 Continuing Organisational Costs

Researchers have argued that an instrumental factor in the decision to close institutions was the rising costs associated with their continuing maintenance and upgrading

[12] Conversation with Nikki Riley, July 4th 2011.
[13] Anonymised extract from a research interview.

(Castellani 1992; Godsell 2002). This assertion has already been outlined in Chapter Two, but one example of such a rationale is provided by Johnson in her Australian deinstitutionalisation case study. She claims that a vital consideration in the decision to close Hilltop was that:

> The cost of renovating the institution was believed to be higher than the cost of closing it (Johnson 1998:80).

Collins develops this general point further to suggest that by the early 1990s, in England, the direction of funds towards the institutions themselves, as opposed to community services, was seriously delaying the rate of hospital closure (Collins 1992). It is difficult to determine the exact degree to which this factor impacted upon the rate of Royal Albert rundown. However, even though officially tied into a contraction strategy, as discussed later in the chapter, considerable monies were being spent on improvements within the hospital during the 1980s and 1990s; indeed, viewed in this light it is possible to see these years, especially those of the earlier period, as ones of institutional reform not rundown. Such a state of affairs accorded with the 1971 *Better Services for the Mentally Handicapped* White Paper which had not envisioned hospital closure (Walmsley 2006a).

During the last quarter of the twentieth century capital and revenue investment in the institutional environment at the Albert, reflected, as with other institutions nationally, a variety of inter-connected factors: the wear and tear of Victorian buildings; critical official reports; the growing currency of philosophies of care emphasising the rights and needs of people with learning difficulties; and increasing local authority monitoring of health, safety and environmental issues. These reforms and renovations, much of which signified pressure exerted by external change agencies, including their budgetary impact, are covered later in the chapter.

4.3.2.2 Economies of Scale

Outlined earlier in the chapter was the imperative, reflecting the demands of the Regional Health Authority and Lancashire County Council, the local authority, to release funds as quickly possible from the Royal Albert as it contracted. Similar to institutions elsewhere, as intimated in Chapter Two, this financial arrangement was dependent upon the closure of *whole* wards. Such thinking was evident in the testimony of managers responsible for ward closures and in the 1988 Royal Albert Hospital Contraction Strategy (LDHA 1988). This document outlines a 'suggested ward closure order' which reflected the layout of the hospital: main building first; then a site located across the road; followed by outlying wards surrounding the main building. According to Geoff Hopkinson, the Director of Nursing Services, this plan was about providing guidance, rather than being prescriptive and was reviewed every two years.[14] At the same time he acknowledged that the closure programme intensified in the last few years of the hospital's life as pressure was applied from the NWRHA, because of the receiving districts, to realise funds. He recollected that:

> *The districts were putting pressure on us as well because they wanted to receive people because they couldn't do it unless they got money from Region so Region were saying, 'We can't give you the money until we get the money out of the Royal Albert. We can't get money out of the Royal Albert until they close more wards, and faster.' And so on. So it really gathered a pace during the last two or three years!*[15]

Phil Morgan, in implementing the 1988 strategy, remembered that he,

> *would negotiate transfers unfortunately of clients around the hospital to make sure that we had viable units of accommodation because it would have been*

[14] Geoff Hopkinson, Interview May 1st 2008.
[15] Geoff Hopkinson, Interview July17th 2009.

very easy just to close the hospital piece-meal with clients going from each, all of the wards all the time, but physically we couldn't maintain the resource of keeping the full hospital open... You might have a ward that only had fifteen clients in now, at that point in time, but in three months time would be down to two clients. You couldn't physically keep that resource open with the staffing resource that that would tie up.[16]

Arguably 'the needs of the residents' in this instance were being subsumed under the greater imperative of maintaining 'viable units of accommodation'. Factored into these financial calculations was the idea that as each resident left the hospital, the Royal Albert would lose that individual's annual income, but would still have to maintain the same level of staffing, as well as all the other costs tied up in maintaining a ward; in other words, there would be negligible reductions in organisational expenditure. In addition, the 1988 Royal Albert policy document highlights the importance of 'estate management priorities', which include 'economic, building, maintenance and works considerations', in determining the contraction of the hospital. Although the document's discussion of ward closure order is framed with reference to the needs of residents, ultimately one phase of this is dependent upon a number of units remaining 'economical to maintain' (LDHA 1988).

Pivotal to the financial imperative of diminishing ward numbers was the reduction in 'the staffing resource'. The contraction strategy for the hospital expressed the desire to ensure that 'staff futures are recognised' (LDHA 1988). Phil Morgan, the manager responsible for this side of things, stated that:

Managing the staff through the contraction process was a completely different exercise to the clients because that had to be done in employment law sense so that you were fair... didn't give anybody significant advantages over somebody

[16] Phil Morgan, Interview March 20th 2008.

else and had to deal with people on an equal footing. That at times brought some very significant challenges[17]*... Everybody had to be linked into a particular ward closure and the ward closure programme had pretty much been set the order in which wards would close, so people knew roughly when they were likely to be either made redundant or offered opportunities elsewhere.*[18]

Calculating their redundancy or retirement packages was remembered as an important feature of demoralised staff life in the early 1990s.[19] Tony Dennison, for instance, recalled that, as his ward came under increasing threat of closure, nurses were asking:

'What's going to happen to me? Should I be applying now? Should I wait for redundancy?' People were working out their redundancy packages based on their ages - everybody became very adept at working out how many weeks and years they'd be entitled to![20]

Geoff Hopkinson remembered this issue of staff reductions as both a managerial logistical challenge and a process which impacted negatively upon hospital residents. Particularly during the latter years as contraction gathered pace he recalled an increasing reliance upon:

bank staff and temporary contracts... There was no concept of permanent contracts.[21]

With the hospital 'in considerable flux' Hopkinson recollected the impact of contradictory pressures:

It was a strange situation encouraging as many people as possible to apply for the new posts coming up. We had our own developing service in Lancaster... I was responsible for that as well. So obviously, no bones about it, I wanted the

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[17] Adding to these 'challenges', highlighted elsewhere in his interview, but beyond the scope of this thesis, was the regrading of NHS staff which occurred during the late 1980s: Lancaster Guardian August 5th, November 11th, 18th 1988.
[18] Phil Morgan, Interview March 20th 2008.
[19] Nursing officer (male), Interview March 11th 2009; Tony Dennison, Interview September 1st 2009.
[20] Tony Dennison. Ibid.
[21] Geoff Hopkinson, Interview May 1st 2008

best people working there. I knew that was going to be at a cost to the residents who remained at the hospital until their time came. So that was always a juggling act. I gave that role almost totally to Phil (Morgan) because somebody simply needed to co-ordinate it and Phil has that sort of mind. He was very good at that sort of thing. His was a balancing act.[22]

In this managerial account the memory of complexity, further referenced in Chapter Six, is emphasised by the game metaphors of 'juggling' and 'balancing' (Morgan 1997). However, the admittance of this 'flux' incurring a cost to the remaining residents betrayed a regional positioning. Ignoring concerns expressed by Lancaster and District Health Authority, the review working group at the NWRHA stated that:

> If the price of a rapid closure in that hospital (Royal Albert) was a slightly reduced quality of life for a short period then it was a price that had to be borne, given that the residents would be moving to a much enhanced quality of life in the community... (NWRHA 1989).

Overall it can be argued that the imperatives of closure often threw up unintended consequences which were not always in the best interests of residents or staff; a point which is developed in the following section.

4.3.3 Impact of Financial Imperatives

The combination of substantial organisational costs along with institutional economies of scale, both examined above, had two major impacts on the shape, and pace, of Royal Albert contraction: compromises were made as to the order in which people with learning difficulties moved out, with cost rather than individual needs being the key determinant; and, particularly in the later years of rundown, pressure was applied by the Regional Health Authority to close as quickly as possible, prioritising the criteria of 'cost effectiveness' (NWRHA 1989:3).

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[22] Geoff Hopkinson, Interview May 1st 2008. My emphasis.

4.3.3.1 Compromises

Part of the drive to realise funds for resettlement was fuelled by the need for the NHS to furnish each resident with a dowry (defined in Chapter Two) upon leaving, but in the early part of resettlement the sums involved seem to have been a sticking point between the hospital (NHS) and social services (Lancashire County Council), who were to receive the monies. David Jordison, the senior manager at the Royal Albert at this time, explained this problem:

> *The big problem politically was the County Council who felt they'd be landed with all the costs. They didn't object to the philosophy but they thought they would get all the costs of people in the community and so huge negotiations about the dowry that went with each person. And it was an average dowry, I think I can even remember it, it might have been eighteen thousand pounds or something, it was quite a lot of money, per annum. And some people needed a lot more and some people needed a lot less and some argy bargy was a) eighteen thousand pounds isn't enough, if that was the figure and b) some people will need a hundred thousand and what are you going to do about them? So that we got absolutely nowhere for 12 months, so we'd lost a year.*[23]

This comment reinforced his earlier quote which implied that costs issues impacted negatively upon hospital residents with higher support needs. The tension between Social Services and Health over dowries also played out at a local level. Paul Kenny, an important local social services manager, raised the issue of inadequate dowry financing, at a Lancaster and District Community Health Council meeting, with the District Health Authority's Treasurer.[24] Nationally, as Collins argues, such funding issues were not unusual, and slowed down the pace of resettlement (Collins 1992). Indeed in the north west, as explored later in the chapter, the joint local authority and

[23] David Jordison, Interview February 15th 2008.
[24] Lancaster Guardian, March 20th, 1987.

NWRHA 1989 policy document, *Shared Proposals for Shared Problems*, attempted to address these inter-agency obstacles (NWRHA 1989).

From 1989 NWRHA, through bridging finance, provided additional funds for resettlement; accepting that 'double running costs are inevitable for a period' (NWRHA 1989:i). However, it is questionable as to what extent this changed the lower priority for resettlement generally afforded to those with higher support needs, and therefore requiring a proportionally greater slice of monies. From early on in this organisational contraction, there were indications that those with higher support needs posed a particular challenge to services, and may be resettled later in the process. In the Royal Albert's 1988 Hospital Contraction Strategy, for instance, there was a consideration of,

> the needs of the residents who were likely to be in hospital the longest. Only subjective judgements were able to be made as to probable numbers, dependency and age of the people who would be in hospital during the later years of contraction, but it was considered that they would have special needs and/or be elderly (LDHA 1988:4).

Similar approaches seemed to have been replicated elsewhere in England. Godsell, for instance, as discussed in Chapter Two,[25] suggested that preferential treatment occurred in the relocation process during the 1980s at Stoke Park, to the disadvantage of older people, those with 'challenging behaviour' or with 'multiple impairments' (Godsell 2002:175-6). Such observations have a strong resonance with a 1990 Royal Albert social work document which is critical of the official resettlement rhetoric, suggesting that 'the large majority' of the 400 or residents still to depart have 'additional difficulties' (RAH 1990). These include:

> Mental illness; often extreme physical disabilities; increasing age; a history of sexual and other offences; those whose damaged childhoods are manifested in

[25] See Chapter Two: 2 3.3.

so called 'challenging behaviours'; those who are reluctant to leave the institution and those who have already tried and 'failed' in the community (RAH 1990).

The conclusion is that as the closure deadline encroaches 'the most vulnerable residents are in line for the most stress'. Conversely, the emphasis on those perceived as easier to resettle was signified by the dominant expectation of the early 1980s that, although the hospital would downsize, possibly upwards of 300 individuals would remain.[26] The resettlement procedure for the hospital, produced in the mid-1980s, indicated, for instance, that older residents could be given leeway to stay:

> It is to be expected that some residents of the hospital, particularly those who have been in the hospital for a long time, will wish to spend the rest of their days here or within the locality. The Resettlement Team will try to ensure that such wishes are respected, and plan to maximise the quality of life for those residents (RAH c.1986:1).

Such a statement reflects an ethos of individual choice; exemplifying the Scandinavian rights model of normalisation as opposed to Wolfensberger's SRV.[27] However, in practice there did appear, as suggested above, to be resourcing issues which could work against those with higher support needs; resettlement was not purely about the best interests of an individual resident. Difficulties of this nature were recalled by those implementing resettlement policies. Steve Mee, the first Resettlement Co-ordinator, for instance, during the early period of formalised resettlement was very clear about the way some districts were approaching the Royal Albert:

> *In those early days (what) was happening was districts were cherry picking the least challenging people. And there was NDT (National Development Team) categories, people who'd been assessed prior to me going in, and it was one to four. And it was basically how much of a problem you were to support. That's*

[26] Geoff Hopkinson, Interview May 1st 2008; Dave Spencer Interview April 3rd 2009.
[27] See Chapter Two.

what it boiled down to, so it included physical disability and challenging behaviour... Some districts wouldn't even talk to people who were a category four ...[28]

Such sentiments are resonant in Johnson's ethnographical study of women on a locked ward in Australia in the 1990s. She asserts that when it came to resettlement some of these individuals,

> were judged not to be able to live in the community. The explicit reasons given for this were those of duty of care to the woman with a disability and danger to the community. However, there was also a more pragmatic reason. There were only sufficient resources to fund half the residents in supported accommodation in the community. The rest had to go to other institutions. The cards were stacked (Johnson 1998:72).

Johnson goes on to argue that, 'in the closure of the institution decisions were made which did not really focus upon these women as individuals' (Johnson 1998:75). Indications are that such a state of affairs did occur as part of a cost-led agenda permeating the Albert contraction, but, as illustrated later in the analysis, was tempered by more humane considerations.

4.3.3.2 Increased Pace of Organisational Change

The oral testimonies of senior Royal Albert and Lancaster and District Health Authority managers suggested that from 1986 onwards there was an imperative to close the Albert, thus releasing funds for community service developments. Both in England, and further afield, such an imperative was not unusual (Korman and Glennerster 1990; Enbar, Morris et al. 2004; Manning 2008). This closure remit, highlighted earlier in the chapter, of the new Royal Albert General Manager in 1986 was at odds with the prevailing assumptions of the time, already mentioned above, that the institution would

[28] Steve Mee, Interview February 18th 2008.

be downsized but not shut. Throughout the period of rundown, the organisation's senior management recalled the pressure applied by the Regional Health Authority. Geoff Hopkinson, next in seniority to Jordison, recalled that the region 'were continuously pushing to close wards and threatening to withdraw money'.[29] Even at District Health Authority level, Paul Whitfield, the Chief Executive, remembered his encounters, probably in the early 1990s, with NWRHA's chairman who would,

> *come on his own with somebody carrying a bag. And he'd have a limited brief - he'd talk about the things he'd want to talk about... 'I've been to see that big hospital, why is it still there?'... And the detail, whilst he was prepared to listen, it was – 'Sort it out. That's what you're there for!' ... 'Whitfield, you're here to sort that out. We want Royal Albert closed. That's what the Secretary of State is asking me to do. I report to the Secretary of State, you report to the Region ...' And so there was this real push to deliver on the government policy and so there was this very much top down approach of - it wasn't so much, 'Was the essence of the policy the right direction? Because the decision's been made.'*[30]

It was from the late 1980s that this 'push to deliver on government policy', as recalled above by Whitfield, became *overtly* expressed at a regional level, impacting decisively on the pace of Royal Albert contraction. The NWRHA and Lancashire County Council (LCC), in response to logistical difficulties restricting the pace of resettlement from its three major institutions, reflecting some of the issues already highlighted above in the previous section, adopted a far more aggressive strategy towards policy implementation than previously. Their joint 1989 document *Shared proposals for shared problems* (*SPSP*), was dominated by a discourse of targets, economics and closure for Calderstones, Brockhall and the Royal Albert (NWRHA 1989). Although being careful to reference the principles laid out in the *Model District Service*, *SPSP* contrasted radically

[29] Geoff Hopkinson, Interview May 1st 2008.
[30] Paul Whitfield, Interview October 28th 2009.

with both the tone of that 'bible'[31], and the Regional Health Authority's 1985 document, *Run-down of hospitals for people with mental handicap in the N.W. Region* (NWRHA 1983; NWRHA 1985). Pledging itself to bridging finance to help fund community care, the NWRHA specified that, rather than each of the institutions closing down concurrently, Brockhall would close in 1992, the Royal Albert in 1995 or 1996, depending on whether the rate of resettlement was 100 or 120 residents a year, and lastly Calderstones would finish in 2003 (NWRHA 1989). The reasons for this particular sequence seemed to have very little to do with the needs of people with learning difficulties. *SPSP* specified that there were two reasons, both economic, as to why the Royal Albert was specified for closure: it was the smallest of the three institutions with 450 residents, and through 'a targeted closure programme it would be possible to release its costs very rapidly'; and secondly, possibly to the Albert's credit, 'the average costs (£14,200) of providing care for a person' were higher than the other three institutions and 'thus reduces the gap between cash withdrawals and resettlement 'dowries'' (NWRHA 1989:2). [The latter being £17,100 in 1989, with the expectation that this would rise to £18,900 the following year (NWRHA 1989:iv)]. Furthermore, for Brockhall to close by early 1992, thus enabling increased resources to be directed at the Royal Albert, upwards of half of its resident population of around 950 were to be transferred to Calderstones, not into community settings, during a period of four years. Thirty three of these Brockhall residents went to the Calderstones Medium Secure Unit (Peters and Freeman 1992:48-50). *SPSP* advised, as exemplified in the regional policy on Brockhall, that a key mechanism for resettlements, and for the contraction process overall, was that wards, not individuals, would be the focus of implementation within the respective units. Indeed, as researchers into resettlement in the north west claim, 'the shift' in NWRHA policy, only six years after its visionary *Model District Service*, did

[31] David Jordison, Interview February 15th 2008.

seem to be one from 'individual-led to institutional-led resettlement' (Walker, Ryan et al. 1993:17).

In many respects the regional targets laid out in 1989 were achieved: Brockhall closed in 1992; the Albert in 1996; and Calderstones in 2003, although at the time of writing, in 2011, there is a still a secure unit on the latter site (estimated in 2008 to have a population of 150 people[32]). For Brockhall, this meant that 414 individuals moved as part of whole ward resettlements, with some going in smaller groups, to the neighbouring institution of Calderstones, part of the same administrative unit, a factor presumably aiding this transfer of individuals (Peters and Freeman 1992:2). Achieving institutional closure by transferring residents to other institutions occurred elsewhere in England, perhaps because, as a CMH report suggested:

> To move people across from one institution to another is a comparatively easy exercise (Wertheimer 1986:17).

This document cites particular instances where such transfers took place during the early 1980s, claiming that: one hospital shut its doors by moving over 100 people with learning difficulties to a larger institution, doing this by the use of buses over two days (Wertheimer 1986:17); and Essex Hall's closure in 1985 was facilitated by the majority of the remaining 125 people moving to other NHS hospitals, with 'no one moved into staffed or unstaffed ordinary housing' (Wertheimer 1986:14). Also when Leavesden and Cell Barnes Hospitals closed in 1995 and 1998, respectively, individuals were moved to Harperbury, part of the same management group (Brown 2001:27). In 2010 there were 753 former hospital residents still living on NHS campuses in England suggesting that this particular expression of a resource or bureaucratic-led agenda was not unusual (DH 2010).

[32] Tom McLean, Interview September 8th 2008.

In contrast to the Albert, prior to *SPSP* Brockhall was already promulgating a policy of wards being transferred to Calderstones; two, containing 57 people with learning difficulties, having done this in 1988 (Peters and Freeman 1992:49). In the late 1980s the pace of resettlement at the Royal Albert[33], as documented in *SPSP* and the local press, was around 12 people per year: 'a significantly lower rate of resettlement than Calderstones or Brockhall Hospitals' (NWRHA 1989:2). During the 1990s, especially from 1992, the numbers of people leaving the Albert did increase rapidly:

> ... planned resettlements from Royal Albert increased from 22 in both 1990/91 and 1991/2, of which they achieved 19 and 21 respectively, to 75 resettlements in 1992/93 (Walker, Ryan et al. 1993:26).

Such a dramatic acceleration, which continued to be maintained until closure, was fuelled by the imperative of transferring funds tied up in institutional care, and represented a contrast to the earlier phases of Royal Albert rundown.

4.4 Pressure of Individual Need

It is possible, as propounded above, to present a coherent case for cost being a dominating force in the design, implementation and ultimately the pace of Royal Albert contraction. Evaluating the extent to which meeting the needs of people with learning difficulties, although placed centre stage in the rhetoric of individual change agents, *drove* this organisational change is more problematic.[34] What can be asserted is that this motivating force was essentially a *reforming* and humanising one, which influenced the shape of rundown, rather than ultimately pushing it through. During the 1980s and 90s, as will be charted here, there were important changes in organisational structures, as well as a re-direction of resources towards improvements in both care and the physical environment. These shifts represented a response to desired and imposed

[33] See Appendix iv.
[34] Phil Morgan, Interview March 20th 2008; Geoff Hopkinson, Interview May 1st 2008; Mary Lawrenson, Interview September 9th 2009.

pressures upon the organisation from NWRHA, and other change agencies. Core elements in these external forces, directed towards the well-being of residents at the Royal Albert, were changing philosophies of care and the inter-connected arena of public scrutiny.

4.4.1 Normalisation and Social Role Valorisation (SRV)

NWRHA's seminal value-based policy document was *A Model District Service (MDS)* which was adopted in 1983 (NWRHA 1983). This strategy paper, referenced earlier in the chapter, proposed fundamental changes to services in North West England for all people with learning difficulties, including those in long stay institutional care. In creating a template for community services *MDS* touched upon ways of meeting people's needs, organisational structures, and resourcing requirements. Infusing its recommendations are explicit, and implicit, references to 'the principles of normalisation', which it summarised as:

> The use of ordinary means which are valued in the local community in order to enable people to live ordinary lives... The status of people who are mentally handicapped should be enhanced by services, both by what is done and the ways it is done... People who are mentally handicapped are individual human beings with their own abilities, preferences and needs (NWRHA 1983:5).

These principles, in turn, were based on the twin 'basic axioms' of:

> People who are mentally handicapped have the same human value as anyone else and so the same human rights... (and) are developing human beings and services should assist them towards the greatest independence possible (NWRHA 1983:4).

Further weight is given to the assertion of the rights of people with learning difficulties by quoting from the 1971 *United Nations Declaration on the Rights of Mentally Retarded People*. In many ways the underpinning principles of *MDS* appear to be a

mixture of the two different strands of normalisation thinking: the emphasis on rights, including the UN statement, reflecting the original Scandinavian school of thought; and the emphasis on 'value', influenced by Wolfensberger with his focus on deviancy and labelling theories (Wolfensberger and Tullman 1989; Mee 2005), and indicated particularly by points such as:

> Normalisation presents a great challenge to the designers of services. They must develop tools, techniques and styles of service which enhance the ways in which their consumers are perceived. An important goal of these services is for their users to embody culturally valued and age-appropriate behaviour, to lead valued life-styles and to have extended access to the valued experiences and resources of society. Personal autonomy and freedom of choice are major priorities in achieving that goal (NWRHA 1983).

This latter statement inadvertently highlighted, as discussed in Chapter Two, what some saw as an inherent source of confusion in this approach for practitioners: the conflict between 'valued life styles' and 'freedom of choice' (Mee 2005). Nevertheless, as illuminated earlier in the chapter, *MDS* was heralded nationally as a progressive policy document (Wertheimer, Ineichen et al. 1985:31; Walker, Ryan et al. 1993:2).

Although there are dissenting voices, the dominant consensus, as discussed in Chapter Two, among researchers is that normalisation and SRV played a principal role in the design and philosophy of services for people with learning difficulties during the late twentieth century, both in the United Kingdom and beyond (Anninson and Young 1980; McCarver and Cavalier 1983 cited in Emerson 1992:1; Race 1999; Walmsley 2006). The regional adoption of *MDS* supports such an argument, as does the translation of its principles into organisational policy at the Royal Albert. The latter's resettlement procedure of the mid-1980s, for instance, states that,

> The guidelines adopted by the (resettlement) team are those of the Region's policy document *A Model District Service* (RAH c.1986:1).

At the core of the latter document, and the hospital's resettlement strategy, itself reflecting the impact of normalisation, was the mechanism of Individual Programme Planning (IPP). The latter, in theory at least, placed the individual person at the heart of decision making about their own lives. Involving multi-disciplinary teams, comprising families as well as professionals, this approach was consistent with those aspects of normalisation emphasising individual needs, autonomy and choice.

It was Geoff Hopkinson, one of the senior Royal Albert managers, who, not long after his appointment in 1983, introduced IPP:

> *One of the things I wanted to implement, before resettlement gathered apace I wanted each resident to have an individual plan. So we introduced a policy of individual programme planning and this ultimately formed the basis of resettlement planning for each individual. But first of all I wanted staff to get used to the idea of devising a plan for each resident so that their lives, even on the wards, just weren't aimless, that they had a plan. All of us have a structure for our lives, you know! And the residents have the same right. So Steve*[35] *introduced IPP, just to use the abbreviation, to all of the wards in the hospital.*[36]

Not all institutions were as well advanced in implementing person-centred planning. In the south of England, at Harperbury, for instance, it was only in 1991 when:

> Individual care plans replaced the former policy of planning for the general care of residents on a block basis. Staff were encouraged to foster the participation of the residents in their own welfare (Brown 2001:28).

This procedural focus on the individual resident at the Royal Albert was embedded in the resettlement process document (RAH c.1986); after which time IPP, which had

[35] Steve Mee, at that point, Nursing Process Co-ordinator.
[36] Geoff Hopkinson, Interview May 1st 2008.

started out as this more open-ended engagement with individual residents and their wishes, was referenced within a resettlement framework: that is moving out of hospital or not was not a choice. In these early days, however, there was 'provisional discharge', with residents having a three month period during which time if they were unhappy with their new home they could return to the hospital. This notwithstanding, both resettlement officers talk about residents approaching them on their own initiative to ask about moving.[37] Illustrating this latter point, and discussing how normalisation impacted on the shop floor of the organisation will be considered in Chapters Five and Nine. Central to IPP at the Royal Albert, and reflecting *MDS*, was multi-disciplinary team working, elements of which were in place by 1983.[38] Although, and explored in subsequent chapters, team working was not without its difficulties, documentary and oral evidence indicates that this approach was a salient feature of working with residents throughout the period of rundown (RAH 1990; RAH c.1986).[39]

The appointment of Geoff Hopkinson as divisional Director of Nursing Services in 1983 was entirely consistent with the Regional Health Authority's adoption of normalisation/SRV. On arrival, he completed a tripartite consensus Management Team, the norm across the whole NHS at that time, with the other elements being the Senior Consultant Psychiatrist and the hospital Administrator (Harrison 1994; Webster 2002). As discussed later in the thesis this was a hierarchy heavily influenced by medical model thinking. An analysis of the oral testimony reveals that Hopkinson's appointment was an ideological counterbalance, reflecting changing policy agendas.[40] The new appointee's role put him in the front line of organisational change, with responsibility for the development of nursing services, both in the institution and the community, in which

[37] Steve Mee, Interview February 18th 2008; Dave Spencer Interview April 3rd 2009.
[38] Norman Woodward and Ron Bettany, November 13th 2006; Gudrun O'Hara, Interview June 22nd 2009; Malcolm Alston, Interview May 19th 2009.
[39] Tony Dennison, Interview September 1st 2009; Dave Spencer Interview April 3rd 2009; Steve Mee, Interview February 18th 2008; Gudrun O'Hara, Interview June 22nd 2009.
[40] Geoff Hopkinson, Interview May 1st 2008; Steve Mee, Interview February 18th 2008.

the design and implementation of resettlement policies comprised a key constituent element.[41] According to Hopkinson's interview data, he had been in learning disability services since 1962, was a very experienced senior nurse, but importantly, given the acceptance of *MDS* as regional policy around the same time, was an experienced trainer in normalisation/SRV, an ideology he enthusiastically embraced. Prior to coming to the Albert in 1983, he recalled working at Prudhoe Hospital, Northumberland, for people with learning difficulties:

> *It was there that I was introduced to the concept of normalisation and really my whole thinking changed about devalued people... They arranged a PASS workshop, Programme Analysis for Service Systems, right in the middle of Northumberland ... We were segregated ourselves (laughs) for a week whilst we did this course and it was total immersion and I'm sure that we worked 24-7. I can't remember getting very much sleep at all. We were plunged straight into it, but I found it enormously stimulating, physically knackering, but enormously stimulating. That really changed my whole perspective about how devalued people could become valued again ... So I suppose I became a man on a mission thereafter... (What) I saw was that everybody with a learning disability has a right to live like most other folks do and our job as a service was to make that possible. I didn't want to make it possible in Northumberland. I was preparing myself for taking the message somewhere else, and that was the Royal Albert.*[42]

As well as being explicitly stated, Geoff Hopkinson's evangelical tone is also suggested by his metaphors: 'total immersion' and 'we were plunged straight into it'. These could be describing a baptismal experience, and such a discourse also corresponds to the idea that normalisation was the 'new gospel' (Korman and Glennerster 1990:64; Mee

[41] Geoff Hopkinson, Interview May 1st 2008; David Jordison, Interview February 15th 2008; Minutes of the Royal Albert Hospital League of Friends 1983-1995.
[42] Geoff Hopkinson, Interview May 1st 2008.

2005). This ideological positioning was mirrored elsewhere in the NWRHA. Tom McLean, in a similar senior post at Calderstones Hospital, and member of the National Development Team, recollected that[43]:

> *I did one of those Wolfensberger normalisation courses at the Spastics Society as it was called then, at Wokingham in Surrey. If you liked them they were seminal, if you didn't like them they were brainwashing sessions. And people talked about them in those sort of terms... It did have a terrific influence on me.*[44]

Significantly for the Royal Albert, McLean hinted that Hopkinson was appointed precisely because of his adherence to normalisation/SRV:

> *I remember being an assessor on the appointment panel that appointed Geoff and he had the right kind of forward thinking ideas, and wanted to get the place shut, so he was appointed.*[45]

The recruitment of the new Director of Nursing reflected changing philosophies at regional level and was, as touched upon already, instrumental in the implementation of a strategy of ideologically infused organisational change.

4.4.2 Public Scrutiny

The sharper edge of a pressure to, at the very least, reform the quality of care received by residents at the Royal Albert was applied by means of critical appraisals emanating from external change agencies. Throughout the institutional rundown period the Lancaster Guardian, the local newspaper, carried reports from various sources which condemned aspects of Royal Albert living conditions or resettlement practice. These critiques originated locally from the Community Health Council,[46] Lancaster City

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[43] Tom McLean, Interview September 8th 2008.
[44] Tom McLean. Ibid.
[45] Tom McLean, Interview September 8th 2008.
[46] Lancaster Guardian, September 30th, 1988; Lancaster Guardian, January 25th, 1990; February 2nd 1990.

Council[47], the District Health Authority[48], as well as nationally in the form of the Audit Commission[49], along with the Mental Health Act Commission[50]. In addition, in 1984 David Brandon, the Director of Mind, the mental health charity, and a member of the committee which drew up the *Model District Service*, issued a stinging attack on the Royal Albert as an unsuitable form of care; describing it as a 'workhouse hospital'.[51] However, these assessments can be construed as maintaining pressure originally generated by three earlier critical reports published in the late 1970s.

As discussed in Chapter Two, heralded by the Ely Report in 1969, inadequate levels of care in long-stay institutions had been exposed in public enquiries throughout the 1970s (Butler and Drakeford 2005). In the case of the Albert, Wangermann argues that as early as 1971 the sensitivities regarding its overcrowding had led to the erection of two prefabricated 'villas', each of which became home to thirty residents (Wangermann 1992:94). Then at the end of that decade the organisation was subject to a number of damning public reports. The latter, according to a former member of the clinical psychology team meant that, like a truculent child, 'the Royal Albert was dragged screaming into the changes'.[52] These, as will be charted below, contributed to substantial revenue and capital funding being directed towards the care of hospital residents, at a time when paradoxically monies were required to develop community based provision.

In 1978 NWRHA was so appalled at the conditions on the hospital's Richard Smith Ward that it ordered the ward's immediate closure (Wangermann 1992:94); a decision

[47] Lancaster Guardian, September 16th, 1988.
[48] Lancaster Guardian, July 6th, 1984.
[49] Lancaster Guardian, November 3rd, 1989.
[50] Lancaster Guardian, August 16th, 1991.
[51] Lancaster Guardian, February 3rd, 1984.
[52] Bernadette Hobson, Interview August 26th 2009.

probably of no great surprise to those who had seen that area of the Royal Albert. Mrs. Ann M. Wilson, the deputy administrator at the time, recalled that:

> *Some of the wards, there was a basement one - Richard Smith in the Main Building - I mean it was absolutely awful. Most of the patients were doubly incontinent so it wasn't just the gloom, it was the smell, the whole ambience, it was - I remember that was the one that was that the worst and was one of the last to be sorted out.*[53]

Making similar observations at other points in his interview, Brian Illingworth recalled that Richard Smith was part of an induction process for porters:

> *Some of the wards were what they used to class as 'low grade wards' depending on residents that were on them. They used to take you round what they used to call low grade lock-up wards and I think it was a test, if you could stand that you could stand anything, you'd be all right... And I can remember they took us down this corridor... there was two wards close together there. One was called Richard Smith and the other was called ————. They were both male lock-up wards. Believe me if you could stand that you could stand anything.*[54]

Brian Illingworth decided that he could 'stand that', and became a porter not long before Richard Smith closed in 1978. In response to the closure, Wangermann, the former Senior Clinical Psychologist, claims that 'eight prefabricated bungalows were hastily erected', as part of what he calls 'a constructive *resettlement preparation* policy' (Wangermann 1992:94). The ward itself, as a further reflection of changing philosophies of care, was revamped and in 1979 opened as a Communication Development Centre which 'introduced signing systems for people with language impairments' (Wangermann 1992:97).

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[53] Mrs. Ann M. Wilson, Interview November 17th 2009
[54] Brian Illingworth, Interview September 8th 2009.

At the same time as the closure of that particular unit, the General Nursing Council (GNC) withdrew its recognition of the Royal Albert Nursing School (Wangermann 1992:94). The local paper reported that this was because of poor institutional conditions, especially overcrowding.[55] Mary Lawrenson, then a student nurse, indicated that the nursing curriculum itself may also have been the cause:

> *We had inspections of the School of Nursing and about the time of the Jay Report[56] ... we did lose the status to train nurses, because the philosophy wasn't up to date, so that's how bad it was. We knew what we should have been doing, but nobody put it into action, and we lost our status as a training school. We were allowed to train the people that were already going through but they couldn't take new students on until they sorted it out.*[57]

Furthermore, the Regional Health Authority, because of its concerns, mentioned above, invited the National Development Team (NDT) to inspect the institution. Executed in 1979, this investigation highlighted: serious overcrowding; a lack of adequate training for the residents; and a need to develop community based services, as an alternative to institutional provision (Wangermann 1992:94-5). However, Wangermann argues that by this time,

> the Royal Albert had already turned the corner and in some respects the (NDT) report served to reinforce a change in orientation which had taken place in the hospital (Wangermann 1992:95).

Adaptations, he asserts, were already being made to nurse training as a basis for restoration of GNC status (Wangermann 1992:95).

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[55] Lancaster Guardian September 8th 1978.
[56] See below, and Chapter Two.
[57] Mary Lawrenson, Interview September 9th 2009.

Others are more convinced about the impact of NDT criticisms on internal changes within the Albert. Tony Dennison, a Royal Albert nurse during this period, remembered that:

> *Just after I qualified, the National Development Team had visited. There was a need for more decent accommodation, and the bungalow portakabins ordered. They wanted to free up staff accommodation for residents so staff corridors were cleared. Lathom House was going to be emptied... and staff were moved down to —— cottages.*[58]

The implication here was that, in response to external coercion, the management rapidly prioritised the accommodation needs of residents over those of staff. David Jordison, in explaining the institutional culture when appointed in 1986, also hinted at the impact of that investigation:

> *There had been a big sort of enquiry I think into the Royal Albert... it was found wanting sometimes in the late seventies. I think improvements had been made and clearly you know they had drafted people in like Steve Mee and Geoff Hopkinson and other champions of people with learning disabilities.*[59]

The latter point made by Jordison is developed in the next chapter, where it will be argued that key internal appointments were made, during the 1980s, to change the culture of the organisation.

These external criticisms of the organisation in the late 1970s, according to a former Royal Albert nursing lecturer, came as something of a shock to a bemused senior management:

> *The world had passed it all by. They were institutions - literally. Nobody went in. The people that worked there had worked there for years. There were inspections and basically when the inspectors came whoever was the boss*

[58] Tony Dennison, Interview September 25th 2005.
[59] David Jordison, Interview February 15th 2008

rushed them into the committee room and gave them a few glasses of wine and a nice meal. And there would be two wards that had been tarted up especially for the occasion. The inspectors would go round, write a nice report... This is when things had started to change, they had an inspection and it got a real slating did the Albert... I would think it's the late 70s and it really got a slating. And of course the Albert hadn't changed, what had changed was people's perceptions, so what ten years ago was good was suddenly not very good at all. But the boss at the time made a very good point, 'What I want to know is for the last 25 inspections we've had, everything has been absolutely fantastic, and now everything's appalling. Why is it suddenly changed? Because the institution hasn't changed.' And the point he was making was valid. It wasn't the institution that had changed in any way whatsoever, what was happening was that people's expectations were different... And that was right and that's how change happens isn't it?[60]

Echoing Bob Dewhirst's concluding comment, the assertion here is that the changed expectations, around the quality of life for people with learning difficulties, impacted enormously on the Royal Albert. However, as with other institutions, these reports forced the management, as discussed below, to reform the hospital's practices, not to close it.

4.4.3 Expressions of the Reforming Agenda

The combination of critical reports and shifts in national and regional policy, all of which were infused to differing extents by the ideology of normalisation, contributed to the strong presence of a reforming agenda during the rundown of the Royal Albert. A particular expression of this, referenced earlier in the chapter, was that training, both for

[60] Bob Dewhirst, Interview June 9th 2009.

students and existing staff, underwent a radical overhaul. In his interview Hopkinson claimed that he,

> *developed a staff training role... because I wanted to introduce the ideas of social role valorisation to all of the staff and so, with other people, we devised a training programme and we got most people through that training programme.*[61]

Oral and written testimonies indicate that this training focus was both delivered and received with differing degrees of enthusiasm (Mee 2005);[62] a point examined in subsequent chapters. However, it was a structural attempt to move away from medical model thinking towards a more holistic focus upon the person with a learning difficulty. A similar shift had already started to occur in the Royal Albert School of Nursing prior to Hopkinson's arrival in 1983. This was initially prompted, as already highlighted, by an attempt to regain its status, removed as a result of a critical GNC report. In her third year of training in 1980, Mary Lawrenson remembered that, in contrast to the preceding blanket emphasis on the 'clinical control model', suddenly student nurses were discussing the implications of the Jay Report. She also recalled, with overt excitement, the appointment of Jim Bow, a senior nurse brought in to implement changes in nurse training:

> *Jim Bow came from outside, He came from Wales. It was like, 'Oh this guy's come from Wales! Who is he?! What's he doing here?!' Kind of thing. I can remember - I can still see his face... Jim Bow being brought in to sort it out. He was the one who had to get our status back as a School of Nursing.*[63]

Ironically, during the early 1980s, Bob Dewhirst, one of the Royal Albert training lecturers, left for a time to carry out the same trouble-shooting brief at the Turner Village School of Nursing in Colchester.[64] These attempts to raise training standards reflected

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[61] Geoff Hopkinson, Interview May 1st 2008.
[62] Malcolm Alston, Interview May 19th 2009; Mary Lawrenson, Interview September 9th 2009; Tony Dennison, Interview September 1st 2009.
[63] Mary Lawrenson, Interview September 9th 2009.
[64] Steve Mee, Interview February 18th 2008; Bob Dewhirst, Interview June 9th 2009.

the changing agendas of the General Nursing Council, as evidenced by the introduction, discussed in Chapter Two, of a new curriculum in 1982 (RCN 1989). Dewhirst returned to the hospital, taking charge of learning disability student nurse training, and recalled the impact of normalisation and other non-medical philosophies of care upon the curriculum:

> *It was quite difficult at first because people used to teach all about anatomy and physiology because it was there, it was a body of knowledge that you passed on. Well if you don't pass it on,...what body of knowledge have you got? So things like normalisation and behaviour modification and philosophies and looking at enquiries and looking at people's behaviours were good because it did give you a body of knowledge, because you could say, 'What makes you special as a nurse? And why are you different to the next person?'*[65]

This change of emphasis was remembered by Dave Spencer, a Royal Albert student nurse in 1983:

> *We went from being assessed on whether we could set up a drip stand and a tray for doing the flattest tube and make a bed properly to the social model of disability and the like and there was lots of discussion about the role of nurses just as there is now.*[66]

Such reforms based upon changes in dominant philosophies of care, were, as illuminated below, echoed elsewhere in the institution's infrastructure.

During the 1980s when the organisation's budget was being increasingly squeezed by the NWRHA, with funding also needing to be released for the development of community care services, ironically the Royal Albert was directing increased funding into the hospital itself. As already suggested, there is a strong case to be made that at the heart of such a state of affairs, emanating from external change agencies, was an

[65] Bob Dewhirst, Interview June 9th 2009.
[66] Dave Spencer Interview April 3rd 2009.

agenda based upon concerns for the welfare of people with learning difficulties. Oral testimonies, quoted above, the 1988 Hospital Contraction Plan (1988), the Lancaster Guardian[67] and the former Senior Clinical Psychologist (Wangermann 1992) all reference capital and revenue investment in: ward renovations, especially to those that would be the last to close; three new blocks of flats, with small living units intended to facilitate resettlement preparation; an upgraded hospital phone system; new hospital kitchens; as well as replacement fire doors. The latter two items were a response to local city council concerns regarding health and safety. In addition, interviews with former members of nursing staff suggest that in pockets of the hospital, especially on wards for respite care and young people with higher support needs, this period witnessed an increase in staffing ratios and resources.[68]

In 1991, prior to the surge in the pace of hospital contraction, the overall budgetary implications of this expenditure were evident in the Lancaster and District Health Authority's Annual Report (1989-90) which stated that:

> In mental handicap and mental health services, the health authority again used all its available finance to improve quality of care. The level of spending in these services was maintained although there were fewer hospital residents.[69]

The ironic state of affairs highlighted as occurring at the Albert did not seem to be unusual in studies of institutional rundown. Although it is argued here that the investment at the Royal Albert was based upon welfare issues, at least one researcher presents an alternative viewpoint. Jean Collins, in analysing why hospital contractions in England were stalling at the start of the 1990s, intimates that increased institutional investment was actually a deliberate blocking tactic by those meant to be implementing

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[67] Lancaster Guardian: August 5th 1988; September 16th 1988; January 24th 1992; June 6th 1992.
[68] See Appendix iv; Tony Dennison, Interview September 1st 2009; Steve Mee, Interview September 22nd 2005; Mary Lawrenson, Interview September 9th 2009; Eric R., Interview August 11th 2009
[69] Lancaster Guardian, February 15th 1991

closure (Collins 1992). Whether this was the case or not, other institutions did invest, like the Albert, in their infrastructure as they were running down; amongst these were Normansfield, Harperbury, Stoke Park and Ida Darwin Hospitals (Malster 1994; Godsell 2002). With respect to the latter institution, the head of Cambridge Priority Services Unit made it clear, that if 'we had spare cash we had to invest it in the institution'.[70] At times this apparent conflict between the reforming and closure agendas could be revealed in quite a blatant fashion. Further afield, for instance, Johnson notes in her case study of deinstitutionalisation at an Australian establishment:

> The closure announcement came on the day that the dormitories in Unit N began to be subdivided into more private bedroom spaces. The irony of this was not lost on the staff who had fought hard for the renovation (Johnson 1998:89).

However, and hinting at the pressures faced by those managing such complex organisational changes, a study of the closure of the Kimberley Centre, in New Zealand, notes:

> that most families commented on their displeasure at the way the institution had been left to deteriorate during the lead-in to deinstitutionalisation (Stewart and Mirfin-Veitch 2008:21).

The central problem in the UK, Australia, and New Zealand was that funds for community care were seen as being dependent upon the contraction of the institutions. The paradox, as specifically demonstrated in the case of the Albert, was that external pressures to improve the quality of life for people with learning difficulties occurred within strict budgetary constraints; funding directed into the institution meant there was less for the development of community care. So, as previously suggested, NWRHA's solution for the Albert, promulgated in 1992, and dependent upon bridging finance, was for the institution to close as rapidly as possible (NWRHA 1989). Perversely, according to the former estates manager, huge costs associated with asbestos and heating

[70] Stephen Thornton, Interview with Jan Walmsley, March 2005

systems meant that ultimately when it was sold, in 1996, the sale was a deficit transaction.[71] This, and the other tensions highlighted, suggests a lack of systemic thinking at best, or ideological short sightedness at worse, on the part of policy makers at the time.

4.5 Conclusion

This chapter has charted those pressures, emanating from external change agencies, which were present during the contraction of the Royal Albert. Testimonies, particularly of those managing this formidable organisational change, re-inforced by documentary data, indicated that an intricate mix of ideological, financial, logistical and compassionate imperatives all impacted upon hospital rundown. Cost and logistics, it has been suggested, ultimately dominated the drive to close the institution, with welfare concerns acting as a reforming agenda. The latter at times, because of financial demands, undermined the pace of organisational contraction. However, pervading both the reality of the push to close, and the need to prioritise the needs of people with learning difficulties (as well as staff) in the contraction process was a powerful rhetorical framework infused with the ideology of normalisation/SRV. In its focus upon the role played by change agents *within* the institution, Chapter Five provides further illumination of this latter point.

[71] Notes from a conversation with Alan Sharples, February 7th, 2007.

CHAPTER FIVE

AGENTS OF CHANGE: A HEGEMONIC APPROACH

5.1 Introduction

Chapter Four examined key external pressures, emanating from change agencies, which impacted upon the organisational contraction of the Royal Albert Hospital. In contrast, the focus here and in Chapter Six is on the second of the key research questions:

> *How did managers implement the rundown of the Royal Albert Hospital, Lancaster?*

In their roles as instigators and implementers of organisational change 'deemed desirable by a change agency' members of the institution's senior and middle management can be described as 'change agents' (Rogers 2003:27). So attention in the thesis now shifts from the *structure* of Royal Albert change to its *agency* (King 2009;

Wilsford 2010). These constructs constitute ways of interpreting what was an intensely complex affair; they are about *emphasis*, an analysis of the oral testimony, as already intimated in Chapter Four, indicating there was considerable interplay between elements of agency and structure.

Policy implementation throughout the rundown period, as outlined in Chapter Four, was highly elaborate. Permeating much of the interview data, for example, are references to 'negotiation'– inter and intra residents, staff, social workers, relatives, councillors, trade unions, the public and external agencies – with all the pressures and diplomacy and, at times, bloody mindedness that implied. Added to which, those bringing about change often referred to the unknown nature of the process. One of the senior managers encapsulated such a perspective when he recalled that:

> *It was pretty much make it up as you go along. I suppose we had no template that we could work to because one didn't exist.*[1]

In organisational change terms, and specifically borrowing conceptual paradigms employed by soft systems methodology (SSM), this institutional contraction could be described as a 'mess' (Checkland and Scholes 1999).[2] Such a notion presupposes ambiguity and uncertainty as inherent in certain problematic *human* situations. SSM thinkers contrast this with a 'difficulty' which can be tackled as a discrete and linear matter, with factors knowable from the start. A 'mess' encompasses complexity of entanglements, relationships (which includes the researcher), and disparate worldviews or weltanschauung as integral to the particular dilemma. This has parallels with what Rogers (2003) describes as a 'radical innovation':

> Some innovations are so radical and create such a high degree of uncertainty that they must be adopted through an innovation process that is relatively unstructured and almost completely unroutine. An unstructured decision process

[1] Phil Morgan, Interview March 20th 2008.
[2] Systems Thinking and Practice: A Primer (Open University T551) 2005.

> is one that has not been encountered previously in quite the same form and for which no predetermined set of ordered responses and routines exist (Rogers 2003:426).

One former member of Royal Albert middle management summarised this notion of 'mess' or 'unstructured problem'. During the 1980s, Dave Spencer recalled feeling that:

> *I don't think people ever would have questioned we should do something, if only we could get from here to there without any kerfuffle in between it would be great but it was the, what is the kerfuffle going to be like, how do we go through that process?*[3]

This, and the next chapter, focus upon how the *kerfuffle* of Royal Albert rundown was implemented by those members of its senior and middle management who comprised the organisation's change agents. While Chapter Six concentrates primarily upon the impact of the personal attributes of management, this chapter examines what can be construed as the adoption of a value-laden hegemonic approach.

5.2 A Hegemonic Approach

The definition of hegemony used here is in essence the one developed by the Italian Marxist thinker, Antonio Gramsci. 'The starting point' for the latter, claims Roger Simon,

> is that a class and its representatives exercise power over subordinate classes by means of a combination of coercion and persuasion (Simon 1985:21).

From this conceptual platform Gramsci was able to develop a theory of hegemony which went beyond both the original Greek definition, and the one employed by Russian revolutionaries, especially Lenin. In the former case hegemony was taken purely to mean domination, or leadership, of one group or individual over others; for the latter, hegemony was a strategy whereby a revolutionary group could build alliances to overthrow the state (Simon 1985:21-23). Although embracing these prior definitions,

[3] Dave Spencer Interview April 3rd 2009.

Gramsci was primarily interested in hegemony as a means of understanding how the state attains and maintains power. His central argument was that the ruling class did this through the organisation of consent (Simon 1985:21). This in turn hinges partly on coercion but also crucially on persuasion and rhetoric, pivotal to which is, as Gramsci states, the striving for an 'ideological unity' which 'serves to cement and to unify' the diverse social forces and classes (Simon 1985; Forgacs 2000:330).[4] The winning of hearts and minds, in other words, was instrumental in political domination. Important to this hegemonic adoption is that it has an imperceptible, almost invisible, quality; the ideological core constitutes a 'common sense', taken for granted, view of the world (Simon 1985:58-66; Humphreys and Brown 2002). Around these central, and here briefly outlined, ideas Gramsci identified other facets of hegemony, some of which will be referenced in an explication of the relevance of this theoretical framework to the institutional contraction at the heart of this study.

Royal Albert Hospital contraction displaced hundreds of individuals – people with learning difficulties as well as employees. A major challenge for change agents, as discussed in this chapter, was to *persuade* those essential to enabling hospital rundown, such as staff and families, to be supportive of the process. In some institutions, referenced in Chapter Two, particularly in North America and Australasia closure processes were vehemently resisted by trade unions and family groups (Johnson 1998; Enbar, Morris et al. 2004; Malacrida 2008). The wider research implies that pre-empting and overcoming opposition was a crucial element in achieving institutional contraction. Moreover, it suggests that if staff had guarantees regarding future employment then they would be supportive of the moves towards deinstitutionalisation. King, for instance, in his Exeter study, stated that:

[4] The quoted phrases are Gramsci's own words taken from Selections from the Prison Notebooks (1971), edited and translated by Hoare and Nowell Smith. London, Lawrence and Wishart.

> Offering the hospital staff the guarantee of a place in the new services was an *essential* plank to win their support (King 1991:61-2).[5]

In other settings, however, such assurances were not always forthcoming (Enbar, Morris et al. 2004). This was the case in the Royal Albert rundown. Geoff Hopkinson, one of the former senior managers recalled that jobs were *not* guaranteed for any member of staff in community services; appointments would be made purely upon merit.[6] In the same interview he was clear that people would lose their jobs, and that 'redundancies were part of our strategy'.[7] However, unlike some other institutional closures, this state of affairs did not result in collective resistance. Arguably one of the primary reasons why this did not happen, as will be illustrated, was because those driving organisational change used an amalgam of hegemonic devices (Simon 1985; Forgacs 2000).

5.2.1 Hegemonic Dialogue

Oral evidence suggests that core facets of hegemony, defined above, were prevalent in the managerial framing of dialogue about Royal Albert institutional contraction. Meaningful discussion and exchange of views were managed within strict parameters, enabling the change agenda, as defined by the institutional hierarchy, to proceed largely uncontested. The tone of the dialogue which occurred at the Royal Albert during these years was encapsulated in a 1985 North West Regional Health Authority (NWRHA) policy document:

> In considering the proposals for run-down of hospitals it is *essential*[8] to involve all the people who have a stake in the situation... The planning process should be an open and continuing dialogue with many and varied channels, both formal and informal, for all concerned to use to feed in their contribution... It means

[5] My emphasis.
[6] Geoff Hopkinson, Interview May 1st 2008.
[7] Geoff Hopkinson, Ibid.
[8] My emphasis.

> more opportunities for making a contribution than is often the case in large organisations (NWRHA 1985:3).

These stakeholders comprised residents, staff, relatives, policy makers, community workers, and the public, with all having 'an interest which must be recognised'. However, the 'open and continuing dialogue', as the document illustrates elsewhere, was limited to details of the contraction planning processes. This appears to be similar to what one historian describes as 'effects bargaining' in the context of *deindustrialisation* in North America (High 2005). Steven High laments:

> the narrowing scope of US labour law which once required companies to negotiate plant closing decisions with unionized employees, but which now only requires bargaining over the effects of these decisions (High 2005:196).

Where deinstitutionalisation studies reference consultation strategies (Korman and Glennerster 1990; King 1991; Peters and Freeman 1992; Johnson 1998; Manning 2008) the lack of planned involvement of key stakeholders, other than managerial professionals, in influencing fundamental aspects of policy agenda does seem to have been the usual state of affairs. One exception to this was in New Zealand, where deliberations over the future of the last remaining institution for people with learning difficulties, the Kimberley Centre, at least nominally, involved the families' organisation from the outset (Stewart and Mirfin-Veitch 2008). The regional health planning group, with input from the Kimberley Parents and Friends Association, although apparently not staff representatives, considered three options: 'status quo with refurbishment of the Kimberley Centre; partial deinstitutionalisation; or complete deinstitutionalisation' (Stewart and Mirfin-Veitch 2008:7). With various twists and turns the ultimate decision, made in 2001, was to opt for full closure, much to the chagrin of some parents (Stewart and Mirfin-Veitch 2008:7;29). In contrast, for the Royal Albert, and other similar long-stay institutions in the north west, there was no involvement of people with learning

difficulties, their families or staff in the formulation of overall deinstitutionalisation agendas (Peters and Freeman 1992). This was despite there being, as will be illuminated in subsequent chapters, a range of serious misgivings about the direction, and impact, of both learning disability policy and its implementation in the case of the Albert.

Although interviews with senior management and rank and file staff illustrated that doubts about this specific organisational change were allowed to be expressed, the hegemonic nature of the dialogue constrained the degree to which these concerns could impact on the overall policy direction. The research data indicated that the primary formal forums, in which deinstitutionalisation issues could be raised, included: briefing sessions; and normalisation/SRV training workshops.

Shortly into his time at the Royal Albert, the new unit manager brought in the Industrial Society[9] to train staff in team briefings. David Jordison recalled that the rationale underpinning this initiative was,

> *so that people could get facts about the closure from their immediate line manager rather than a big meeting in a hall with a thousand people where there's no communication backwards or forwards.*[10]

These briefings aimed to facilitate 'effective communication' to a body of employees numbering upwards of 800 personnel.[11] Jordison explained that:

> It is important for all our staff to know and understand what the community care policy is, how our services for the mentally handicapped are adapting and how staff themselves are affected in their jobs.[12]

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[9] The Industrial Society, now renamed the Work Foundation, was concerned with promoting welfare and good relationships in the workplace.
[10] David Jordison, Interview February 15th 2008.
[11] Lancaster Guardian, November 13th 1987.
[12] Lancaster Guardian. Ibid.

These sessions, as the Unit General Manager stated explicitly, were about the dissemination of information to teams of around ten staff:

> *There was not much debate in a sense of two-way communication. The manager would stand in front of his team and say this is how it is, this is what's going to happen this month and then staff had a chance to come directly to me or to go back to their manager outside that half hour. The idea was that the half hour wasn't going to interfere with the routine of the work. It was information...*[13]

The lack of dialogue was recalled with a degree of frustration by former members of staff. Mrs Creed, a Royal Albert nurse of over 40 years service, for instance, and on her own admission a very active trade unionist, remembered that:

> *We had lectures. We didn't want it to close.*
>
> You had lectures?
>
> *We had meetings. We said it wouldn't work. But they said it would... We had meetings with staff - the senior staff, nursing officers - saying, 'Oh we don't think it will work.' 'Oh it will. Oh it'll definitely work. It's got to happen whether you like it or not.' So we had no say in the matter, because we were only staff. It had already been sorted that they were going to get them in the community.... We didn't have a say in the matter, we just had to accept it.*[14]

Similarly, a nursing manager said that, at the time, he was 'really, really angry' about the way the hospital was closing, and would express this to 'anybody who would listen'. However he implied that this had no effect on the overall process, because:

> *it was a done deal anyway. They had consultations but the consultation was, 'We're doing it, that's it'.*[15]

The, in many ways commendable, emphasis on keeping stakeholders informed extended to the League of Friends. Throughout the rundown period, the two most

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[13] David Jordison, Interview February 15th 2008.
[14] Mrs Creed, Interview, June 17th 2009.
[15] Ward manager (male), Interview August 2nd 2008.

senior managers regularly attended annual general meetings in order to brief relatives and answer any questions.[16] In contrast, Jordison admitted that staff team briefings, because of his own increased responsibilities, had lapsed by the end of the 1980s.

Normalisation/SRV training workshops, explicitly providing the ideological framing of rundown, constituted another seminal formal arena in which issues relating to institutional closure were aired. Geoff Hopkinson, the Director of Nursing Services, remembered that staff,

> *did express their reservations but then we'd wanted an open talking environment anyway. That was the nature of our workshops especially, they weren't all sort of chalk and talk. There was a lot of discussion that took place in those workshops, especially the later ones because we changed the format considerably, so we had to be prepared to listen to remarks that weren't supportive to the ordinary life model... To be fair, to their credit the staff who just did not believe in it they would say so but they didn't make life particularly difficult for the effort, for the mission.*[17]

Elsewhere in his interview, Hopkinson implied that a lack of trade union opposition was a result of the persuasive impact of this training regime. Although many staff were faced with the prospect of losing their job, he recalled that:

> *It always amazes me that they (the unions) accepted it without too much difficulty. I suppose it came down to how we (the management) approached it really... We had discussions about people's right to live in the community. We had to spend some time working with our union people and we got those to come through the normalisation workshops as well. They were able to give some thought to people being about to live their life, and so there needs to be the right sort of staff for it. Not everybody wants to do it, not everybody has the*

[16] RAHLOF Minutes 1984-95.
[17] Geoff Hopkinson, Interview, May 1st 2008.

ability to do it and so fortunately the unions were able to see this and they gave us no more hassle after that.[18]

As outlined later in the chapter, the recruitment of trade unionists into change agent positions was perhaps also a key factor in undermining collective staff resistance. Strong traces of a hegemonic agenda are evident in these extracts in which oppositional perspectives, although voiced at the time, ultimately held minimal sway in a rundown discourse. The tenor of this argument is further substantiated through referencing a recollection from one of the people who trained Royal Albert employees in normalisation/SRV. Steve Mee states that:

> My experience of this training was that groups had to reach conclusions consistent with the ideology and there was a lot of peer pressure to come to the 'right' conclusion. The service discourse seemed to change overnight. I have been involved in the teaching of the theory to bewildered staff from 1984 to the present day (Mee 2005:11).

A sense of 'rightness', as will be demonstrated below, was a crucial underpinning element in developing and maintaining the managerial hegemonic approach; although Mee implicitly questions the efficacy of the latter with his allusion to 'bewildered' staff.

Overall, the research evidence, whether relating to briefings or training, is consistent with what Zappen (2000) described as the Aristotelian view of dialogue as a form of rhetoric i.e. one voice trying to persuade another of its viewpoint, and in doing this not being really interested in the perspective of the other for its own sake. Importantly, given the specific context of this study, this rhetorical stance accords with the position adopted by Wolfensberger, the architect of SRV. He argues that:

[18] Geoff Hopkinson, Interview, May 1st 2008.

> SRV relies largely on educational and persuasive strategies that change people's mind content about certain classes of other people by changing their perceptions, expectations, and attitudes (Wolfensberger 2002:253).

Such a definition, as with the Aristotelian perspective, contrasts sharply with the egalitarian stance of Socrates and Bakhtin, who saw dialogue as an open-ended exchange and exploration between voices of equal weight (Bakhtin 1984; Zappen 2000; Korritz 2006).

5.2.2 Construction of Legitimacy

Analysis of interviews with former members of Royal Albert management, especially those with greatest seniority, indicates that integral to hegemonic practices was the construction of legitimacy. This latter concept can be applied to organisational change when there is: 'a normative acceptance of (its) rightness'; a belief that it is reasonable and fair; and a perception that it is 'desirable, proper and appropriate' (Humphreys and Brown 2002:423-4). These authors claim that for managers 'to maintain employee acquiescence and commitment' they need to nurture perceptions of 'themselves and their strategies as legitimate' (Humphreys and Brown 2002:424). In other words:

> legitimisation involves portraying a situation as though it is fair and worthy of support (Thompson 1990; Watson 2003:160).

It has been suggested by researchers that the concept of legitimacy, or fairness, is particularly appropriate in the 'downsizing' of organisations. In her Finnish case-study, for instance, Lamsa suggests that:

> managing downsizing can be ethically demanding, even a problematic experience for a manager (Lamsa 1999:245).

Watson argues that in the USA, 'restructuring, through layoffs, has been an accepted practice since about the mid-1980s.' However,

> because of its profound impact on people's lives, corporate leaders often

find it necessary to *justify* their restructuring and downsizing policies (Watson 2003:158).[19]

A crucial outcome of such an approach is that resistance is 'effectively silenced' (Watson 2003:158). Illuminated below is the argument that Royal Albert management created a *legitimate* account of institutional contraction.

Amongst those interviewed, with the exception of one of the resettlement officers, middle and senior management presented historical meta-narratives which viewed the closure of the Albert, along with similar establishments, as an *inevitable* consequence of liberalising attitudes.[20] These accounts, infused with a Whiggish idea of historical progress (Butterfield 1973) stressed the impact of scandals, legislation such as the 1959 Mental Health Act, behaviour modification, critiques such as Goffman, the Jay Report and normalisation. Phil Morgan captured the moral tone of these viewpoints when he suggested that hospitals like the Albert

> *closed because they should never have been opened... It shouldn't have been there in the first place.*[21]

Likewise, David Jordison, who was from a business not a therapeutic background, argued that:

> *clearly they're from another time, aren't they these institutions? I think even the most unenlightened government minister just would need to walk around and see that there was something vaguely Dickensian about the whole thing that wasn't fit for even the last century.*[22]

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[19] My emphasis.
[20] Bob Dewhirst, Interview June 9th 2009; Mary Lawrenson, Interview September 9th 2009; Dave Spencer Interview April 3rd 2009.
[21] Phil Morgan, Interview March 20th 2008.
[22] David Jordison, Interview February 15th 2008.

Furthermore, in the eyes of change agents the emphasis on the 'rightness' of closure extended to the process itself. Such a perspective was exemplified by a former middle manager, who recalled an interaction with a Lancaster Guardian reporter in which:

> *I actually said to him, 'It is really important that you get this bit right.... The hospital is closing because people were leaving and finding new places to live, it isn't that people are having to leave because the hospital is closing.' The story came out the following Friday, and said, '——— says we have to find new places for people to live because the hospital is closing.' He had a tape recorder as well and I did all those things you do trying to get in touch with them and say, 'You weren't listening right. I demand an apology and all this because that is exactly the opposite of what I said.' Of course nothing ever appeared and I refused ever to speak to them again.*[23]

This extract, as with the meta-narratives illustrated, exuded a uni-dimensional ethical clarity. This viewpoint belied both the complexities of Royal Albert contraction, as narrated in the *same* interviews, and, as discussed in Chapter Two, the broader politics of deinstitutionalisation. Importantly, however, these moral accounts helped to *legitimise* the rundown of that particular institution.

In their interviews, members of institutional management revealed vestiges of legitimising their viewpoint of rundown by 'othering' those staff who questioned this organisational 'downsizing'. This distancing provides insights into a constructed hegemonic stance in which hospital contraction, and its embedded ideologies, was the only 'right' way; the corollary of which was that any opposition or doubt was 'wrong'. Senior and middle management, in their inner interview dialogues, presented these other staff 'voices' as ones which viewed the hospital as being there for their own interests, rather than those of people with learning difficulties. This latter sentiment was

[23] Anonymised extract from a research interview.

expressed very clearly by David Jordison, who described a meeting, prior to his arrival as Unit General Manager, involving all the Royal Albert staff. Those present were addressed by the District Health Authority's General Manager, Paul Whitfield, who:

> *quite courageously stood up and said, 'We're going to close the Royal Albert. We're getting a general manager in and the target time is three years.' I think he was reported as having said, quite rightly, 'We're only here because of the residents.' I think that surprised many people, because I think many people in their hearts felt they were there because they were there and the hospital was there for them. So he got a fairly good message across there. But it didn't go down too well in all quarters.*[24]

In addition, Jordison's extract intimated that Whitfield's action bordered on heroic, facing the body of hospital employees 'quite courageously' (Gabriel 2000). Traces of a similar theme, expressed conversely, was evident in the oral testimonies of members of middle management. They implied that individuals who opposed change were cowardly, because, in contrast to those implementing change, they were not prepared to *openly* express their views. Such a stance is exemplified by the following interview extract:

> *I know we always rubbed up against the ones that didn't quite believe in it. They weren't brave enough to speak out against us, but they weren't brave enough to speak out against the rest of the staff either.*[25]

Likewise, Dave Spencer suggested that the reason why one former staff critic of institutional closure would not talk with me on tape was because the individual knew that, contrary to his claims, he would be exposed as representing a minority viewpoint; he was not prepared to take that risk. However, elsewhere in the interviews of the change agents cited here, there was an acknowledgement that some staff did indeed

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[24] David Jordison, Interview February 15th 2008.
[25] Anonymised extract from a research interview.

'speak out'. The suggestion was, as in the recollection of Hopkinson, quoted earlier, that this was 'to their credit'.

The prevailing implication in senior managerial interviews was that opposition to institutional contraction was ultimately entwined with staff's own personal limitations, rather than a considered assessment of what was best for hospital residents. One of the senior managers, for instance, argued that closure for some staff,

> *didn't fit in with their life plan. It meant that they would have to change their comfort zone I suppose. There were quite a lot of people like that, some more than others, depends how comfortable you were there I suppose. Some people managed it quite well. Some people actually thrived on the change and went into the community and worked with clients in the community and they thought they were contributing more in the community, they were very happy, but there were people who didn't want the place to close in their hearts.*[26]

In this extract these 'other' staff are positioned vis-a-vis those employees who 'actually thrived on the change'. Elsewhere, in the same interview, the interviewee developed this dichotomy between nursing viewpoints, even describing some of his staff who were implementing change as 'crusaders' or 'champions'. Likewise, the suggestion of an inability to change is evident in this extract from an interview with another senior manager:

> *I know that there were some casualties among the staff. Some staff I know found it difficult to become re-established after the Royal Albert closed, after their redundancy, because they were sort of older and felt they couldn't adjust to the new way of doing things as it were.*[27]

[26] Anonymised extract from a research interview.
[27] Anonymised extract from a research interview.

Overall the tone of these extracts is what Thompson (Thompson 1990), quoted by Watson (Watson 2003), defines as 'rationalisation', a prime legitimisation strategy. Such a viewpoint is regretful about the negative impact which justifiable change, especially contraction, has on employees. A comparative example, in theme if not scale, from the corporate world is cited by Watson:

> When Christopher Galvin, Chief Executive officer of Motorola, announced the loss of 15,000 jobs he commented: 'While we regret the impact this will have on certain of our employees, we must adjust our production capacity to the reality of the current market . . .' (Brown 1998:1). The relative importance of adjusting production capacity despite the loss of jobs is presented as an assumed imperative (Watson 2003:160).

In the case of the Royal Albert change agents, the 'assumed imperative' was the shift to community care through the closure of the Albert, which, unfortunately, did incur 'casualties' amongst 'some staff'. Reflecting upon the latter, one of the senior managers, already quoted, expressed genuine compassion for their plight:

> *I felt sorry for the staff, many of them, `cause I know that a lot of them were disillusioned, many of them did believe that when they went there they could have a job until they retired and they saw that opportunity being forcibly taken away from them.*[28]

However, in an emotionally charged statement, made at the time of the global financial crisis, this individual went on to assert that:

> *When it closed I didn't experience one tinge of regret at all. Absolutely none. `Cause I do feel in the case of the staff we gave them years notice. How often do you get that in industry? How much notice did staff get who have worked in the car industry, in the housing industry in the last year? Some of those in the*

[28] Anonymised extract from a research interview.

banking industry were told to clear their desk on the same day. Our staff had years, years notice. So I feel that we did it very maturely.[29]

Strongly intimated here was another strand of a managerial perspective which emphasised the legitimacy of contraction. The cost of a necessary and right organisational change was mitigated by an emphasis on procedural justice, which ensured that the organisation treated displaced employees in a fair manner. The veracity of the latter claim, which included official ceremonies (reported in the local press[30]) marking the departure of long-serving hospital employees, resonated with myriad oral and documentary research data.[31] In a study of downsizing in an Australian company, however, the researchers suggest that a similar focus on procedural justice 'arguably served less to ensure ethicality and more to secure the organizations' instrumental goals' (Rhodes et al. 2010: 536).

Interwoven into these managerial testimonies was the sentiment that 'they', these 'other staff', regarded people with learning difficulties as being less than equal in status to themselves. This is the implicit message of a statement made by the senior manager, just quoted, that:

It's always been a mystery to me why, why people didn't understand what ordinary living was all about, 'cause I mean that's what they do themselves, so I don't know why they could never apply it to people who were in their care.[32]

This assertion is interesting not only because it alludes to staff seeing residents as 'different', but also to failures in persuading staff to embrace a new mind set, a fresh ideology, and laying the responsibility for these shortcomings firmly with them. Problematising the latter assertion, however, were assertions made by change agents

[29] Anonymised extract from a research interview.
[30] Lancaster Guardian, April 26th 1991, March 12th 1993, March 4th 1994, October 7th 1994.
[31] Lancaster Guardian, January 22nd 1993, April 16th 1993. Male Ward Manager, Interview August 2nd 2009. Tony Dennison, Interview September 1st 2009.
[32] Anonymised extract from a research interview.

themselves that adopting normalisation/SRV, and its implications, could require a profound leap of '*blind* faith'.[33]

The inner dialogues of the senior managerial accounts do encompass a moral dimension, a moral distancing in relationship to these 'other' staff. As referenced above, there were remarks referring to staff lacking imagination, struggling to adapt, unwilling to move out of their comfort zone – all of which may suggest some degree of moral judgement on the part of the tellers. In other words, it was felt that it was incumbent upon these staff to adapt, and it was their own failure if they were unable to do so. These managers, in this instance, were claiming to be on the side of the residents, espousing an egalitarian perspective, and importantly expressing willingness to move out of their own 'comfort zones', to be imaginative, to dream of a changed future which would improve the lot of people with learning difficulties at that time residing within a closed community. It is possible to detect a hegemonic theme focussed upon risk and safety. Those opposed to change were doing it purely because they wanted themselves, and their clients, to remain protected and safe, as implied in a senior managerial interview:

> *Many of the staff were firmly of the belief that many people with learning disabilities could not live outside, just could not live outside, and that the hospital was the best place for them.*[34]

This viewpoint is in juxtaposition to those who, whether professionals or clients, took risks. The latter viewpoint was entirely consistent with the ideological stance of the 1983 regional policy document, discussed in Chapter Four, the *Model District Service*:

> In changing over to a developmental approach it becomes clear that some element of risk is inevitable as people move towards a greater degree of independence (NWRHA 1983).

[33] Mary Lawrenson, Interview September 9th 2009. See Chapter Nine: 9.2.5 Liberation.
[34] Anonymised extract from a research interview.

Such positioning by senior agents of change can be construed as hegemonic, legitimising the community care agenda and distancing, and devaluing, the viewpoints of staff who did not concur. This othering could justify alternative perspectives to the dominant community care narrative not being heard as 'fully valid voices', in what Bakhtin would describe as a polyphonic dialogue: their concerns were not taken on board as authentic (Bakhtin 1984; Dentith 1995). It provided an important ethical dimension to legitimising the rhetoric of normalisation, and the agenda of organisational downsizing. The dominant ideology, and orthodoxy (Rolph and Walmsley 2006) replaced other viewpoints which were held by people whose stance was viewed as ethically dubious, as not being 'right'. Similar to other organisational changes, these findings indicate that;

> ethics can be regarded as the domain through which power asserts legitimacy (Byers and Rhodes 2007; Rhodes, Pullen et al. 2010:356).

In the hegemonic dynamic of Royal Albert rundown it is arguable that the varied voices of dissatisfied staff, illustrated in Chapters Seven and Nine, concerning their future, genuine concerns about residents, the meaning that the institution had as a community, as a workplace, became lost as the hospital ran down. These 'other staff' could be viewed primarily as 'objects', rather than the subjects, of a community care narrative.

5.2.3 Ideological Leadership

Crucial to management's construction of a legitimate account of institutional rundown was its ethical reliance upon normalisation/SRV. Reflecting the stated ethos of regional health policy both the former Director of Nursing Services and Unit General Manager, in their oral testimonies, were explicit about the core impact these ideologies had on their mind set at the very start of their respective tenures. Hopkinson, as demonstrated in Chapter Four, was a man on an ideological 'mission'. In contrast, Jordison did not arrive with such evangelical zeal. He recalled a background in private and public accountancy,

and finance management, albeit including employment in the NHS in the years preceding the Royal Albert. For him, coming to the hospital,

> *was just a career move. I wanted to get into general management. I was never a natural accountant. And I saw it as a way into general management.*[35]

By 1986, when he was appointed, general management had already been introduced at district and regional level in the north west, reflecting the implementation of recommendations made by Griffiths in 1983 (Griffiths 1983; Harrison 1994).[36] In a departure from the tripartite consensus management structure, of which Geoff Hopkinson had been a part, David Jordison as the Unit General Manager had sole executive decision making powers, although, ironically, for some staff the new arrangements actually felt more consensual than the previous system.[37] The world of learning disability services was completely new to Jordison, but crucially he recalled that he was receptive to learning, including the enthusiastic adoption of normalisation. Shortly after his arrival, he remembered that:

> *People started to educate me, there's no doubt about it. People like Steve Mee, Olive Carol, Geoff (Hopkinson) in his own sort of gentle way, you know. I would say something that was clearly outrageous and Geoff would just sort of say, 'Yes you could say that, but let's look at another way.' And they'd all been on these PASS courses and they'd got their minds right and gradually they worked on my sort of block of stone and got me* thinking straight.[38]

Such an experience may not have been unusual. In their seminal study of the closure of Darenth Park Hospital in Kent, for instance, Korman and Glennerster note that:

> The coming of general management introduced a new group of managers to many districts, some of whom came with the conviction that normalisation

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[35] David Jordison, Interview February 15th 2008.
[36] Paul Whitfield, Interview October 28th 2009; Gordon Greenshields, Interview December 16th 2009.
[37] Phil Morgan, Interview March 20th 2008; Mary Lawrenson, Interview September 9th 2009.
[38] David Jordison, Interview February 15th 2008. My emphasis.

should be the driving force behind reprovision. Others came largely ignorant of the whole field of mental handicap but quickly learned the new gospel (Korman and Glennerster 1990:64).

The latter sentiment accords with the account presented by Jordison, although Hopkinson's testimony, as well as that of Tom McLean (discussed in Chapter Four), suggests that ideological conviction at a senior level was not related purely to the introduction of general management.

In their remembered accounts of the rundown both Hopkinson and Jordison imply that the principles of normalisation played a crucial role in opposing escalating NWRHA pressures to prioritise hospital closure. Geoff Hopkinson recalled, and this probably relates to the 1990s, that he was,

> *a thorn in the side of the Regional Health Authority sometimes because they were continuously pushing to close wards and threatening to withdraw money from it. And I've said that, 'This is not the right way to do it; the right way to do is to put as much effort as possible into resettling everybody who lives here. If you be patient the wards will close as a result of that and you'll get the money.'*[39]

In this extract he emphasised closing the hospital 'in the right way'. Echoing this sentiment, Jordison remembered that:

> *It wasn't an option that it was going to stay open, so our line was, 'Well let's close it well. Let's do it properly. What's the point in going out in a bedraggled retreating shambles.'*[40]

In contrast to Hopkinson's natural metaphor of 'a thorn', Jordison employed imagery, echoed elsewhere in his testimony, which suggested that he viewed the management of this process as being akin to a military campaign. Although, like his Director of

[39] Geoff Hopkinson, Interview May 1st 2008.
[40] David Jordison, Interview February 15th 2008.

Nursing, he claimed that he was willing to confront the regional authorities on this matter, initially in relation to his original remit of hospital closure within three years:

> *It became obvious fairly early on that three years wasn't viable. We got all kinds of big cheeses from the region coming up piling pressure on. And the response that we gave was, 'Yeah we can close it in three years. Managers can manage, they can manage anything you want but there's always a huge price. And the quicker it goes the higher the price. And the price is unhappy clients, unhappy members of the public, unhappy politicians' - and that was the one that got them really. So we managed to stretch it - I marvel at it sometimes, because at one stage there were about fifty people left in that huge place but we weren't bussing them out in lumps. And so I was quite proud of people like Phil (Morgan) and Geoff who sort of hung on to that principle.*[41]

At the centre of this resistance, it was claimed, was the notion of closing the hospital 'properly', in the 'right' manner, an ethical position underpinned by the ideologies of normalisation and social role valorisation.

While his approach was imbued with normalisation thinking, David Jordison, in the extract above, suggested that tactically he was open to using diplomatic persuasion to resist the pressures coming from the Regional Health Authority: their fear of 'unhappy politicians' was a key bargaining tool. Geoff Hopkinson, on the other hand, possibly reflecting a nursing as opposed to an accountancy background, used 'the emotional blackmail' of their own policy statements regarding normalisation. He remembered that:

> *We had a strategy document for the hospital which showed when wards would close but as far as we were concerned these were only ever estimates you see. And some of the discussions that we had with them [NWRHA] became pretty hairy sometimes because there was a little bit of emotional blackmail. We had to*

[41] David Jordison. Interview February 15th 2008.

say, 'We are resettling people, this is our number one priority. We are working with all of the areas that people are going to be resettled to, but we can't just push people out. We want to ensure that they are going to valued living schemes. Your own strategy document, the Model District Service, says this.' So we had to use their own material. [42]

In 1994, a conflict of values, such as intimated here, was reported in the local press:

> In what could be described as a complete u-turn, the chairman of the North West Regional Health Authority has suggested that surplus NHS properties could be used to provide services for ex-residents,[43] rather than residents being accommodated in houses within the community.[44]

This 'u-turn' was based upon concerns over 'cost effectiveness'. The reply of the Morecambe Bay Health Authority, that represented the Albert, accorded with Geoff Hopkinson's stated position. The Lancaster Guardian reported that Barrie Abram, the Chief Executive,

> expressed the HA's opposition to reverting back to institutional care. 'Our commitment to transfer people from institutional to community care is important and shall continue.'[45]

On one occasion Hopkinson remembered turning his ethical rhetoric on one of his senior managerial colleagues, in order to prevent the closure of specific wards in the Main Building. This occurrence would have been well into the 1990s, towards the end of the Royal Albert's existence, and exemplified the mounting pressure from the Regional Health Authority to secure the sale of the main hospital site. Hopkinson recalled that the Chief Executive of the local Priority Services Trust,

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[42] Geoff Hopkinson, Interview May 1st 2008.
[43] In the introduction to the article, the residents are defined as being those living at the Royal Albert and Lancaster Moor Hospitals. The latter was the local psychiatric institution.
[44] Lancaster Guardian September 23rd 1994.
[45] Lancaster Guardian. Ibid.

wanted me to close the two remaining wards to enable the university (of Lancaster) to acquire it. I expressed my opposition to this... Not them acquiring it... The idea was to close one of those wards and enable them to move into the one that we'd vacated whilst we emptied the other one and that was what I was opposed to because we weren't ready to close it at that time... We had this closure plan, (the Chief Executive) approved the closure plan, that was what we sent to Region, so Region knew what our closure plan was, and there he was trying to change it. So I wasn't very happy about it. I put all of the good value stuff in my opposition speech and we didn't close it before time and the university didn't acquire it. So I'm bloody pleased about that![46]

In what Geoff Hopkinson presented as a heroic tale, he was clearly very proud of the fact that what was 'right', heavily influenced by principles of normalisation ('the good value stuff'), won out against economic imperatives (Gabriel 2000).

Integral to the *Model District Service*, and its normalisation approach, was the emphasis on the *individual* person with a learning difficulty, and their needs and abilities, in opposition to the congregate living environment of institutional care (NWRHA 1983). In David Jordison's interview extract, mentioned above, he reflected this dialogue, with his statement that 'we weren't bussing them out in lumps'. This may have demonstrated an informed view of hospital closures elsewhere; earlier in the same interview, for instance, he recounted what had happened in the United States:

One of the things that had gone wrong in America was that they'd say, 'Okay tomorrow this institution is closing and a thousand people are coming your way'. And they'd played the trumpets and a huge sort of fanfare and it's all okay.[47]

Perhaps in making this statement he was aware of a national report, published at the time of his appointment, which reported that a hospital,

[46] Geoff Hopkinson, Interview July17th 2009.
[47] David Jordison, Interview February 15th 2008.

which had over a hundred residents, when it was due to close was able to move them all out in two days by bussing them to another (larger) hospital (Wertheimer 1986:17).

Further evidence of congregate responses was evident nearer to home, when during the late 1980s and early 1990s, 490 residents, just over half of the residents at Brockhall, one large long stay institution in Lancashire, transferred to the neighbouring hospital of Calderstones (Peters and Freeman 1992:48).

David Jordison's focus on the individual was implied in an interview with one of his middle managers. Dave Spencer, the Resettlement Co-ordinator in the 1990s, remembered his fury at finding out that there was a regional directive to increase the pace of resettlement. He recalled bursting into Jordison's room to confront him with this discovery:

> *'So this is true then is it?' And he (David Jordison) said, 'Yes. Just calm down a bit.' And started to explain. And I said, 'So do we need to change all our policies then? Because we have got policies and staffing levels and everything else about resettling about 20 odd people a year.' And he said, 'I am hoping Dave that we have got policies that tell us how to resettle one person at a time, and it doesn't matter whether we are doing 100 a year or 200 a year or one person, if we have got a policy that tells us how to do it right for each person.' Which put me in my place.*[48]

What the above extract, along with the others quoted in this section, implied is that at the senior level of Royal Albert leadership there was considerable homage paid to the ideologies of normalisation and SRV. This provides further support for the argument

[48] Dave Spencer, Interview April 3rd 2009.

that such ideologically framed rhetoric was a central facet of a hegemonic strategy being applied during the years of Royal Albert rundown.

5.2.4 Construction of Authority

Studies charting the introduction of general managers into the NHS, and learning disability institutions specifically, tend to emphasise their executive *power*. Less is written about their *authority* (Korman and Glennerster 1990; Webster 2002). An analysis of oral, and documentary material relating to the Royal Albert in the late twentieth century hints at attempts by the senior leader to establish his authority. These endeavours, it will be argued here, constituted a important strand in the hegemonic strategy adopted during that particular organisational change.

Baldwin and Williams distinguish the concepts of power and authority thus:

> The difference between authority and power... is that power is inherent in the person, or in their situation, whereas authority is afforded to you by other people. It is a decision that they make for themselves: whether to grant you authority or not (Baldwin and Williams 1988:26).

Although this comment is made by trainers wishing to achieve the active participation of learners, nevertheless the distinction is pertinent to the focus of this research. In both contexts there was a perceived need to persuade a group of people about the desirability of change. Further clarification is provided by one of the trainers, who asserted that: 'Power is what you start with. It's how you use it that will give you authority or not' (Baldwin and Williams 1988:27).

Although not overtly using the concept of 'authority' Rogers (2003), in looking at organisational change, offers the framework of *credibility*, arguing that:

> Change agents' success in securing the adoption of innovations by clients[49] is positively related to credibility in the clients' eyes (Rogers 2003:385).

Like the idea of authority, the notion of credibility is something bestowed on the change agent by others. Rogers suggests that this credibility can take two forms: 'safety credibility' and 'competence credibility'. The former is defined as 'the degree to which a communication source is perceived as trustworthy' (Rogers 2003:384-5). Such a state of affairs is easiest to achieve when the change agent is perceived as being *homophilius*, that is having similar attributes to those they are leading; a peer, for example. Competence credibility is

> the degree to which a communication source or channel is perceived as knowledgeable and expert (Rogers 2003:385).

Often, Rogers argues, this is the type of credibility external change agents have to attain. These individuals in many instances do not have key attributes in common with the members of the organisation to which they are introduced; in other words they are *heterophilius.* This concept, along with the others discussed here, proved useful in making sense of the relationship between the Royal Albert's senior manager and his staff.

The indications, as examined in Chapter Seven, are that David Jordison on his arrival as the hospital's first Unit General Manager was viewed with great mistrust by many of the staff. In their eyes, as an accountant, he represented a business culture, and was neither part of the nursing profession nor had any specific links with learning disability services. He was, both by objective criteria, as well as in the perceptions of others, a heterophilius agent of change. Jordison's own testimony intimated that this was not necessarily an issue with other members of senior management who had,

[49] 'Clients' for the purposes of this study can be defined as the employees and others involved with the Royal Albert.

been waiting for a few months for, not a messiah, someone so that everything could centre on a leader. They'd all got ideas and thoughts.[50]

The suggestion was that they were keen to welcome someone who had power to make things happen. However, Jordison recalled that early in his tenure he had evidence that he had a few bridges to build with the wider body of hospital employees. He invited the Industrial Society to carry out a survey of staff attitudes, and recalled that they uncovered some,

amazing urban myths going round: one of which was that – I don't know if you remember but the whole thing about general management was produced by one of the Sainsbury's... So they asked what the staff knew about me and they said, 'Oh well he's employed by Sainsbury's and he's coming here to close the hospital. And for every resident that he gets out he gets a hundred pounds.' So you wonder how that goes from you know, from the truth to that. But that's what they believed and so there were one or two myths to get rid of.[51]

An analysis of the oral testimony indicates that, whether consciously or not, in order to 'get rid' of these myths Jordison adopted a number of strategies which could be construed as attempts to establish his *authority* at the Royal Albert. At the heart of these was a sense that he humanised his presence. He did this through a number of interconnected avenues, which included: treating people and situations on an *individual* basis; being visible and available; exuding a sense of his own vulnerability, as well as power; and *acting* quickly. Taken as a whole these approaches were entirely consistent with attempts to win the 'hearts and minds' of staff, in particular, as an integral part of a rhetorical strategy.

Conveyed by Jordison himself was that he made efforts to make contact with staff face-to-face. He recalled that, from early on in his appointment: 'I did get around. I went to

[50] David Jordison, Interview June 12th 2009.
[51] David Jordison, Interview February 15th 2008.

see them all, or as many as I possibly could'.[52] One of the former staff, although initially sceptical of a non-nursing manager, nevertheless remembered Jordison being,

> *as a person very likeable, very approachable, presented himself well. I can only remember being with him two or three times. One, when he arrived, introduced himself, he went round various departments. Also, probably to do with resettlement, I went to his office once or twice. He was human, he listened and gave you a sensible answer.*[53]

Similarly another senior nurse, although at odds with the General Manager's remit to close that place down', recollected that:

> *I dealt with Mr. Jordison on quite a few occasions and we were always on first name terms and... he was a nice fellow.*[54]

Bernadette Hobson, who worked in the Clinical Psychology Department at the Albert, echoed such a viewpoint:

> *He could remember everybody's name after the first time... It gave him an edge, because everyone took to him.*[55]

This 'edge' around the use of first names was illustrated by a former ward nurse when she compared Jordison to a previous senior manager:

> *Jordison came then. But it was this other bloke before-hand. I don't remember his name to be honest because he wasn't that personal with staff - it was 'them' and 'us' again. And he stayed in his office and just shouted things from above and you had to get on with it... This other he was Mister 'So and So'... And David Jordison, you knew his first name. It got better again then.*[56]

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[52] David Jordison, Interview February 15th 2008.
[53] Tony Dennison, Interview September 1st 2009.
[54] Ward Manager (Male), Interview August 2nd 2009.
[55] Bernadette Hobson, Interview August 26th 2009.
[56] Freda Dennison, Interview May 31st 2006.

These quotations suggest that David Jordison made efforts to establish contact with individuals in what may have appeared to be an homogeneous alien organisational culture. There are similarities to that described by a trainer who, as an outsider, engaged with a group of police officers, arguably another example of an institutionalised culture. Williams recalls being 'quite anxious about doing it, worried about what they would be like, and whether they would reject me' (Baldwin and Williams 1988:28). However, in an endeavour to earn authority with the group he went early to the venue to 'have time around the group'. This preparation, as is suggested in the memories of Jordison, was spent breaking down the homogeneity of the group. Williams recalls that:

> I forced myself to become aware of them as individuals, to focus on the *differences*[57] within the group, the different faces, the different clothes, the different accents, to stop me from lumping them together in one big stereotype (Baldwin and Williams 1988:28).

The outcome was that he felt 'much more relaxed' and importantly gained 'a sense of my own authority in relation to the group.' As is implied about Jordison and his first actions at the Albert, Williams suggests that his strategy was employed from the outset.

Intimated in the above extracts relating to David Jordison is that linked with developing authority, was the notion of building trust, establishing a rapport with the staff. Rogers argues that:

> A change agent must develop rapport with his or her clients. The change agents can enhance these relationships with clients by being perceived as credible, competent, and trustworthy, and by empathising with the clients' needs and problems. Clients often must accept the change agent before they will accept the innovations that he or she is promoting. The innovations are judged, in part, on the basis of how the change agent is perceived (Rogers 2003:369).

[57] My emphasis.

As cited earlier, Tony Dennison's memory of Jordison was that he 'listened and gave you a sensible answer'. The suggestion here is that his authority was not merely based upon approachability, but on treating staff concerns seriously, and on their individual merits; in other words, on being empathetic. Jordison himself remembered having a respect towards staff, regardless of their viewpoint:

> *I was very impressed with most people, you know even the ones that weren't crusaders, many of them still had a great affinity with the residents. So I didn't feel any sort of animosity.* [58]

When the Unit General Manager arrived Steve Mee claimed that, as will be explained in more detail in Chapter Eight, the adoption of a resettlement strategy was being held up due to internal hospital politics. He recalled that:

> *When I first met with him, I'll be honest, 'cause we got an accountant leading a principled process it's bound to be a disaster. So I went to him to say, and his usual approach was, 'Right, how do you see your job?' First meeting, and, 'What are your problems?' And I said, 'Getting this implemented'. And he said, 'Right'. And I just remember it, it was so clear. 'What do you need me to do? Who are the blocks?' And then he said, 'Would you please write it in a more coherent way?' So suddenly - 'Whoa Christ! Somebody's taking this seriously.*[59]

According to Mee, shortly after that, with the help of the hospital's Senior Clinical Psychologist, the strategy was adopted. Although explicitly stated in that recollection, the idea of being taken 'seriously' is implicit in the oral testimony of one of the primary hospital trade unionists during the contraction period. In 1996, MJ Kiernan, who was a storeman at Lancaster Moor Hospital, decided that it was time to finish:

> *I saw the Chief Executive, David Jordison, in the pub one night with a couple of other senior figures in the local NHS. And I waltzed up to him, just getting on for closing time, and I said, 'Hey Dave! I'm sick to death of working for your cock-a-*

[58] David Jordison, Interview February 15th, 2008.
[59] Steve Mee, Interview February 18th 2008.

minnie bloody outfit, where's my redundancy?!' And everybody – you know lots of laughter all round. Two days later he turned up at my little stores, and said, 'Did you mean what you said the other night?' And I said, 'Yes'. He said, 'Can we talk?' I said, 'Yes'. Did the deal.[60]

As with Mee's extract, the implication here is that Jordison responded to Kiernan's concerns, taking the initiative to come down from on high to the latter's 'little stores'.

Intimated in Kiernan's story was a sense that David Jordison had authority because he did not flaunt his power. There is no suggestion in the trade unionist's account that the Chief Executive was put out by being accosted in a pub. Jordison himself also implied that he made efforts to extend this personal touch to people with learning difficulties. In his testimony, amidst other fond memories of former residents at the Albert, he recalled that:

Some of the residents took the piss out of me on a regular basis really... I was leaving one day and a lad called S—— used to hang about the steps. I always used to say, 'Cheerio S——. Are you all right?' And he'd go, 'Yeah, Yeah.' And get in my car and go. We'd got this new initiative on quality and it was a very good initiative and I thought this evening I'd try and extend the conversation a bit. 'Hi S——, you all right?' 'Yeah.' I said, 'Have you had your tea?' He said, 'Yeah.' I said, 'Was it warm enough?' Because one of the complaints living in the Flats (away from the main kitchens) was that the food was cold by the time they got it. He said, 'Yeah, Yeah. It was.' So, I'm not getting anywhere here, so I headed across to the car and he shouted after me, 'It was salad!' It felt like an arrow going between my shoulder blades, you know saying, 'I've got you!!' Yeah – beauty![61]

[60] M.J. Kiernan, Interview September 23rd 2009.
[61] David Jordison, Interview February 15th 2008.

In addition to humour being an integral element in both that story and the earlier one of Kiernan's, was a sense of the 'boss' making himself vulnerable. Again referencing Baldwin and Williams, they indicate that revealing vulnerability, not weakness, is important in establishing a rapport with a group (Baldwin and Williams 1988-3). From the start of his tenure Jordison indicates that he was willing to learn, that he recognised he was in a new situation and did not know it all:

> *I gradually met people and got a feel for it. And people started to educate me, there's no doubt about it.*[62]

Mary Lawrenson re-inforced the sentiment of that memory, when she recalled that:

> *I think that we, 'we' not just me, the people that were linked to the project, instilled some very strong values in him that he either had already or we re-inforced them and actually throughout his time at the Royal Albert he was regarded as somebody who was a people's person.*[63]

This sense of Jordison being regarded as a 'people's person' was, it has been argued here, partly a result of efforts on his part to construct his own authority as a change agent. Having authority, or, in Rogers' terms, credibility, can be construed as a predominant element in a rhetorical hegemonic strategy.

5.2.5 Recruitment

Already highlighted in this chapter have been the changes in personnel, and posts, which occurred during the final fifteen to twenty years of the Royal Albert's existence. While not arguing that it offers an all encompassing explanation, a key interpretation of some of these shifts is that they reflected a hegemonic strategy of organisational change. Such a viewpoint has already been touched upon in relation to the senior management of the hospital, but can be extended to include the manner in which student nurses, in particular, were recruited to *lead* the development of new services.

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[62] David Jordison, Interview February 15th 2008.
[63] Mary Lawrenson, Interview September 9th 2009.

This claim of hegemonic recruitment practices is predicated upon the Gramscian concept of 'intellectuals' (Forgacs 2000). Although one commentator suggests that at times Gramsci himself was unclear about elements of this notion, nevertheless there is sufficient clarity to make it pertinent to the organisational contraction under the spotlight in this study (Simon 1985:96-98). For hegemony to be developed and maintained, the Italian Marxist argued, there had to be 'leaders', whom he termed 'intellectuals'. The latter were not defined by their ability to think, because:

> All men (sic) are intellectuals... but not all men have in society the social function of intellectuals (Coben 1998:19).

His emphasis was on the 'social function' of an intellectual, who was a 'constructor, organiser, permanent persuader'; these individuals were the moral and intellectual 'organisers and leaders', charged with 'the task of articulating and disseminating the hegemony of their class over society as a whole' (Coben 1998:20). Gramsci differentiated between *traditional* and *organic* intellectuals (Simon 1985; Coben 1998). The former group he saw as deputies of the ruling class and instrumental in ensuring its hegemony over the people, through both civil society and the state. Roger Simon implies that the 'superiors', those instructing the traditional intellectuals in this instance, can be described as 'leading intellectuals' (Simon 1985:98). Gramsci defined organic intellectuals as those who were allied with the oppressed working class. In early twentieth century Italy the latter primarily included industrial workers and peasants; in the context of an institution such as the Royal Albert, those wanting radical change viewed the 'oppressed' as being people with learning difficulties (Collins 1992; Malacrida 2008). Gramsci also argued that 'the working class must produce its own organic intellectuals' (Coben 1998:20). Furthermore, the latter, unlike those who were traditional, had a reciprocal, and democratic, relationship with those they were leading. This leadership in turn needed to be collectively expressed, according to Gramsci, in

the form of a revolutionary party, forming the vanguard of fundamental moral and intellectual change.

Strands of this Gramscian conceptual framework of 'intellectuals', albeit summarised briefly, can be applied to the organisational contraction of the Royal Albert in the closing years of the twentieth century. The 'intellectual leadership' in the 1980s was changing with the appointments, already mentioned, of Geoff Hopkinson in 1983 as Director of Nursing Services, David Jordison as Unit General Manager in 1986 and at the start of the 1980s, according to the oral testimony, individuals such as Steve Wade as a nursing officer and Jim Bow. The latter, discussed in Chapter Four, was brought in to implement changes to the curriculum at the Royal Albert School of Nursing, in response to a heavily critical report from the GNC. A former charge nurse recalled that at the senior level during the early 1980s, 'there was a reorganisation. A lot had to re-apply for their own jobs.'[64] Crucially, a casualty of this process was the previous divisional Director of Nursing Services who 'didn't get it.' According to another former employee:

> *The regime, as I call them, that we had before were people who were complicit in the system. Those senior managers were complicit in the system, so they weren't ever going to change anything. But when you got new people coming in, seeing it with different eyes, you could see things starting - not change, but the debate starting to happen.*[65]

And, as part of the senior management hegemonic strategy to *influence* outmoded care practices in the institution, student nurses were seen as having a core role in carrying 'the debate' forward. These can be viewed, in Gramscian terms as the 'intellectuals' of a movement of change. (Although as discussed later in this section, this is not an

[64] Tony Dennison, Interview September 25th 2005.
[65] Anonymised extract from a research interview.

unproblematic concept when applied to the Albert.) Geoff Hopkinson, the Director of Nursing, made the claim that:

> *We had the nurse training school for the district actually on the Royal Albert campus ... We had a lot of students and although I wasn't responsible for them, I was responsible for ensuring that they had a good experience in their allocations on the wards and that was enormously helpful because these were the new people. And because we had so many of them it was good to be able to capitalise upon fresh minds who wouldn't be too contaminated, and I'm not afraid of using that word, by the hospital system.*[66]

This statement re-inforces the point, as discussed in the previous chapter, that in the early 1980s the nursing curriculum was moving away from a medical model emphasis. It implies that this shift was crucial in a political sense; it created 'new people' who were not 'contaminated' by traditional institutional philosophies of care. Dave Spencer remembered the impact of these ideological changes on these 'new people'. Starting his nurse training in 1983, he recalled that a pivotal moment in his approach to people with learning difficulties,

> *was when we started to get the right language to use - when we started hearing things like normalisation and hearing people talk about things being age inappropriate. 'That's what is wrong and all these toys and these middle aged men.' Very strange experience to walk round a place and think there is something wrong but I don't know what it is. It is kind of a parallel universe with a different set of rules and you couldn't quite put your finger on why those rules are wrong. Then later, not necessarily through the official training but through things you picked up and other courses you went on you realised that you were being given a way of analysing and a language that you could use that could explain why. I think there was a lot of things sort of coming together that*

[66] Geoff Hopkinson, Interview May 1st 2008.

encouraged a critical way of looking at something that people had just accepted would always be there.[67]

The 'right language' enabled this young nurse to make sense of 'a parallel universe'. The former head of learning disability nursing at the Albert during the 1980s, Bob Dewhirst, in an impassioned testimony, recalled the young student nurses coming through:

> *What you needed was young people with ideas, that was what you needed, you didn't need a boring old fart who'd worked there for 25 years, you know like the lads that I've mentioned. These young lads, they were aggressive, they had their ideas they had the philosophy, they knew what they wanted... We didn't need boring old farts. We needed to change things. You don't change things by appointing boring old people. You change things by getting the young lads in who've got ideas.*[68]

An insight into how these 'lads' (sic) could make an impact whilst training was remembered by a manager involved in a smaller institutional setting in the Lancaster District. For instance, Jenny Dunkeld, the Officer-in-Charge at Lancaster's Riverview Hostel, recalled that when students came on placement,

> *at first I used to get a bit uptight about it, not them coming on placement, because I liked student nurses coming, but they'd say, 'Why do you do so and so?' 'Well because da di da!' 'Yes, but why?' And I'd think, 'Because we've always bloody done it.' That's the honest answer! No good reason at all. So it was good. They brought new ideas in, did student nurses.*[69]

According to Geoff Hopkinson there were 'so many' of these individuals, who were 'enormously helpful' and it was good 'to capitalise' on their 'fresh minds'.[70] Given that his agenda, as claimed elsewhere in this chapter, was to implement ideologically fuelled

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[67] Dave Spencer, Interview April 3rd 2009.
[68] Bob Dewhirst, Interview June 9th 2009.
[69] Jenny Dunkeld, Interview August 12th 2009.
[70] Geoff Hopkinson, Interview May 1st 2008.

change, it is entirely plausible to argue that this mass of individuals were being used as 'intellectuals', and as such were persuasive elements in a hegemonic strategy.

These student nurses, moreover, were being groomed *to lead* the radical organisational changes demanded by senior management. The Director of Nursing Services saw them as being people who would go on to hold vital managerial posts in the developing service:

> *One of the beautiful things about ... having so many student nurses on the wards is that one knew that many of those were going to occupy key positions in the new service.*[71]

This was the case for Steve Mee, Mary Lawrenson, Dave Spencer and Eric R. who, according to their testimonies were all outspoken critics of the institutional system, but all went on to middle management roles, as charted elsewhere, which carried a remit of change.[72] In addition, particularly in the case of Mary Lawrenson, they then used their position to continue the cycle of recruiting other individuals who 'were not complicit with the system'.[73] As illustrated in Chapter Nine the testimonies of these 'intellectuals' convey a *collective* sense of being at the forefront of a new dawn. A flavour of this was provided by two interview extracts from those who viewed themselves as change agents. Eric R., as cited in Chapter Three, recalled intense conversations in the early 1980s with other young nurses (including Steve Mee) in which the appropriateness of institutional care was questioned:

> *I think I was at the beginning of a generation who began to think, 'Hang on a minute, is this all good?*[74]

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[71] Geoff Hopkinson, Interview May 1st 2008.
[72] Steve Mee, Interview February 18th 2008; Mary Lawrenson, Interview September 9th 2009; Dave Spencer Interview April 3rd 2009; Eric R., Interview August 11th 2009.
[73] Mary Lawrenson, Interview September 9th 2009.
[74] Eric R., Interview August 11th 2009.

Moreover, in her testimony, Lawrenson recalled a seminal moment, which can be construed as symbolising a core facet of the shifting hegemony of these years of contraction. She remembered her entry, during the mid-1980s, into the organisation's middle management:

> *I became a nursing officer when I was only 26 yrs old and I was line managing people who were 50, 60 years old... And I remember supervising Sister ——. And she terrorised me when I was a student nurse... I remember her tearing a strip off me for not wearing my hat, and me being rude to her and saying, 'Well I'm not wearing a hat anyway, it just gets pulled off!' And she gave me a heck of a time but I became her supervisor at twenty six.... And I remember sitting down and having to have to do these appraisals thinking, 'This is bizarre'.*[75]

However, there are problems with the argument that the recruitment of these student nurses, allied with shifts in the higher echelons of the organisation, represented a Gramscian notion of *revolutionary* change. For one thing, as pointed out, Gramsci argued that the 'organic intellectuals' were recruited from the 'oppressed' masses. In the case of the Royal Albert, during these years, the oppressed, in the eyes of its change agents, were people with learning difficulties who resided at the hospital; the 'intellectuals' described above were either students or employees, not hospital residents. Mee, in his PhD thesis highlights this anomaly:

> Normalisation and SRV encourage professionals to 'do' things to and for people with a learning disability... language used suggests directly, or indirectly, that power is vested with professionals and others. Those of us who have worked for services which support people with a learning disability are commonly thrust into the role of 'architects' for the lives of the people we support (Mee 2005:17-18).

[75] Mary Lawrenson, Interview September 9th 2009.

These 'life architects' described in this section were all appointed by the organisation itself. They were paid professionals; they did not rise from the ranks of the 'oppressed'. Furthermore, involvement in hospital rundown contributed to enhanced career prospects. David Jordison, as discussed in the previous chapter, saw his appointment as a way of establishing a career in general management. Through embracing the demands of the post of Royal Albert General Manager, he went on to become the first Chief Executive in 1992 of the new Priority Services Trust, beyond which he advanced even further into a career as an NHS trust chief executive. Similarly, Mary Lawrenson and Steve Mee left the Albert in the early 1990s, becoming involved with Social Services as managers overseeing resettlement in the community. Dave Spencer, another of the resettlement officers, left about a year before closure, and in 2010 was a senior regional figure in Valuing People. As is clear in other sections of this chapter these individuals invested a great deal of personal commitment and energies into the rundown of the hospital. Nevertheless, in contrast to some other hospital staff, arguably their careers were improved as a result.

The Gramscian dichotomy between 'organic' and 'traditional' intellectual is problematic in relationship to the contraction of the Royal Albert. As argued in Chapter Four, the dominant driver for institutional *closure*, not reform, originated in the neo-liberal agendas of a Thatcher Conservative Government. Viewed through this prism, those agents of change whose *actions* were pushing through the closing of the institution were deputies of the ruling class at that time. In other words, people like Mee, Lawrenson and the others alluded to here, can be seen as predominantly 'traditional' not 'organic intellectuals'. This is *not* to assert that their interventions on behalf of people with learning difficulties were without considerable merit, but it is to say that *politically* their position was more problematic than was intimated in the oral

testimonies. The movement to shut the Royal Albert was imposed from outside the organisation; it was a 'top down' change.

5.2.6 Opinion Leadership

Illustrated in the preceding sections are ways in which key members of senior and middle management, as part of a hegemonic strategy, engaged *directly* with those they wished to influence. On occasions, however, it was suggested that a more *indirect* approach was employed. In his testimony, Dave Spencer recalled the difficulty of persuading sceptical relatives of the potential benefits to their learning disabled family member in leaving the Royal Albert:

> *One family actually put it in a nutshell for me... I went on a home visit to talk through the process... They were very polite, a very nice family, and I had finished explaining what was going to happen and they said, 'It is 42 years since somebody who looked not a lot different from you sat down in this same room and said all the same things about why we should admit him to the Hospital, about how things were going to be much better and it was really going to be much easier for us.' And she said, 'I am not calling you a liar but why are you any different and why is what you are saying right?' And we did expect a lot of people to take a lot of stuff on faith because it hadn't by and large (been done), because we were kind of starting things off nationally in the north.*[76]

Expressed here, along with the notion of the pioneering role of the north west in deinstitutionalisation, was a sympathetic perspective on families having 'to take a lot of stuff on faith'. However, for the purposes of the present discussion, the important point is the reference to Spencer's limited credibility as a persuasive change agent. He reinforced such a notion when he admitted in his interview that:

[76] Dave Spencer, Interview April 3rd 2009.

I had never known anybody who had been admitted to a long-stay hospital, let alone had a family member admitted to one. I couldn't talk through what that felt like.[77]

Overcoming this rhetorical dilemma, because of his heterophilius[78] standing, required a less direct approach:

Eventually of course there were lots of other people you could talk to and say, 'Don't listen to me go and talk to Mrs. 'So-and-So'. She was really worried about her son or her brother or whatever.' And some of the people who had been most opposed to us resettling people... became some of the best advocates for us, for the (resettlement) process, because they could go and talk to people and say, 'I was worried sick, I couldn't sleep...' But they said, 'It is fantastic now.'[79]

The crucial reassuring role played by certain relatives was possible because they were what Rogers describes as 'opinion leaders'; that is, members 'of a social system in which they exert their influence' (Rogers 2003:27). In addition, Dave Spencer's claim that he *deliberately* used these individuals as 'best advocates' accords with Roger's assertion that:

> Change agents often use opinion leaders in a social system as their lieutenants in diffusion activities (Rogers 2003:27).

Diffusing the resettlement agenda in this manner can be construed as an essential element in the execution of a hegemonic strategy. Consent for organisational change was manufactured via what were considered to be the most appropriate channels.

5.2.7 Coercion

Evidence suggests that the hegemonic strategy at the heart of Royal Albert rundown relied upon a potent mixture of both rhetoric *and* force. When necessary, coercion was

[77] Dave Spencer, Interview April 3rd 2009.
[78] Defined earlier in the chapter.
[79] Dave Spencer, Interview April 3rd 2009.

applied by agents of change to push through organisational contraction. Former members of management claimed that they were conscious of the *power* vested in them. Mary Lawrenson, for instance, newly qualified in the early 1980s, recalled her first post as acting sister on what was regarded as one of the most challenging male wards in the hospital. Her remit set by her line manager was to improve clients' standard of living. Her memory was that:

> *It probably took me a good six months to find my feet but in those six months I realised that I had the power, and it was about power, to make some changes. And I didn't like what I saw and it kind of threw me back I suppose to where I was when I started that, 'This just isn't right'.*[80]

This sense of having 'power to make changes' was intimated in the testimony of the institution's Chief Executive. David Jordison recalled that:

> *Coming to the Royal Albert (in 1986) was a wonderful thing for me because... people before that had asked for advice, but once you're in that kind of job people want you to make decisions, and that was new. And it was quite liberating really because you were taking advice and you had a lot of good advisors around and you were actually at that time able to make decisions... In the NHS you never make a decision entirely on your own, you've got to take advice and weigh things up... But it was possible to take decisions.*[81]

Examining the data indicates that an early, and crucial, expression of this decision making power was in relationship to the hospital consultants.[82]

Touched upon here, but examined in more detail in Chapter Eight, is the strong suggestion, based upon the oral testimony, that *certain* consultants behaved in ways

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[80] Mary Lawrenson, Interview September 9th 2009.
[81] David Jordison, Interview June 12th 2009.
[82] The consultant psychiatrist in learning disability hospitals had, prior to the 1980s, carried 'the final medical responsibility for admission, treatment and discharge' (Mittler:193). This role definition, as discussed later in Chapter Eight, became increasingly unclear, both nationally and at the Royal Albert, during the 1980s and 1990s.

which impacted negatively on a resettlement agenda. Steve Mee, as the first Resettlement Co-ordinator, argued that it was the executive powers of Jordison, as General Manager, which enabled these issues to be resolved. One of the sticking points, under the previous consensus management regime, was that the consultants were delaying the release of residents' medical notes, an essential prerequisite for an individual leaving the hospital. Mee recalled that, at a meeting, Jordison told the consultants that these medical documents would be released because it was demanded by the Regional Health Authority, their employers.[83] In addition, the resettlement strategy itself was also, according to Mee, being held up by the consultants. They had assumed, it was claimed, a power of veto within the multi-disciplinary Royal Albert Hospital Resettlement Team. However, Jordison, again at a meeting, exerted his power as hospital Chief Executive and told one of the consultants, in Mee's words, that the delay to the adoption of formalised resettlement guidelines had:

> *'Been long enough now, we can always amend it in the future if it's not seen to be working.' And it never was.*[84]

Overall, Mee argued that David Jordison's use of his power meant that the negative influence, particularly of the Senior Consultant, gradually withered away during the 1980s. Such a viewpoint is supported by other oral and documentary data. Dave Spencer for instance, who succeeded Mee in post in the early 1990s, in stark contrast to his predecessor, did not mention the consultants in his testimony at all.[85] Likewise, although the hospital's social work department in 1985 documented major concerns, in line with Mee's own memories, by 1990 the consultants (in particular the Senior Consultant) were not highlighted in the list of issues they faced (RAH 1985; RAH 1990).

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[83] Steve Mee, Interview February 18th 2008.
[84] Steve Mee, Ibid.
[85] Dave Spencer, Interview April 3rd 2009.

Having introduced 'consultants' to the research narrative, certain sensitivities need to be noted and observed. Although they are often referenced in the study data, as Mee did in his testimony, as though they were a homogenous body, such an impression is perhaps misleading. One of the other interviewees depicted the individual consultants during the 1980s, suggesting that within a hierarchy, overseen by the Senior Consultant, there were considerable differences in attitudes.[86] Furthermore, this former senior nurse's testimony intimated that, as the decade unfolded, professionals were recruited who had a greater respect for the rights of people with learning disabilities than their predecessors. This new wave of appointments included Dr. Prasad, who was interviewed for the research, and another man who were both adjudged to be 'lovely guys'.[87] These descriptions have added weight because they originate from an individual, who was both a strong advocate of deinstitutionalisation, and who, in a middle management capacity, had clashed vehemently with the Senior Consultant over issues of care. However, in general, the documentary and oral data, tended not to discern between individual consultants. In what, as examined in Chapters Seven and Eight, were trenchant criticisms of their actions, they were referred to merely as 'the consultants'. This thesis also uses this catch-all definition but does not presume that such an epithet implies that *all* the consultants, at any given time, either engaged in, or agreed with, the actions being recounted.

The drive to persuade staff to adopt the ideologies of normalisation and SRV was, as has already been intimated, a complex one. Staff, and families, were exposed to a hegemonic dialogue, in which views counter to the dominant one of community care being a 'good thing' were given little currency. However, the dialogue did provide a semblance of a rhetorical exchange in an attempt to win over the hearts and minds of those involved in supporting people with learning difficulties at the Royal Albert. On

[86] Anonymised extract from an interview with a former member of nursing staff.
[87] Ibid.

other occasions, an analysis of the oral testimony suggests that management used their power in a more direct way to push through ideological change. As nursing officer, in the mid to late 1980s, Mary Lawrenson 'stopped Father Christmas coming round the wards'[88]. According to another member of staff at the time, this was done because, in line with normalisation, it was not 'age appropriate' for adults. She became known as 'the woman that murdered Father Christmas'.[89] It is claimed by Malcolm Alston, the nurse in charge, that the annual hospital summer camp was also ended upon ideological grounds. He recalled that because the camp catered for upwards of 40 residents it was viewed by the hospital authorities as a congregate institutionalised activity. However, Alston remembered that:

> *The residents themselves got together because they were feeling concerned. I arranged a meeting with their spokesman to talk to the hospital management. We sat down and they (hospital management) were saying, 'Why do you want to keep camp?' And this bloke was doing so good, and he said, 'We help to look after the low grades.' And I thought, 'Oh God! Why did you say that?' Because he just set fire to the whole thing. So camp went... I thought that's it gone, gone in a couple of words and it was a shame because what they had built up in Silverdale (the village local to the camp) was a real good rapport with the population.*[90]

The clear suggestion here is that the decision to terminate this activity was carried out contrary to the wishes of some of those with learning difficulties. Although Alston emphasised that overtly the reason was ideological, in particular the use of institutional language, he also argued that this cessation was partly due to the resentment harboured by some of the hospital staff. This latter emotion, he claimed, was because

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[88] Mary Lawrenson, Interview September 9th 2009.
[89] Winnie Buczynski, contributor to Malcolm Alston, Interview May 19th 2009.
[90] Malcolm Alston. Ibid.

they (staff) were booking holidays on the continent and going to America and things like that, but they (residents) wanted to go to camp and people couldn't understand that and I could see that was causing resentment.[91]

Examining the nature of this annual camp is beyond the scope of this thesis; however it was, as indicated in the quotes above, symbolic of a complex relationship between 'institution' and 'community'. In the end its demise, like 'Father Christmas', appears to have been the casualty of an ideologically based decision by management.

Indicated in interviews by those who implemented change was that the 1980s and 1990s saw an increasing effectiveness at dealing with abusive practices by staff. This, as will be illustrated below, was claimed to be a fundamental shift from practices prevalent prior to the years of rundown. One interviewee asserted that in this earlier period:

the hospital was run for the staff... and they didn't want that to stop did they? They got overtime. They drank on duty... All sorts of bad things were going on.[92]

However, dealing with these 'bad things' was problematic. Bob Dewhirst argued that, 'nobody ever got the sack from the Royal Albert'. Oral testimonies indicated that the 1980s witnessed a radical departure from this lax disciplinary culture.

Mary Lawrenson claimed that during the years of contraction, she was 'part of a group of managers who tackled (staff) culture through discipline'. This caused a great deal of consternation on the part of the hospital trade unions, who she recalled exclaiming:

'Disciplinary hearing because you hit somebody? This is mad! What are you thinking about? Sacking somebody because they've stole somebody's clothing?'

[91] Malcolm Alston, Interview May 19th 2009
[92] Anonymised extract from a research interview.

And I remember it being like this – 'You must be mad. You can't sack someone for doing that kind of thing!'[93]

Concerning this matter, Lawrenson intimated that recruitment practices may have been critical in quietening opposition. Echoing the discussion above regarding opinion leaders, she recalled her appointment of a senior Royal Albert trade unionist to play a key nursing role:

He actually helped us union wise to turn things round, because of course he was the manager having to tell staff not to do it, so he couldn't then come and say, 'I'm going to defend them'.[94]

Mee, also a strong trade unionist recruited into a managerial role, implied that this disciplinary culture emanated from the top of the organisation during the early 1980s:

There were a couple of senior people there who actively encouraged reporting - Jim Bow and Geoff Hopkinson - they wanted to know, and Steve Wade as nursing officer, they were more visible, they'd suddenly turn up and comment and criticise.[95]

Particularly in dealing with other staff, the indications are that change agents were able to complement a rhetorical approach with a cutting edge. Such a combination provided a powerful hegemonic framework for the contraction of the Royal Albert, particularly from the mid-1980s onwards.

5.3 Conclusion

Evidenced in this chapter has been the argument that Royal Albert management, whether deliberately or not, pushed through hospital contraction with the assistance of a hegemonic approach. The latter, imbued with the ideologies of normalisation/SRV, embraced powerful political, rhetorical and ethical dimensions. However, as examined

[93] Mary Lawrenson, Interview September 9th 2009.
[94] Mary Lawrenson. Ibid.
[95] Steve Mee, Interview September 22nd 2005.

in Chapter Six, this is only a partial explanation of the ways in which managers impacted upon Royal Albert rundown.

CHAPTER SIX

AGENTS OF CHANGE: Personalities and Providence

6.1 Introduction

It is possible, as argued in the previous chapter, to discern powerful elements of a hegemonic approach in the way Royal Albert contraction was implemented by the organisation's agents of change. This, however, offers an incomplete depiction of middle and senior managerial influence during these years at the end of the twentieth century. Touched upon in Chapter Five, but developed here, is the assertion that these individuals demonstrated a range of personal qualities to enable hospital rundown to proceed. In addition, the chapter, to a lesser degree, examines the role played by good fortune or providence.

6.2 Personal Qualities

Senior and middle managers' oral testimonies illustrate the relative inexperience of these individuals when faced by the daunting and complex task of hospital rundown.

Many of those interviewed who played leading roles were from a therapeutic, not a managerial, background; their experience and training resided predominantly in nursing. Geoff Hopkinson, with a touch of ironic humour, recalled that the challenge of recruiting community staff:

> *contrast(ed) radically with the role, the non-existent role specification which I was given when I was interviewed at the end of 1962!*[1]

Evident elsewhere in his testimony, but, similarly, in that of managers such as Mary Lawrenson and Dave Spencer and, at regional level, Tom McLean, was their commitment to values which promoted the rights of residents; their recollections were predominantly of a moral hue. This dichotomy between principles and managerial expertise was epitomised by Steve Mee who recalled being fast-tracked into the new middle management role of Nursing Process Co-ordinator. His memory was that:

> *I got that job because they thought I would do it in a principled way, wouldn't waver, that sort of thing. But I'd no experience. I'd never been a manager of anybody. I'd never managed a process and I'd never been involved in resettlement! ... So you're saying, what was I drawing on? Nothing! But on the other hand there was no precedent for it so nobody really knew how to do it.*[2]

Although not a nurse, the new General Manager appointed in 1986 was, as the DHA Chief Executive recalled, coming 'from a finance background rather than a management background'.[3] The decision to appoint David Jordison was based upon 'the strength of personality and the ability of the individual'.[4] Allied to which, according to Paul Whitfield, he had an excellent team of staff to help him 'get up to speed very quickly'.[5] Jordison himself remembered that 'I was a backroom boy until I came' to the

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[1] When he started his training as a student nurse at Balderton Hospital, Newark.
[2] Steve Mee, Interview February 18th 2008
[3] Paul Whitfield, Interview October 28th 2009
[4] Paul Whitfield. Ibid.
[5] Paul Whitfield. Ibid.

Albert. Although motivated to take on the task of contraction, he did recall some degree of trepidation:

> *I'd always been fairly good at managing my own group of finance staff and I used to get down and see them and talk to them and I thought, 'Christ how am I going to do that with 600 staff or whatever?'*[6]

An analysis of research data suggests that personal qualities constituted an integral element in the way that Jordison, and other managers, overcame their relative lack of experience. In particular, allusions were made by a broad range of interviewees to the personalities of managers, as well as their commitment, creativity and ability to handle highly complex tasks. These facets are now dealt with in turn.

6.2.1 Personality

In discussing the hegemonic approach, the themes of authority and power, especially that of position, were touched upon vis-a-vis agents of change. However, commentators suggest that those attempting to elicit transformations can draw upon their 'power of personality', a trait which is inherent to an individual (Baldwin and Williams 1988). Such a perspective seemed to resonate with that of two Royal Albert managers who theorised about the process of that particular institutional contraction. Mary Lawrenson, for instance, argued that:

> *my personal view is that the changes that happened at the Albert were to do with individual personalities.*[7]

Dave Spencer, in echoing that sentiment, illuminated what it meant for him, comparing the power of personality with that of position. He reflected that:

> *I have thought about this quite a lot: what was it that made that (the closure of the Albert) happen and why did I sign up for it? And it was about leadership. It*

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[6] David Jordison, Interview February 15th 2008

[7] Mary Lawrenson, Interview September 9th 2009.

was 'I am the chief exec or I am the nursing manager or whatever, and I am making the decision' kind of leadership; but it was also the leadership of individuals and their personality... You start off being a young student nurse or staff nurse and see people and think this is actually as much about him as a person as it is about his position. You could see that there were people who eventually something would push them to say, 'I am having nothing to do with that. I resign or you do it, but I am not and don't put my name to it.... That is leadership of a different kind from, as opposed to management I suppose. We were very fortunate in the north west at that time that there were people who took that perspective; that said, 'No. I am going to make a nuisance of myself on this issue rather than do the thing I have been told to do,' or, 'I am doing this because I believe in it not because someone is performance managing me'.[8]

The conflation in this extract is of 'leadership' and 'personality', with the stress on leadership accruing from the qualities of the 'person'. In other words, Spencer, like Lawrenson, was signifying the impact of the power which resided in an individual: it was as much about *who*, as it was about *what* the person was. This emphasis will be examined, drawing upon other oral testimony, by looking at two inter-related elements of this particular form of power: charisma; and forcefulness, or bloody-mindedness.

Already discussed have been the ways in which David Jordison attempted to establish his authority, as part of a hegemonic narrative. However, there are indications that such a viewpoint only provides a partial explanation of his impact as a senior change agent. Suggested in the oral testimony of others is that a significant dimension of his power lay in his personal charisma. The latter was a key factor in his appointment, according to

[8] Dave Spencer Interview April 3rd 2009.

the General Manager of the District Health Authority.[9] Likewise, one of the staff on the ground talked in her oral history interview of his,

> *wonderful personality, a youngish man, very go-getting... He didn't have to bully or do anything. He could make things happen. He was a wonderful manager... And I think that his personality got this change through... He looked nice. Everything was right. So all the women were fine, you know. He could get away with it.*[10]

In his theorising on organisational change, Rogers recognises the importance of charismatic individuals, describing them as 'champions',

> who throw his or her weight behind an innovation, thus overcoming indifference or resistance that the new idea may provoke in an organisation. An innovation champion can play an important role in boosting a new idea in an organisation (Rogers 2003:414).

Such an individual, ironically given her own emphasis on the importance of personalities, appeared to have been Mary Lawrenson. As a recently qualified staff nurse, Steve Mee recalled in his interview that he was on the verge of leaving the hospital.[11] He was recruited, however, to Lathom House (Ward) where,

> *I worked for Mary. She was inspirational, a level of professionalism that was unheard of in the hospital...And a great manager.*[12]

This experience was pivotal in persuading Mee to remain at the hospital and ultimately become Resettlement Co-ordinator. Likewise, another interviewee, whom Lawrenson line-managed in the community in the 1990s, described her as being 'wonderful'.[13]

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[9] Discussed earlier in the chapter.
[10] Bernadette Hobson, Interview August 26th 2009.
[11] Discussed in more detail in Chapter Nine.
[12] Steve Mee, Interview September 22nd 2005.
[13] Jenny Dunkeld, Interview August 12th 2009.

Charted in the oral testimonies, and possibly contributing to the charismatic appeal of certain managers were expressions of assertiveness and bloody-mindedness in the face of opposition to change. Bernadette Hobson, for instance, talking about her boss, Otto Wangermann, the Royal Albert Clinical Psychologist, remembered that, 'He wasn't a threatening person'. However in attempting to push through changes vis-a-vis nursing and social services, although:

> *very charming... (He was) stubborn as a mule... He wouldn't bend... He wasn't a threat but determined to be a pin in the side.*[14]

Likewise, this sense of persistence was conveyed by Mee in a story about himself, and the way he was 'fast-tracked' into the post of Nursing Process Co-ordinator in the mid 1980s:

> *I was up against people who'd been qualified for years and actually done more planning than I had ... I'd been on strike the year before, there'd been health strikes, while I was still a student. And it was Bob Dewhirst, who was in charge of the School of Nursing, who had watched how two of us students had stood on the picket line and got quite a lot of abuse. And he'd wondered about, 'He's taking his finals next year and wants a job'. He spoke to me about it afterwards. I basically said, 'Well a principle's a principle'. And so the ironic thing ... was that six months into qualifying, Bob was on the interview panel for that new job. Geoff (Hopkinson) had said to him, 'Well he's only just qualified, he's young, what's going to happen if he goes on a ward and people tell him to piss off?' And he says, 'Well he'll just go back the next day! He doesn't seem to mind what people think of him.' Bob told me that afterwards, 'You know the reason you got that job.' And when I checked it out with Geoff he was actually very embarrassed but, yeah, 'cause we did talk about that.*[15]

Although Dewhirst himself did not recall this specific memory, he admitted that:

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[14] Bernadette Hobson, Interview August 26th 2009.
[15] Steve Mee, Interview February 18th 2008.

I probably would have given Steve it if he'd been what I saw as a young and aggressive lad with the right ideas.[16]

The claims made in these recollections were that the personality traits of bloody-mindedness and assertiveness were both prevalent and valued in times of change. Overall such assertions, especially when taken with the memories cited earlier in this section, hint at the importance of the power of personalities in that period of organisational change.

6.2.2 Commitment

As part of its 1986 evaluation of the progress made in England by regional health authorities in progressing a deinstitutionalisation agenda, CMH invited the views of those involved in such a process. It reported that one respondent:

> felt that in her region a continuity of staff who were committed to change in mental handicap services had been a significant factor in ensuring that the situation was not allowed to stagnate (Wertheimer, Ineichen et al. 1985:65).

Such sentiments are replicated in other studies of institutional closures in the UK (Korman and Glennerster 1990; King 1991). A data analysis for the Royal Albert, moreover, indicated that such a statement may have some currency when examining the contribution made by agents of change to its contraction. In illuminating this point, there is an awareness that the analysis probably excludes a number of 'unsung heroes' at a managerial level. This state of affairs merely reflects the pragmatic limitations of the study, not the potential significance of their efforts. This caveat notwithstanding, it is possible to identify key figures at a senior level, for instance, who were involved throughout most of the rundown period. Geoff Hopkinson, for instance, as divisional Director of Nursing Services was in post from 1983 to the end of November 1995; likewise, Phil Morgan, a nurse from the late 1960s, was responsible for the ward

[16] Bob Dewhirst, Interview June 9th 2009.

closure strategy from the mid 1980s into the 1990s. Furthermore, he was the hands-on senior figure, after the departure of Geoff Hopkinson, overseeing the hospital's final months. David Jordison, from his introduction as Unit General Manager in 1986, was still involved as Chief Executive of the Priority Services Trust in 1996. Arguably such commitment at a senior level provided a significant degree of stability amidst such organisational upheaval.

Similarly, there were signs of continuity amongst Royal Albert change agents, other than those operating at the top of the hierarchy. From its inception in 1985, the organisation only had three principal Resettlement Co-ordinators: the first of these, Steve Mee was in post until the early 1990s; and the second, Dave Spencer, who had worked as an assistant to Mee for a number of years, took over until leaving less than a year before closure. Another significant member of the team of people actively involved in resettlement, as well as other aspects of the changing agendas of these years, was the Senior Clinical Psychologist, Otto Wangermann, present from the late 1970s onwards. In addition, documentary and oral evidence suggests that many of the social workers were present throughout most of the years of rundown.

Referenced in the oral testimonies was the contribution of hospital staff departing to work with former hospital residents in their new homes. At a managerial level, for instance, this was the case for Steve Mee, Eric R., Mary Lawrenson, Dave Spencer – all committed to promulgating a deinstitutionalisation agenda while working in the hospital. The importance of this personnel bridge between institution and community for the closure process, which included key contributions from rank and file staff, was highlighted by Spencer. In his testimony he intimated that resettlement, which was crucial to the running down of the hospital, could,

never have worked if people who had lived and grown up in Lancaster hadn't decided that they were going to go and work in Manchester or Liverpool or wherever... The knowledge and skills both about individuals and about people with learning disabilities in general sat in a few locations and if people hadn't been prepared to get up and move and take some fairly big life decisions of their own; which I didn't do. I never lived more than 12 or 15 miles away from the Royal Albert Hospital and it was fairly easy for me. I didn't have to uproot my family, but there were people who did and I think that they are the ones that made the biggest difference in the end. Because if they hadn't I don't know what we would have done. I think we would have had people being supported by people who had no idea what they were doing, which did occasionally happen, staff being recruited in a rush because there was a deadline to meet.[17]

Although the *primary* focus of this study is on what happened *within* the institution during the 1980s and 1990s, the clear implication of the above statement is that the rundown process was also shaped by staff willing to leave and ensure that a resettlement agenda could thrive; minimising the negative impact of staff recruited in a hurry because of 'deadline(s) to meet'. While difficult to evaluate its scale and impact, the research findings indicate that those final years at the Royal Albert witnessed to some degree at least 'a continuity of staff who were committed to change in mental handicap services'(Wertheimer, Ineichen et al. 1985:65).

6.2.3 Creativity and Problem Solving

As referenced in Chapter Two, Castellani in his study of institutional closures in New York pinpoints the importance of creative leadership skills (Castellani 1992:208). Such an observation was echoed by Tony Dennison, one of the Albert's charge nurses, when he recalled the advent of the general manager in the mid-1980s:

[17] Dave Spencer, Interview April 3rd 2009.

I always felt that nursing should be a profession and we should make our minds up about things, but I'd realised by then that it wasn't a profession, it was some sort of semi-profession populated by people who dithered and couldn't manage their way out of a paper bag. ... The management tends to be a style akin to ticking boxes for nurses very often, so not too bad at managing people but they tend to over-manage and under-lead - so not very many leaders in nursing. So we probably did need somebody in...[18]

Made explicit in Dennison's extract is the distinction between management and leadership. Analysis, particularly of the oral history data, suggests that in the 'rough and tumble' of Royal Albert organisational change, the General Manager along with other senior and middle managers often had to think and act in creative, innovative and risk taking ways. In other words, they had to display personal qualities of 'leadership', which went beyond a bureaucratic notion of management and, as explained in Chapter Five, a considered hegemonic approach.

In the midst of this contraction with major implications for their relatives residing in the institution, and explored in Chapter Seven, many families had fears about an uncertain future. Documentary and oral evidence indicates that, for those implementing change, working with these families on occasion proved a challenging task, requiring creativity and flexibility.

Mee, when Resettlement Co-ordinator, recalled a potentially difficult situation in which a social worker had already had contact with a resident's family. According to Mee, this social worker,

presented as rather the stereotype of social worker and this family were as working class as it's possible to be and were proud of what they were, took no

[18] Tony Dennison, Interview September 1st 2009.

bullshit, took no prisoners. And the first I'd heard of this family was they'd sent a letter to the hospital saying, 'Don't send that hippy round to my house again. And if you make any attempts to resettle my son I'll go straight to the newspapers and the MP.' So leave him alone basically. And this had sort of stayed on the back burner.[19]

However, 'it had come round to his son's time'. At this point another social worker was involved who, in contrast to the previous one, 'was very straight, very working class himself'. He wanted Mee's help, asking him:

Would you come round, just be like a normal bloke and see if we can get him on board. Swear a bit, do that sort of thing.' (Laughs) So we went round ... 'You're the one in charge are you?' He said to me, 'You'd better get it fucking right. What are you going to do with him?' So I thought, 'We've got to get this right, we really have.' And he came on board. I discovered afterwards (from the social worker) that he thought I was all right, no bullshit, I wasn't hippy. I had gone on my bike, my old Bonneville, and that was a succ(ess) - in the Army he'd ridden an old Triumph as a dispatch rider and so we talked motorbikes.[20]

Persuasion, not coercion, was at the core of this interaction between professional workers and the family. The task for the former, in order to advance the resettlement of a hospital resident, was to 'see if we can get him (the father) on board'. Achieving this state of affairs was presented by Mee as predicated upon the father viewing him as 'a normal bloke', not a 'hippy'. Moreover, the recollection is of a *spontaneous* attempt at image manipulation, heavily gendered, on the part of the change agents. The incident is recalled as an example of a high risk strategy, involving lateral and creative thinking. Missing from this testimony is any mention of what was said, or promised, about the son's resettlement, the implication is that any re-assurances ultimately hinged upon the

[19] Steve Mee, Interview February 18th 2008.
[20] Steve Mee. Ibid.

quality of relationship between the parent and the Resettlement Co-ordinator. Mee implied that such a free-thinking approach was not unusual, citing this as 'an *example* of how we tried to work with a family'. Sadly, Steve Mee recalled that in that instance:

> *the resettlement was an absolute disaster... The fellow died not directly through the resettlement but that could have been interpreted that way. He had a heart defect which had come with the Down's Syndrome that hadn't been detected and he had heart failure not long after resettling. But it was a very poor resettlement. It was a new model we were trying with a private provider and it was rubbish. And when I went to see the family, when he'd died I thought, 'I am, we are going to get roasted'. And he basically said, 'No you're good lads, you tried your best. It didn't work out' So we actually got him on side.*[21]

So, even though the parents, as Mee said elsewhere in his testimony, 'were fiercely protective' of their son, the assertion here is that the father, at least, did not blame the hospital for the death of his child. The implication is that the personal agency of the professional workers which 'got him on side' was vital to the management of a very difficult situation; in the father's eyes, according to Mee, he and the social worker were 'good lads'. However, the former Resettlement Co-ordinator intimated that there may have been strong grounds for complaint because, not only had the son had an 'undetected' heart defect, but also a 'new model' of resettlement was being attempted, which 'was rubbish'.

Picking up on the latter point, throughout this organisational change, but particularly in the early days, there was a need for change agents to embrace trial and error as they developed procedures. Phil Morgan, a senior nursing officer at the time, intimated that:

[21] Steve Mee, Interview February 18th 2008.

It was pretty much learn as you go along and what we did was learn by our own mistakes.[22]

The problem, and pressure, was, as highlighted in Mee's narrative extract, that this experiential process could impact on vulnerable people; 'they're not', as one social worker stated, 'cans of beans'.[23] Mee provided an example of where an error of judgement resulted in a tightening of procedures for dealing with families. In his early days as Resettlement Co-ordinator he recalled a situation in which the family contacted the hospital to see their brother only to discover that he had been resettled without their knowledge. Understandably they were irate, threatening, as with the family quoted above, to take the matter to their MP. So,

David (Jordison) said,' What are we going to do about this?' I said, 'Well I'll write to them.' I actually laid the cards on the table and said, 'This must have been dreadful for you but there is a resettlement taking place and we believe that where he has gone to now will benefit him. Can't apologise enough... As a result of this happening we've put contact with the parents as the very first stage ... And it's not much help in your case but it has actually helped us to tighten up.' And he wrote back saying, 'Oh thank you for being honest.'[24]

According to Mee's account, instrumental to the dissipation of tension in this situation was a willingness of the middle manager to openly admit the mistake; reducing the conflict to a *human* dimension. This concern to involve families was re-inforced by the senior manager being very clear that if the hospital ever became embroiled in a legal battle with relatives, the institution would lose. Arguably such a perspective gave an edge to the persuasive efforts made with families. After the particular incident quoted above, Steve Mee claimed that 'families were always invited to planning meetings' and

[22] Phil Morgan, Interview March 20th 2008.
[23] Gudrun O'Hara, Interview June 22nd 2009.
[24] Steve Mee, Interview February 18th 2008.

that such a critical break down in communication 'almost never ended up as a problem'.[25]

6.2.4 Complexity Management

As outlined earlier in this chapter, and in Chapter Four, the contraction of the Royal Albert was, like other institutional contractions, a highly intricate affair. The core rundown activities occurred over a period of ten to fifteen years and involved hundreds of people, as well as an array of different stakeholders. At the core of this maelstrom were people with learning difficulties, who needed support and guidance through extremely challenging times. This situation required individual change agents who were personally attuned to handling complex and often open-ended situations heavily reliant upon the ability to negotiate.

Those entrusted with developing, and implementing new procedures recalled the uncertainty with which they were confronted. Steve Mee, for instance, remembered teething problems with apparently 'simple things' in the formalisation of resettlement processes in the mid-1980s:

> *It was logistically fairly complex at the time because there was no precedent for it, so even simple things like when do you let the person (the client) know. Because we'd had the experience of working with somebody about resettlement... We asked the person first, got to negotiating, 18 months later we hadn't managed to get the receiving district to get online. So we worked out you started talking to districts in principle about how many they'd resettle. It seems obvious in hindsight but we got a lot of it back to front.*[26]

[25] Steve Mee, Interview February 18th 2008
[26] Steve Mee. Ibid.

In addition, as touched upon in Chapter Four, devising and implementing the ward closure programme presented elaborate managerial challenges. Phil Morgan, in charge of this facet of hospital contraction, recalled that:

> *In practice it was pretty much finger in the air and hope there was a good following wind! It was an awful lot of negotiation with nursing officers, clients' relatives, the Resettlement Department - because obviously what was guiding us was the speed of resettlement as people moved out, then we found we hadn't got viable units to accommodate people in the hospital... What we had to do was to plan how we were going to accommodate the people that were still living there for the short period of time that they'd still be there in the most appropriate manner, without putting anybody at risk and trying not to move people too often... Logistically it was like playing eight games of chess at the same time and trying to keep all the pieces in the right squares! Which was a nightmare! A nightmare! I remember some very sleepless nights. And some very difficult negotiations. Because nurse managers and nursing officers were quite protective, quite rightly, of their services and wanted to minimise the impact on the clients but I had to take an almost objective view and say, 'Look we've got a service to manage. We've got to maximise the input to the clients so we can't employ people for which we don't have the income.'*[27]

Conveyed here is a strong indication of the various stakeholders, the continuing requirement to negotiate, the vulnerability of people with learning difficulties caught up in this major change, and the impact on Morgan himself who recalled 'some very sleepless nights'. Also, although having spent most of his working life as a nurse at the Albert, his reference to *maximising the input* indicated the influence of a managerial business discourse (Johnson 1998). Later on in the same interview he added that this complex manoeuvring was further complicated by taking account of all the individual

[27] Phil Morgan, Interview March 20th 2008.

districts across the north west. In his eyes the challenges amounted to that posed by an incredibly complex game of chess; later in the interview extending this game metaphor to describe the process as one of 'juggling'.

6.3 Providence

In their interviews a number of former Royal Albert change agents highlighted that for all their purposeful plans, they believed that they relied on providential fortune on occasions. Steve Mee highlighted the fear which could surround the resettlement process:

> *Every time it seemed like an act of faith, a leap in the dark. ...Alan Cohen, one social worker I got on really well with, we used to say, 'It feels like flying by the seat of your pants. And something is going to go horribly wrong at some point - either something horrible will happen to the client or a member of the public or a house go up in flames... What happens if they start a fire and the staff don't notice. 'Cause unlike a ward where you can see everybody, people could be all over the house and you don't really know what's going on.' And so we always worked under that fear. 'And then what will happen? Will there be an outcry in the media? And there'll be a thousand people wanting to say, 'I told you so'.*[28]

In this extract Mee communicated not only the sense of being exposed to forces beyond one's control, but also the risk-taking aptitude required on the part of change agents. Involved at the forefront of that hospital contraction was recalled as feeling like 'flying by the seat of your pants'. In the same interview he recollected a particular instance which represented a resettlement which 'could have really gone horribly wrong'. Three men, who were former Albert residents, lived next door to 'an old lady', who had 'been very friendly'. His recollection was that:

[28] Steve Mee, Interview February 18th 2008.

The three people who lived there, I mean this sounds almost like a situation comedy. There's one little man who was frightened the police were going to pick him up. There's one fella who used to work at the horticultural project, and one who liked to dress up in women's clothing. And he was at home doing that and the fella who was at work came back from work and the little fella was out with the staff and they were just as it happened coming back in a taxi. And the fella who'd been at work got back to the house and he'd forgotten his key, so he was knocking on the door. And the guy who was dressing up upstairs never heard him. And the woman next door heard the commotion, 'cause he was getting crosser and crosser 'cause he couldn't get in. And the old lady asked him in, 'Oh come and have a cup of tea and they'll be back soon.' And he thumped her. And knocked her over. And she wasn't exactly frail but this fella was twice her size. And she rung the police. So the police arrived and frog-marched this bloke out, just as the fella arrived back who was frightened of police. He started crying because he thought the police had come for him. And with all the commotion going on the guy arrived in his dress at the front door to see what was going on. And this member of staff, 'Why am I in this job?! What am I going to do?' But nothing happened and the woman didn't want to press charges and she was completely sympathetic despite the fact that she'd got a bruised face. ... She kept a key in case it ever happened again. But that could have gone completely horribly wrong, couldn't it?[29]

Although taking place outside the organisation, incidents such as this, particularly in the early days of contraction, could have affected the shape and pace of the latter. The successful outcome of this narrative hinged upon the generosity of the neighbour, which may have reflected carefully nurtured good relations, but was nevertheless, given the assault, perceived by Mee as a fortuitous act of goodwill. As is touched upon in Chapter

[29] Steve Mee, Interview February 18th 2008.

Eight, there were instances of neighbourhood opposition in Lancaster, and internationally public resistance did impact upon deinstitutionalisation agendas (Enbar, Morris et al. 2004; Malacrida 2008).

Discussed in Chapter Five is the specific way that, as Resettlement Co-ordinator, Dave Spencer encouraged relatives to talk with other individuals, whose family member had moved out of the institution. This, it was argued, exemplified a change agent using opinion leaders to advance an agenda of resettlement. However, Spencer recalled that, at a critical stage, potential opposition from families was dissipated in a more providential manner:

> *I remember there being one meeting in the Board Room (at the Royal Albert) of probably only about fifteen families, one or two of whom were very strong. They had been in touch with Rescare[30] and other organisations. They had brought information proving that if you moved people out they die ... It had taken quite a while for this meeting to actually come about... It had taken that long that somebody who was wanting the meeting, her son had been resettled in the meantime... She was at the meeting and it got going and there was a few people all a bit aerated. And she said, 'Can I just say something?... I was part of this group and I wanted this meeting and this is what I wanted for our (son), but since he has moved out he is so much happier.' I could have written it for her and I didn't know she was going to say it. She said, 'I am still worried about this and I am still worried about that... But you only have to look at him to see that it was the right thing to do.' It was like that was the end of the meeting, it never came up again... It sucked the wind right out of everybody's arguing.*[31]

[30] Referenced in Chapter Two.
[31] Dave Spencer, Interview April 3rd 2009.

In this instance the mother was portrayed as acting as an opinion leader, with her message having a powerful impact upon other members of what was the Royal Albert Hospital League of Friends. The implication is that her intervention, although unexpected, was enthusiastically welcomed by Spencer: 'I could have written it for her'. Her contribution was providential, although, as with Mee's testimony, the efficacy of the resettlement itself may have relied upon a range of other more intentional factors.

6.4 Conclusion

In this and the previous chapter consideration has been given to those change agents at 'the sharp end' of the rundown of the Royal Albert Hospital during the 1980s and 1990s. These senior and middle managers had to deal with the complexity of implementation. Their qualities of personality, of leadership, were undoubtedly instrumental in these years of immense organisational upheaval. However, at the core of the change mechanisms it is possible, as explicated in Chapter Five, to discern the adoption of a hegemonic approach. It is a combination of this hegemony and personal qualities, such as creativity and problem solving, which constituted the contribution made by change agents to Royal Albert contraction. However, embedded in the multi-dimensional management narrative were the viewpoints of those who were critical of facets of deinstitutionalisation. These voices of resistance constitute the main focus of the next two chapters.

CHAPTER SEVEN

VOICES OF RESISTANCE

7.1 Introduction

In contrast to the two preceding chapters which concentrated upon the *agency* of those implementing organisational contraction, this chapter will focus upon the research question:

What were the viewpoints of those who resisted the closure of the Royal Albert?

The primary gaze is on those *voices* who were critical of key elements in the Royal Albert rundown agenda of the 1980s and 1990s. This enables a consideration of oppositional viewpoints *in their own right*, rather than being viewed as merely reflecting the self interest of those who were losing out in the organisational change. The latter perspective, as depicted in Chapter Five, may be construed as an important dimension

of a hegemonic approach which othered those who questioned the rundown agenda of the Royal Albert. Moreover, a focus upon voice acknowledges that some change agents, although broadly sympathetic to deinstitutionalisation, nevertheless harboured profound reservations about specific features of policy and practice during the institution's later years. Complementing this chapter's emphasis on what was said, Chapter Eight will then focus upon what was done to resist institutional contraction.

7.2 Rhetoric of Resistance

The central argument propounded here is that, as with the agents of change, those who were critical of aspects of Royal Albert Hospital rundown claimed their position was predicated upon a profound concern for the well-being of people with learning difficulties. The latter, as will be illustrated, were viewed as *victims* in a community care narrative which ultimately prioritised the imperatives of finance, professional advancement, bureaucracy and logistics over the best interests of individuals residing in the hospital.

7.2.1 Lack of Choice

Interwoven into a critique of the contraction of the Albert was the assertion that it was a policy *imposed* upon the residents, its most vulnerable members.[1] One of the ward managers exemplified this point by referencing a person with a learning difficulty who was forced to leave against his will. His memory was that:

> *One guy went back to his town of origin. But apparently he'd been in this home, he started thumping people. Well, you see, we knew he used to do that anyway under certain circumstances. So they decided they wanted to bring him back to show him how bad things were at the Albert ... The idea was if he didn't behave himself he would be coming back. It was a bit of psychology on their part.*

[1] An alternative perspective is discussed in Chapter Nine: 9.2.5 Liberation.

Anyway they brought him back and he settled straight back in! He just wanted to stop at the Albert. He was straight back to his old chair, TV on... They had a hell of a job to drag him back out again and get it back to where he'd resettled. So it hadn't worked - it back fired.[2]

Integral to this rhetorical anecdote is the assertion that 'we - the teller and the Royal Albert staff – knew' the individual whereas 'they' – the community staff – did not. More than that, in this tale presented as a tragi-comedy, the fools are the community staff, although the victim is the person with a learning difficulty who 'just wanted to stop at the Albert' (Gabriel 2004). The implication was that ultimately his choice was denied through forcible eviction. Such a tale resonates with the observation of a cook at a similar institution, Gogarburn Hospital (Edinburgh). He described the institution's final months as being, in terms of lack of choice, like 'ethnic cleansing' (Ingham 2003). A former member of Royal Albert middle management also implied that underhand tactics were employed in persuading residents to leave the hospital. He claimed that:

When they had this job of discharging everybody in the hospital, first of all they fibbed. Let me just say management because you can't identify people with that. Management had fibbed to the patients because they said, 'There's this massive opportunity that you'll never get again to get out into the community and be like ordinary people.' In other words offering the big sweetie. They said, 'Oh yes, yes please, yes please.' So they got them out and got them into things like sheltered housing and this and that and the other and then eventually they found, after all the volunteers had gone, for those who were very comfortable in the hospital, 'Thank you very much, did not want to go out.' They were frightened, they were angry.[3]

[2] Ward Manager (Male), Interview August 2nd 2009.
[3] Nursing Officer (Male), Interview March 11th 2009.

This discourse around lack of choice extended to one of the primary change agents at the organisation during the 1980s. Steve Mee, in his PhD thesis, argues that:

> Wolfensberger's theories (of Normalisation and SRV)[4] have been adopted by those responsible for service delivery and have been used to justify major changes in services, with consequent impact on the lives of people with a learning disability. These have included a change from hospital to community care. For those people with a learning disability supported by services at this time, the changes were not optional. Some individuals were made to leave the (Royal Albert) hospital against their will (Mee 2005:18-19).

Although the tenor of the findings intimates, as Mee asserts, that the desire of residents to remain was not respected, there was one notable exception. Bill Lamb, who had arrived as a small boy at the Royal Albert in the early part of the twentieth century, had been granted permission to continue living at the institution. Dave Spencer recalled,

> *with full knowledge of what life could be like on the outside (Bill) decided it wasn't for him. The kind of humanity which was making sure he could stay where he was and we had quite high level discussions about making sure, how is he going to get fed and watered... That went right to the very top. The Chairman of the Hospital Trust was involved in the discussions about the kitchens to make sure that he got a hot meal three times a day despite the fact that he was living in a converted pig sty which sounds awful but it had been used as a scout hut and he was supported to do that until he died (in 1994).*

However, the prevailing wisdom was, as presented in Chapter Two, determined by Wolfensberger's argument which propounds that for many people with learning difficulties valued social roles is of greater importance than their own self-determination (Wolfensberger 2002). The ward manager, quoted above, extended the discourse around lack of choice to include senior management:

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[4] Discussed in Chapters Two, Four and Five.

I don't think David Jordison had much of a voice to be honest. I think he was told. It came from above. It came from whichever maggot was in charge of the health service at the time.[5]

This comment notwithstanding, the primary thrust of this critical perspective was that it was people with learning difficulties who suffered the most through not being able to choose to remain in the hospital.

7.2.2 Selling the Hospital Estate

Early in 1986 the local paper reported that Lancaster City Council was considering the potential cost benefits that the closure of local hospital estates, including the Royal Albert, could have for the city.[6] This story in the Lancaster Guardian provoked an angry response from one of the parents, who, although writing in a personal capacity, was the Vice-Chair of the Royal Albert Hospital League of Friends (RAHLOF). In her letter, published under the heading, 'Royal Albert future: Who cares?' Mabel Smith articulated her position:

> The article 'Query on hospital sites' shows the concern of councillors and a prospective MP for the future of the market, but no word in protest at the rundown and eventual closure of the Royal Albert Hospital. What will happen to its residents, and who cares?[7]

She went on to say that:

> Developers and entrepreneurs may cast longing eyes on the Royal Albert Hospital site. Surely the Royal Albert Hospital residents have first claim?[8]

This claim, she argued in another letter a month later, was based upon her concern,

> that the hospital and its grounds shall continue to be used for the benefit of those for whom they were given, not taken over for the development of the city,

[5] Ward Manager (Male), Interview August 2nd 2009.
[6] Lancaster Guardian, January 31st 1986.
[7] Lancaster Guardian, February 7th 1986.
[8] Lancaster Guardian. Ibid.

as the policy and resources committee January discussion would seem to suggest.[9]

Her suggested use for the site, examined later in this chapter, was for a 'village community'. Implied in Mabel Smith's argument is that *she* does indeed care about the hospital residents both by raising the issue of 'who cares' and, with her rhetorical question, indicating that they should have 'first claim' on the institutional site. Furthermore, part of this claim is predicated upon a historic right: the hospital was 'given' to them. The assertion intimates the idea of a family, or community, of people with learning difficulties deserving of recognition. However, crucial to Mabel Smith's rhetoric is that it 'others' those who have an interest in the site. The latter, representing 'the market', are 'developers and entrepreneurs', who, with their 'longing eyes' can be construed as the big bad wolf waiting for the opportunity to take what is not rightfully theirs. These implicit neo-liberal references are expanded by Mabel Smith in a letter written just over a year later to the Lancaster Guardian. In a critique of the move to care in the community for *all* people with learning difficulties, she says that:

> It appears to me that many advocates of community care, spurred on by Whitehall, are actuated by shifting costs from the NHS to local authorities. On a purely financial basis what does it matter to the tax/rate payer? It must be paid for from one pocket or another. Again it would be appear to me that giving adequate care to the severely handicapped in small groups in the community must be more costly but then I'm not an economist.[10]

As well as implying that those 'advocates of community care' had less than honourable motives, she implied, in a tongue in cheek fashion, that institutional closure appeared to make no sense even in economic terms; community care was not cheaper than institutional care.

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[9] Lancaster Guardian, March 7th 1986.
[10] Lancaster Guardian, April 24th 1987.

Echoes of the sentiments expressed in Mabel Smith's letters appeared in interviews with former members of Royal Albert staff. A nursing officer recalled the District Health Authority General Manager's remarks on his first visit to the Royal Albert in the mid 1980s, when he remarked,

> *'Look at this wonderful estate.' And he was, we all thought, thinking of the financial worth of this bloody estate.*[11]

Presumably, in this extract, 'we' were the nursing staff. In a similar vein, Tony Dennison implied that although there may have been elements of a caring agenda behind institutional closure, there were other powerful determinants:

> *Moneywise and policy wise I guess it has got to be the Thatcher government administrations of the 80s who were trying to roll back the welfare state, encourage private monetary provision and get a handle on the money, the bottomless pit that was sucking the budget away.*[12]

In this testimony, as with others highlighted in this section, rundown symbolised financial expediency rather than humanitarian concern.

7.2.3 Cutting Corners

As organisational contraction proceeded, a financial discourse became further entwined with organisational logistics. Interviewees referenced, in particular, the impact of a significant quickening of Royal Albert contraction. As charted in Chapter Four, by the end of the 1980s the North West Regional Health Authority had decided upon a sequential order of closure for its three large institutions, and, as part of this planning, the pace of resettlement from the Albert was to increase enormously from 1992 onwards. Although this acceleration, as intimated by documentary data, did occur from that point, oral history evidence suggests that on the ground people *remembered* an increasing logistical pressure prior to that date. This was viewed by some as being

[11] Nursing Officer (Male), Interview July 23rd 2009.
[12] Tony Dennison, Interview September 1st 2009.

detrimental to the interests of people with learning difficulties. Included in these critical voices were professionals involved, in one capacity or another, in the resettlement agenda.

Gudrun O'Hara, a member of the Social Work Team, commented that the process whereby residents left,

> *was very careful in the beginning. It was later on we had to put our skates on.*[13]

Such sentiments were echoed by Malcolm Alston, a former charge nurse, who remembered that in the 1980s,

> *it was done very slowly and very thoughtfully but as it started to speed up you could see the financial restraints or commitments becoming paramount.*[14]

Carrying out resettlements 'slowly' was because,

> *it was done, groups of friends... groups of compatible people going out together as recognised groups.*[15]

However, towards the end of the 1980s, another Charge Nurse, who, like Alston, left in 1992, recalled that as the imperatives of closing 'date and money' took hold,

> *worries surfaced about people being put with people they didn't necessarily get on with. So in the early days we were looking at people who got on with folk; so if you're looking at a two bedroomed house you'd be looking at two people who got on very well, same with a three bedroomed house. It became clear it was less and less like that - it was a matter of, 'We've got this house here, you're from this area, you can live there, you'll make friends with so and so, there's nothing to say you won't so off you go.' I don't think it was spelt out like that but it felt like that, it felt less human, less individualised. And more a case of, 'We've got to close this place. We've got three people from Hull. They can go and live in*

[13] Gudrun O'Hara, Interview June 22nd 2009.
[14] Malcolm Alston, Interview May 19th 2009.
[15] Malcolm Alston. Ibid

a house in Hull. So we'll gather their histories, make sure there's no great animosity there, but we couldn't care less if there's any friendship.[16]

This claim of a move to a 'less individualised' way of carrying out resettlements was exemplified by Alston when he described how a former resident,

came to me and said that he was very distraught because he had been put into a house with two other people who were friendly and he was left out on his own. And he felt very much out on his own. I said, 'Surely J—— you can make friends now in your new environment.' He said, 'Well I put it to you this way Malcolm, when I was in the Royal Albert out of all the residents there, there was about 50 residents that I liked and of those 50 residents half of them liked me. So out of that 25 I could pick and choose who I was with.' And he said, 'Now I have got to get on with these other two and I feel out of it.' And I thought, 'What a shame that this hadn't been worked through before, just because the money was available and it fitted public financial credentials then that should go.'[17]

According to Alston, his realisation about this individual's predicament was something of an epiphany. He recounted,

That was a real smack because I thought, 'What am I doing?' Because I'm working to try and get people into these group homes and now hearing something like that. But it was a good thing because it woke me up to say, 'Things aren't black and white... and when we are resettling into groups... we've got to be dead careful that we're not putting people who are going to clash and can't stand each other...' I started saying then that old friendships were more important than where the funding was coming from.[18]

The emphasis here, and in the other oral extracts above, is that, as rundown intensified, the needs of people with learning difficulties were of secondary importance to those of

[16] Anonymised extract from a research interview.
[17] Malcolm Alston, Interview May 19th 2009.
[18] Malcolm Alston, Interview September 13th 2005.

finance and organisational targets. Alston's testimony, in particular, conveyed a closeness of relationship with a former resident, whose pleas resulted in a change of attitude on his part. Such a story presents an ethical stance extolling the virtues of listening and flexibility, against the rigid, inhumane and finance driven approach of the authorities.

7.2.4 Business Culture

A symbolic focus of the oppositional rhetoric regarding targets and finance revolved around the advent of general management at the Albert in 1986. One former ward manager recalled that:

> *The guy who was chief exec... David Jordison, the man who shut the place down, I mean his previous experience of management had been as an accountant at a biscuit factory in Blackpool. But they brought this bloke in, ostensibly to run the place and then close it down. I just thought it stank. There was no empathy there with the patients, the clients. There was no empathy there from people like that. In fact some of the senior nurses there was no empathy from them either, you know. I do get very cynical about senior management, I'm afraid that I bore the NHS a grudge for a long time because of that.*[19]

In the same interview, he went on to say that:

> *At the time we felt, as one of the other nurses said to me, 'He's just a hatchet man'. And I thought, 'Yeah, you're right'. Don't get me wrong I dealt with Mr. Jordison on quite a few occasions and we were always on first name terms... He was a nice fella, but that was his agenda, was to close that place down.*[20]

[19] Ward Manager (Male), Interview August 2nd 2009.
[20] Ward Manager (Male). Ibid.

Similarly a former charge nurse in his interview referred to the unit manager as having 'come from Sainsbury's'.[21] It was also claimed by another charge nurse that Jordison was receiving £3,000 bonus for every ward he closed.[22] The sentiments expressed in these testimonies, including the caricature of 'hatchet man', re-inforced the claim made by Jordison, referenced in Chapter Five, that there were some 'amazing urban myths' going round.[23] Although the origins of the reference to Blackpool, a nearby seaside town, are not known, the link with a 'biscuit factory' perhaps reflected the presence of the Chairman of United Biscuits on the panel, chaired by Roy Griffiths, which produced the 1983 report (Griffiths 1983). However, the importance of these extracts is that they personified aspects of the rhetoric which hinged upon the arrival at the Royal Albert of an alien business model of management. Here was an outsider, with strong links to, or even employed by, the business world, motivated by profit to close down the organisation. According to the testimony of the ward manager, 'they' brought in this individual from the private sector, against the wishes, it is implied, of 'we' nurses. As argued in Chapter Five, it was this antipathy which Jordison attempted to counter in order to develop his authority as a senior change agent.

This 'othering' of David Jordison as an accountant not a nurse, epitomised a wider concern about the Thatcher government's introduction of a business culture in general, and managerialism in particular, into the National Health Service (Newman 1998; Webster 2002).[24] In Lancaster, for instance, during the mid eighties those involved in general nursing expressed their disquiet. At a public meeting, the local Royal College of Nursing chairman was concerned that the plan,

[21] Malcolm Alston, Interview May 19th 2009.
[22] Charge Nurse, Interview January 28th 2009.
[23] David Jordison, Interview February 15th 2008.
[24] For further discussion about general management, see Chapters Two, Four and Five.

is to do away with nurses as part of the management structure. I want to make sure that the person running the wards is a nurse – not a former manager of Hepworth's or somewhere.[25]

The implication here, as with the ward manager's testimony, is that nurses understand the care needs of their 'patients, or clients'; business managers do not.

This critique of the onset of managerialism was extended in the Royal Albert, as elsewhere, to include the perspective of psychiatrists (Harrison and Lim 2003; Adams 2009). In his testimony, Dr Prasad, one of the institution's consultants during the rundown period, was concerned:

> *when the managerial came, and there were so many managers... Nursing manager, this manager, domestic manager, this manager, that manager. I had to write a memo to the domestic manager for anything, something wrong, and the memo will go from there, they will decide and then the memo will go back, there's a lot of memo!*[26]

He suggested that the organisation, headed by a general manager, 'started to work like a commercial sort of thing'. In this new climate, he argued that there was little understanding of the needs of people with learning difficulties, who were often non-verbal, and

> *time consuming... required several sessions... These things general managers didn't realise.*[27]

The ethical nature of this rhetoric resonated elsewhere. In his examination of the arrival of general management to Fulbourn Hospital, a psychiatric hospital, during the 1980s, John Adams argues that:

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[25] Lancaster Guardian, February 21st 1986. Hepworth's was a large-scale High Street clothing store.
[26] Dr. Prasad, Interview August 12th 2009.
[27] Dr. Prasad. Ibid.

both parties to this power struggle between psychiatrists and managers portrayed themselves as acting in the interests of the patients of Fulbourn (Adams 2009:320).

Although elsewhere in his testimony he described Jordison as 'a nice guy', the ward manager referenced earlier argued that this managerial lack of empathy led directly to demoralisation amongst the staff. He did this through a narrative within which he emphasised the voices of nursing assistants and student nurses. Their low morale, the blame for which rested with senior management, impacted negatively upon him, and on the quality of care for residents. As he said,

> *I got to the stage of thinking, 'What's the point in doing something? What's the point of making the ward look nice? What's the point of, you know, sort of like getting new, getting the lads new clothes, and that sort of thing because all they're going to be doing is going into some community home.'*[28]

As well as this extract implying a viewpoint strongly at odds with the community care agenda, implicit in his positioning is that he (and other nurses) did care, unlike the management who had 'no empathy'.

7.2.5 'Special Needs'

Underpinning this empathy from nurses like the ward manager, quoted above, according to his oral testimony, was an assumption that the 'patients' or 'clients' had 'special needs', 'special diets' as well as syndromes; in other words, they *were* 'different'.[29] Their nursing backgrounds meant, in contrast to the senior management of the hospital, that they understood these individuals. In this rhetorical framing, as depicted later in this chapter, the latter were often traumatised by resettlement processes. Nevertheless, those critical voices did recognise that for some hospital

[28] Ward Manager (Male), Interview August 2nd 2009.
[29] Ward Manager (Male). Ibid.

residents community living may constitute a viable option. Such a viewpoint was summarised by Mabel Smith, who, as referenced earlier in the chapter, was an important figure in RAHLOF with trenchant concerns regarding resettlement policy. In her letters to the local press during the mid-eighties she acknowledged that:

> With the help of rehabilitation programmes run by the hospital some of the 'higher-grade' residents have already moved out successfully.[30]

Furthermore, she emphasised that:

> Parents are not against a well ordered policy of community care and self advocacy where this is appropriate and adequately catered for.[31]

The tenor of the latter resonates with COHSE's position, regarding the radical changes advocated by the Jay Report in 1980, which expressed sympathy with the idea that:

> There should be as much interaction with, and in, the community as possible, whether residents live at home, in group homes, hostels or hospitals, and we stress that the latter must be part of the community, too (COHSE 1980:9).

However, this nursing union had serious doubts, as did others, including Mabel Smith and the ward manager, about the feasibility of community care for *all* people with learning difficulties. Intermingled with concerns over 'lack of resources' (COHSE 1980:8), a principal sticking point hinged on the perceived 'exceptional' (COHSE 1980:7) or 'special needs' of many hospital residents.

Anxieties about the 'special needs' of hospital residents were expressed by Mrs Creed, a former staff nurse of over 40 years service. Positioning herself as part of a collective nursing 'we' in opposition to 'they', the senior managers, she recalled that:

> *We said it wouldn't work. But they said it would. And then we thought of the people that were bed-ridden – where would they go? The violent. Where were they going? ... Now don't misunderstand me, some could definitely be great in*

[30] Lancaster Guardian, March 7th 1986.
[31] Lancaster Guardian, February 7th 1986.

the community at things. But we were worried about quite a lot of them that were, bed ridden and how do, where do, who was going to take them in the community? But there must have been places for them, so – We didn't have a say in the matter, we just had to accept it.[32]

The implied threat of 'the violent' to 'society' was also echoed by other staff. The former ward manager, quoted earlier, pinpointed those,

who'd had criminal involvement with children, and the ones who were unreasonably violent... I mean sometimes like psychotic overlay ... He'd be a schizophrenic as well being learning disabled.[33]

He suggested that these would not 'fit back into society'. This appeared to be an official COHSE view:

> Many mentally handicapped patients have severe behavioural disorders and are unlikely to be socially acceptable to the outside community (COHSE 1980:6).

Much of the critical discourse about deinstitionalisation, however, focussed upon the vulnerability of people with learning difficulties when exposed to a wider world. Mabel Smith, chair of the hospital's League of Friends, forcibly expressed this viewpoint in a series of letters to the local press during the mid-to-late 1980s. These missives emphasised a frightening world,

> where mugged pensioners are afraid to leave their homes, which holds baby-bashing and sexual abuse at all levels.[34]

In the face of this, individuals, 'of whom my son is one' required

> a necessary modicum of protection and the freedom from being ridiculed, condemned as 'different'. [35]

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[32] Mrs Creed, Interview June 17th 2009.
[33] Ward Manager (Male), Interview August 2nd 2009.
[34] Lancaster Guardian, February 7th 1986.
[35] Lancaster Guardian. Ibid.

Their 'right to lead a normal life' needed to be tempered because of the limitations of 'their mental disability'. She implied, contrary to the dominant rhetoric of the time, that it was not fair to take risks on behalf of people with learning difficulties. Often framed in the correspondence as an adversarial dialogue with those 'officers responsible for getting residents into *community care'*, Smith challenged the officers' claim to have privileged knowledge regarding the needs of people with learning difficulties.[36] 'In fact' she argued:

> our opposition is motivated by love of our children and concern for their future when we are no longer here to keep an eye on them.[37]

Such a perspective resonates with an Australian institutional study. Gleeson argues that the Kew Cottages' family group constituted an 'affective community' (Gleeson 2010). Underpinning the latter were relationships based upon care 'practised and received as a form of love not simply an act of duty' (Gleeson 2010:12). The group's presence, he argues, had contributed significantly to their relative's quality of life and mitigated the worse excesses of institutionalisation. According to Gleeson, although as with the Albert these critical voices were marginalised, this 'affectiveness' added considerable legitimacy to the families' critique of deinstitutionalisation.

7.2.6 Segregation Options

The corollary of this particular 'special needs' rhetoric was that for some people with learning difficulties a segregated setting was required. In the eyes of Mrs Creed this constituted the Royal Albert itself because,

> *it was such a happy place. I don't think any patient was unhappy there. They had everything. They had the cinema, the concert... We took them out in town, we took them on holidays... I mean it was a lovely place and the staff were*

[36] Lancaster Guardian, April 24th 1987
[37] Lancaster Guardian. Ibid.

fantastic, you know it was one big family. And I don't care who you talk to who worked there they will tell you same. Everybody gelled.[38]

Moreover, a senior local NHS trade union figure in his oral testimony argued that, compared with 'the community', the Royal Albert offered a certain degree of freedom, and happiness, for people with learning difficulties:

There were many stories (from staff) about the relatively contented lives that patients at the Royal Albert led. They had a degree of freedom there and they could mix with each other, and there were stories about the fields where they were relatively secluded, summer evenings patients from the Royal Albert would be rutting like rabbits! ... And then they were moved out into these small homes in the community where there would be just two or three of them and staff in and out all the time. They'd lost all that freedom.[39]

The emphasis here was that the hospital represented a safe, happy environment which had 'everything', including the potential of sexual expression. In contrast the 'community' was viewed as a lonely, cruel and restrictive environment. Such a viewpoint was particularly exemplified with reference to people who had moved in the early 1980s, prior to the establishment of more formal resettlement procedures, to bed and breakfast establishments in nearby Morecambe. These individuals had nowhere to go during the day and, as is corroborated by other interview sources.[40] would sit in the local shopping centre. Mrs. Ann M. Wilson recalled that:

living in the area when people started to be returned to the community you only had to go to the Arndale Centre in Morecambe and see half a dozen sat around all day looking lost and lonely, being ridiculed by the local yobs.[41]

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[38] Mrs Creed, Interview June 17th 2009
[39] M.J. Kiernan, Interview September 23rd 2009.
[40] Geoff Hopkinson, Interview May 1st 2008; Steve Mee, Interview February 18th 2008.
[41] Mrs. Ann M. Wilson, Interview November 17th 2009.

Other than the institution as it stood, one of the key segregation options proposed was some sort of 'village community'. Even professionals who were keen advocates of community care for most people with learning difficulties sympathised with elements of such a concept.[42] In her testimony, for instance, a former Royal Albert social worker, was particularly critical of the all encompassing nature of organisational contraction:

> *I would have kept the bungalows open and I would have kept, not the main complex, but various things outside where people still have a sense of belonging, and a sense of social interaction, what they haven't got now. And not as a hospital but as a normal living* —— [43]

In considering this alternative vision, Gudrun O'Hara recalled that at the hospital:

> *Our farm was fantastic. They (the residents) all loved it. Originally you know they had the farm, and they had the cobbler, and they had the butcher. They were literally self sufficient... From a Rudolph Steiner Home where I worked in Switzerland, we were trying to be self sufficient... And it worked. And it was an interaction - people want to live in a commune. And living on a farm ... It's lovely to have that contact with nature.*[44]

During the course of an impassioned interview, reinforced by many photographs, about the people she knew at the hospital, this alternative viewpoint was juxtaposed with a soulless picture of what community care can mean:

> *What do they do, they sit in flats here, being lonely. If they go to staff, always socialise, we have dinner in the pub, they sit there, have their dinner then the staff having a giggle and a laugh, and the client still sits there and doesn't know what to do. We need to look more to nature, with everything.*[45]

As well as emphasising a degree of sanctuary for people with learning difficulties, interwoven with a notion of a rural idyll, the rhetorical visions presented here hinged

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[42] Jenny Dunkeld, Interview August 12th 2009; Gudrun O'Hara, Interview June 22nd 2009.
[43] Gudrun O'Hara, Interview June 22nd 2009.
[44] Gudrun O'Hara. Ibid.
[45] Gudrun O'Hara. Ibid.

upon their striving for 'a sense of belonging', a sense of 'community'. This viewpoint accords with critics elsewhere who, though sympathetic to the human rights of people with learning difficulties, nevertheless have grave concerns about the neo-liberal, *individualised* agenda associated with deinstitutionalisation (Gleeson 2010).

RAHLOF was an advocate of a 'village' option for the hospital site. The family group's vice-chair argued, in a 1986 letter to the local press, that the Royal Albert,

> is eminently suited to the well proven village community concept, which would provide an element of self determination, protection, companionship; yielding to each according to their need and from each according to their ability.[46]

The rhetorical nature of this statement meant that the reader had to take it on trust that the village idea is 'well proven'. By the late 1980s this positioning translated into active support for Rescare[47] in their campaign to retain a form of congregate residential care. Responding to a request from the national campaigning group, RAHLOF wrote to the local Lancaster MP, Elaine Kellet-Bowman, asking her to support the House of Commons Early Day Motion:

> Mental Handicap and Village Communities:
>
> That this House joins with the relatives of severely handicapped people in welcoming the policy aims and service objectives of the Secretary of State's Circular HC (88)43; notes the statement that the closure of mental hospitals is not a primary aim of the community care policy, and expresses its support instead for the evolution of suitable hospitals into village communities serving both in-patients and out-patients who suffer from mental handicap.[48]

The letter to Kellet-Bowman precipitated a flurry of correspondence involving the local MP, the Department of Health, and the Regional Health Authority. In essence, the MP

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[46] Lancaster Guardian, February 7th 1986.
[47] See Chapter Two.
[48] Letter (copy) from Mrs. Ann M. Wilson, Secretary of RAHLOF to Dame Elaine Kellet-Bowman MP, February 10th 1989.

argued that Early Day Motions were futile, but was sympathetic to RAHLOF's pleas, and so contacted the Department of Health directly.[49] The outcome was that the government itself expressed measured support for the notion of 'village communities'[50] but the Regional Health Authority did not;[51] after which point the RAHLOF protest was somewhat dissipated. However, the rhetoric of the families' group had viewed 'residents who are often profoundly handicapped' as a special case requiring segregated care. The latter could be provided in the form of 'a village community, utilising the 'facilities and support' available at the Royal Albert.[52]

In contrast to the views outlined, members of former staff were less prescriptive in their stance on segregated care. Phil Morgan, for instance, a senior member of the management team which closed the Albert, stated that:

> *I did believe there was a need, and this has been subsequently been born out, for some sort of local provision for people who need structured care and support because of their individual complex needs.... It didn't need to be part of that site.*[53]

Likewise, one of the ward managers concurred with the tone of that statement, and argued for some sort of segregated units for people who were either a danger to society, or were particularly vulnerable.[54] Such a model was adopted for Calderstones, as part of its closure plan. The largest of the three long-stay establishments in Lancashire, Calderstones retained secure units on site, estimated in 2008 to be home

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[49] Letter from Dame Elaine Kellet-Bowman MP to Mrs. Ann M. Wilson, February 15th, 1989; Letter from Dame Elaine Kellet-Bowman MP to Roger Freeman MP, Parliamentary Under-Secretary of State, Department of Health, February 15th 1989.
[50] Letter from Roger Freeman MP, Parliamentary Under-Secretary of State, Department of Health to Dame Elaine Kellet-Bowman MP, March 14th 1989.
[51] Letter from Bruce Martin, North West Regional Health Authority Chairman to Dame Elaine Kellet-Bowman MP, April 18th 1989.
[52] Letter (copy) from Mrs. Ann M. Wilson, Secretary of RAHLOF to Dame Elaine Kellet-Bowman MP, February 10th 1989.
[53] Phil Morgan, Interview March 20th 2008.
[54] Male Ward Manager, Interview August 2nd 2009.

to upwards of 150 people with learning difficulties.[55] However, neither of the former Royal Albert staff, in their oral accounts, pressed for the retention of the hospital itself, nor a form of village community.

The rhetoric which questioned elements of deinstitutionalisation becomes further complicated when account is taken of an interview with Steve Mee, the former Resettlement Co-ordinator. He recalled that, during the 1980s, he thought that:

> *'The hospital's clearly wrong and abusive in my opinion, but is this (community care) necessarily the alternative?' And it was always presented as this or that. I used to often have doubts about whether it was really the right thing. It was better than what was there but was it what we should have been pursuing really?*[56]

His core question was:

> *What's the best way of providing support to people? Because I think it's almost become a cliché really but I think that all that happened was at times that we put people into mini-institutions.*[57]

What concerned Mee in particular was that in the congregate setting of the hospital 'there had to be collusion for abuse... 'cause there are so many people about'. He contrasted this with the relative isolation of a house in a community where, as a social services housing manager after leaving the Albert, he recalled that:

> *There would be one person on a sleep-in with particularly vulnerable people and that's what used to wake me up at night thinking it could be happening now and there's no way, they're smart enough, you're just not quite happy about them, but nothing you can pin down, nothing you can quite pin down.*[58]

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[55] Tom McLean, Interview September 8th 2008.
[56] Steve Mee, Interview February 18th 2008.
[57] Steve Mee. Ibid.
[58] Steve Mee. Ibid.

Such observations, as made by the former Resettlement Co-ordinator, extended the oppositional rhetoric beyond 'bricks and mortar' into one focussed upon relationships and accountability.

7.2.7 Trauma

Integral to the rhetoric of those critical of the organisational contraction are claims regarding its traumatic consequences for hospital residents. Narratives are of a tragic nature, portraying the person with a learning difficulty as a victim of uncaring services. An extreme instance of this is the assertion that the disruption of these years, and the way the changes were implemented, directly contributed to premature, and unhappy, deaths of people with learning difficulties. In his interview, a former ward manager, for instance, did not think 'the actual (overall) resettlement itself was done very sympathetically', and cited two instances to support this claim:

> *Not off my ward, but there was a woman there and she was resettled with terminal breast cancer. She died about three or four weeks later. ... Most of her adult life she'd lived there, she loved the Royal Albert. She was a real character. She used to wander around everywhere. She used to come on any ward, you'd make her a brew, that sort of thing, give her a bite to eat - consequently she was quite a big woman! But she was happy. And she was diagnosed with this breast cancer. And they sent her out to some community home or other that had staff that didn't know her and she died about a month after she'd gone.*[59]

In addition the same member of staff remembered that,

> *I used to know a little guy called ——. I worked with him extensively over the years, right from being a student, and they resettled him, or unsettled him as I said, and they sent him to a place ... I think he popped his clogs after about two months. There was quite a few went out and died, quite a few that all of a*

[59] Ward Manager (Male), Interview August 2nd 2008.

sudden found they had these stresses and strains they'd never had before – Yeah, OK it was their right to be able to pay a mortgage or to be able to pay rent but they'd never had to bother with it before. To my mind that was cruel.[60]

This was the viewpoint of a professional who was angry about the agenda of total closure and the indiscriminate resettlement (or 'unsettlement') of all residents. He stayed to the final week-end of closure, losing his job in the process. His is a critical voice, imbued, even in this short extract, with suggestions that resettlement was neither about individual choice, nor executed in a caring manner: both individuals were 'sent', suggesting they were treated as some inanimate parcel; the organisation itself was a happy and loving place, with freedom of movement, cups of tea, staff who knew you; for the woman, in particular, this contrasted with 'some community home or other that had staff that didn't know her'. Ultimately the message conveyed is that resettlement, for 'quite a few' was 'cruel', leading to premature fatalities either from increased responsibilities or inadequate support.

Such a perspective, that trauma associated with migrations within and beyond the hospital could contribute to death, does resonate with some other commentaries on deinstitutionalisation (Blackhurst 1995; Smith and Crome 2000; Hamlin and Oakes 2008). Furthermore, Steve Mee, who was highly critical of the institutional model, claimed that the death rate among older hospital residents did increase during these years as a result of the trauma of inter-ward moves:

Some people ended up moving quite a lot. And one thing that was predicted and it actually happened, the death rate shot up amongst elderly people... It was probably dramatic. It rose significantly, and it was noted. And at regional level, and this is very dark, but you can imagine this being talked about in a meeting in Manchester remote from the people we're talking about... In the early days we

[60] Ward Manager (Male), Interview August 2nd 2008.

slipped behind a bit all across the board because it was new ... so numbers were low on resettlement but the deaths rose and it was noted, it meant that the numbers remained on target. So I remember 'some people being permanently resettled' became a euphemism for death! All very dark but it happens doesn't it? I know when they've had to close some elderly people's homes in Lancaster a lot of people just die, because of the change."[61]

However, as will be illustrated in Chapter Nine, there were members of middle management who vehemently contested a discourse linking hospital rundown to the death of people with learning difficulties.

7.2.8 Professional Advancement

Running through the rhetoric of resistance was the theme that the best interests of people with learning difficulties, particularly those seen as the most vulnerable, were ill-served by a Royal Albert deinstitutionalisation agenda. A further expression of this was the argument that the organisational contraction was carried out for reasons of self aggrandisement by certain individual employees.[62] A former charge nurse, for instance, angrily stated that:

Too many people (staff) jumped on the bandwagon for their own career advancement.[63]

Anecdotally, a ward manager, illuminated a similar point:

I told anybody who'd listen that like – I won't go into names – but the senior managers there, I said, 'I think it sucks, I think it stinks'. The guy that came down and gave me my redundancy notice I gave him a right earful. I said, 'It's all right for you 'cause,' I said, 'You're like Mr. Teflon. You'll just slide across into another

[61] Steve Mee, Interview February 18th 2008.
[62] This provides an alternative perspective on the theme of commitment examined in Chapter Six.
[63] Charge Nurse, Interview January 28th 2009.

job. You'll slide into the community job, you know.' And I said, 'What do we do?' And he couldn't answer it.[64]

Previously, examined earlier in the chapter, this same former member of staff had referred to the Unit General Manager as 'hatchet man'. Here another manager is described as 'Mr Teflon' suggesting a propensity for nicknames to distil the essence of a rhetorical position. Although juxtaposed with a decline in his own job prospects, the implication of this extract, and the previous one, is that the rundown of the Royal Albert was personally advantageous to those prepared to support that change.

7.3 Conclusion

The emphasis in this chapter has been on unpicking the key threads of a resistance rhetoric to the organisational contraction of the Royal Albert Hospital during the 1980s and 1990s. In Chapter Eight the focus shifts to identifying, through the oral and documentary data, ways in which those voices were translated into *acts* of resistance.

[64] Ward Manager (Male), Interview August 2nd 2009

CHAPTER EIGHT

ACTS OF RESISTANCE

8.1 Introduction

Complementing the rhetorical focus of the previous chapter, here attention shifts to an analysis of *acts* of resistance. In doing this it will answer the research question:

How did they (i.e. resisters) express their resistance?

There was a consensus amongst senior management that those members of staff or families who questioned facets of organisational change at the Albert were unable to present an effective response. This viewpoint was expressed by the General Manager, in relationship to disgruntled staff:

If there was any deliberate attempt to hold anything up they must have been spitting in the wind... Any staff action didn't hold it up. Little bits of mischief but that's all. There was nothing significant that worked for that school of thought... There was no mounted opposition. Some people were difficult. And some people constantly said that they didn't think it would work and they were unhappy about it and what a waste you know when we've got this lovely place to - But that was just words... It was just a moan.[1]

Similarly, the former nursing director, although recognising that the actions of 'individual families' may have slowed resettlement down at times, suggested that there was insubstantial collective opposition from the hospital's League of Friends. He recalled that:

They never caused us too many problems, they didn't go public on it and after a while the League of Friends just folded up really... I don't think we ever had a public protest.[2]

These managerial claims that significant collective resistance to institutional contraction was lacking are substantiated with reference to other research data. The latter, however, provided rich insights into micro-acts of resistance. These 'little bits of mischief', as illustrated in this chapter, were expressed in myriad ways via formal, informal and external avenues.

[1] David Jordison, Interview February 15th 2008.
[2] Geoff Hopkinson, Interview May 1st 2008.

8.2 Formal Avenues of Resistance

8.2.1 Meetings involving Management

8.2.1.1 Hospital Staff Meetings

Staff concern, anger, and confusion relating to hospital contraction was, as intimated in Chapter Five, voiced in ongoing meetings with senior and middle management. Arguably, based upon oral data, a pivotal moment in this process of exchanging views was a meeting in the mid-1980s involving all the Royal Albert staff. Already highlighted in Chapter Five,[3] it was claimed that this was the occasion when Paul Whitfield, the District Health Authority's General Manager, formally announced that the hospital would close in three years.[4] According to one who was present, Bob Dewhirst, this message was 'met from some quarters with a lot of hostility'. In particular, he recalled that the Albert had 'a lot of painters and decorators' and:

> *I remember distinctly standing in this meeting and this man shouting and bawling, 'You're not going to do this, we won't let you do it.' ... I think he was a painter and decorator. He was telling everyone, 'We're not going to stand for this! We're not having this! It's wrong!'*[5]

Although, in his testimony, Steve Mee admitted that the agenda to close was stated, he also claimed that there was some vagueness:

> *I'd been at the meeting and he (Paul Whitfield) was a little bit fluffy the way he talked, a little bit ambiguous. But it was clear that resettlement was going to take place and he'd said at that point it was closing.*[6]

This ambiguity, Mee argued, resulted in some staff misinterpreting what was being said:

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[3] See Chapter Five: 5.2.2.
[4] David Jordison, Interview February 15th 2008.
[5] Bob Dewhirst, Interview June 9th 2009.
[6] Steve Mee, Interview February 18th 2008.

After that meeting a couple of women actually were really angry with me, saying, 'Paul Whitfield said that it isn't going to definitely close, so you aren't going to get your own way after all.'[7]

However, regardless of the apparent mixed message, both Mee and Dewhirst recalled staff expressing their oppositional feelings in a direct and unequivocal manner.

8.2.1.2 Senior Managerial Meetings

As highlighted in Chapters Four and Five, prior to the introduction of a unit general manager, the organisation was managed by a tripartite Unit Management Team comprising the Senior Consultant Psychiatrist, Administrator and Director of Nursing. The latter, Geoff Hopkinson, remembered two areas of frustration, during the early to mid 1980s, with the medical branch of this senior managerial structure: the difficulties in recruiting nursing staff; and complaints about nurses who questioned the decisions of the consultants. Concerning the first of these issues he recalled that at a time when the hospital was under pressure, from central government, to save costs,

I had to seek the permission of the Unit Management Team to recruit staff. I'd got vacancies, you see... And I clearly remember the Consultant Psychiatrist saying that it's not right that I should be recruiting staff when we are supposed to be making these costs savings. And I was saying, 'Oh you know it's not right that we should have vacancies on the wards and people aren't going to receive an adequate service as a result of that.' And that became a long protracted argument.[8]

The Senior Consultant, in this inner dialogue, was claimed to be impeding moves designed to promote the welfare of hospital residents. The final sentiment in his interview extract resonates with that of a former Resettlement Co-ordinator, who

[7] Steve Mee, Interview February 18th 2008.
[8] Geoff Hopkinson, Interview February 18th 2008.

recalled that, at this point of change at the Royal Albert, the consultants[9] engaged in 'a desperate power struggle... over a period of time'. In addition, elsewhere in his interview, the Director of Nursing recalled that 'the consultants used to complain to me about my staff'. According to Geoff Hopkinson, this was because,

> *Some of my nursing staff were quite opinionated and that didn't bother me. I wanted them to be opinionated. I wanted them to speak up for the rights of their residents but the consultant psychiatrists didn't always want to hear that.*[10]

So, similar to the previous extract, he presented a case in which the behaviour of the consultants is construed as running counter to the well-being of people with learning difficulties. The outcome of these complaints was that,

> *I had to find out what had happened... And I really was satisfied in most cases. It wasn't rootless at all. It was staff speaking up for the rights of their residents.*[11]

At this time of major organisational change, senior managerial time and energy had to be diverted, it is implied unnecessarily, towards investigating complaints.

However, the claims regarding the actions of the consultants, made here and later in the section, largely originate from change agents themselves. In the previous chapter the rhetoric of Dr Prasad, one of the Royal Albert psychiatrists during the contraction period, suggested that, from *his own* viewpoint, this was a period of great professional challenge. As examined further below, evidence suggests that consultants themselves believed that, like the student nurses referenced in Geoff Hopkinson's interview, they also spoke up for 'the rights of their residents'. In addition, researchers of organisational change argue that, in their sense-making, change agents have a vested interest in

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[9] The use of the epithet 'consultants' does not necessarily signify that *all* the consultants either engaged in, or agreed with, the actions being recounted. For a fuller explanation of this point please see Chapter Five, Section 5.2.7.

[10] Geoff Hopkinson, Interview February 18th 2008.

[11] Geoff Hopkinson. Ibid.

constructing an account which is a 'self-justifying explanation(s) of events and activities' (Ford, Ford et al. 2008:364). The argument propounded is that:

> Change agents' accounts of unexpected problems in a change process can safely attribute those problems to resistance as a way to divert attention from other factors, including their own failings (Meston and King 1996). Change agents are therefore encouraged to engage in sense making that entails scapegoating and sloughing off responsibility by blaming difficulties on resistance (Ford, Ford et al. 2008:364).

Additional complications can arise because change agents in their sense making process can convey a sense of independent objectivity, in which,

> events and meanings become commingled, resulting in what Bohm (Bohm 1996) terms *a net presentation*, in which events and meanings are treated as a single, seamless reality (Ford, Ford et al. 2008:364-5).

These theoretical caveats, along with comments authored by consultants themselves, provide a cautionary prism through which to evaluate assertions about the ways in which consultants, and indeed others, resisted elements of organisational contraction.

8.2.1.3 Resettlement Team Meetings

Steve Mee argued, as referenced in Chapter Five, that the refusal of consultants to engage actively with multi-disciplinary team working held up the formulation of a coherent Royal Albert resettlement strategy.[12] In 1985, under tripartite consensus management he, as the organisation's first Resettlement Co-ordinator, had been drafting a resettlement policy document, drawing upon the experience of Resettlement Team members. He recalled that consultants attempted to delay official acceptance through exercising a veto, predicated upon a mistaken assumption:

[12] Steve Mee, Interview February 18th 2008.

People couldn't veto, which is what had been happening, a decision made by the Resettlement Team. As long as the team was quorate they couldn't veto it by saying, 'Well we weren't there, we weren't of the decision' - which had been going on.[13]

These actions, claimed Mee, had meant delays for the resettlement procedures policy paper:

We'd never managed to get it accepted, never got it through. We'd been months, we met once a month, trying to get it through.[14]

Ultimately the advent of general management in the form of David Jordison pushed the policy through, with Jordison, according to Mee, refusing to accept that the consultants had a power of veto, although even at this stage there was a final attempt to sabotage the process. The draft document had been circulated to all members of the multi-disciplinary Resettlement Team but, at the feedback meeting, the consultant said,

'I've never received it so I haven't had a chance to read it.' ... They hadn't been at one of the meetings. David (Jordison) said, 'Well you were given the opportunity. You were asked to send in your comments.' And that's when he said, well he'd sent in his comments. And it was David that said, 'So you didn't receive it, but you sent in your comments.' And it was actually passed that day.[15]

Significant to the debate about the alleged responses of consultants is that traditionally they had wielded enormous organisational power within the NHS (Harrison 1994; Harrison and Lim 2003). In the years preceding the arrival of general management at the Albert, for instance, the Senior Consultant along with the Director of Nursing Services, and the hospital Administrator comprised the senior management of the institution. However, it was claimed by those opposing their influence that by the 1980s

[13] Steve Mee, Interview February 18th 2008.
[14] Steve Mee. Ibid.
[15] Steve Mee. Ibid.

in the context of learning disability institutions the consultants' responsibilities, as responsible medical officers, lay purely with those individuals who were detained ('sectioned') under the Mental Health Acts of 1959 and 1983 (HMSO 1983).[16] In the case of the Royal Albert this meant a minority of people with learning difficulties, not the whole residential population. Although, in practice, it was claimed that in multi-disciplinary meetings the consultants assumed a clinical leadership, and power of veto, regardless of the mental health status of any individual client; a point explicated later in the chapter. Where one of the consultants was named, the criticism tended to focus upon the actions of the Senior Consultant. However, the oral testimony of one of his colleagues, Dr Prasad, along with documentary data from other psychiatrists, perhaps sheds some light upon their viewpoint.

In his interview, Dr Prasad expressed concern about his role in a multi-disciplinary set-up during the changing times of the 1980s. He believed that:

> *Traditionally patient came to hospital under consultant not under psychologist... But you are responsible at the same time you're saying, 'I'm not responsible'. That's not right because if anything goes wrong what am I doing?*[17]

His allusion here is to the shared decision making of a multi-disciplinary team, but complicated by a sense that as a consultant he had ultimate responsibility for a resident. In his own words, this confusion made his job,

> *a bit difficult. If I make you responsible and you are not allowed to do what you think then you shouldn't be responsible... The consultant is in charge. It's my patient.*[18]

He was particularly concerned that:

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[16] Steve Mee, Interview February 18th 2008.
[17] Dr. Prasad, Interview August 12th 2009.
[18] Dr. Prasad. Ibid.

If anything goes wrong, I said, 'If anything goes wrong.' That's why I asked in multi-disciplinary team everything minuted... what I say minuted... 'If anything went wrong it's not me.' It's minuted I said that.[19]

This is someone who, as quoted earlier, disliked the formality associated with the introduction of general management. However, in this instance, with his claim that he insisted on his views being minuted, ironically he used a management tool as an act of resistance. Overall, the consultant's rhetoric highlighted a tension between responsibility and power, which resonated with other psychiatrists working in hospitals for people with learning difficulties. Writing in 1983, for instance, one of the consultants at Hensol Hospital, Glamorgan, opines that:

> The role of the consultant psychiatrist in mental handicap has always been precarious and seems to be more ambiguous and confused with the changing trends and policy in this field (Singh 1983).

Furthermore, six years later, another consultant, drawing upon a 1977 definitive statement by the Royal College of Psychiatrists, echoed the sentiments of Dr Prasad (RCPsych 1977). In a letter, entitled 'the role of the consultant in mental handicap', GC Kanjilal, based at Cranage Hospital, Cheshire, raised the following issues:

> The consultant has professional, ethical and legal responsibility which cannot be devolved. Other disciplines within the NHS are not so clearly legally defined... While most people acknowledge the responsibilities vested with consultants, consultants are rarely given the authority to pursue their responsibility (Kanjilal 1989).

However, and re-inforcing the idea of clinical leadership, this letter concludes with a 1989 statement from Lord Henley, a government spokesman, who said:

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[19] Dr. Prasad, Interview August 12th 2009.

the question of discharge of a patient into the community is *entirely*[20] a matter for the consultant psychiatrist who must be happy that the patient will benefit from a more independent living environment.[21]

Emanating from this, and the other statements, including the testimony of Dr Prasad, is a powerful rationale as to why the consultants at the Royal Albert may have viewed hospital residents as 'my people' (Adams 2009:320). Such a perspective, leaving aside claims of *abuse* of power, may have brought them unwittingly into confrontation with other senior members of the organisation.

8.2.2 Client Case Conferences

Those charged with enabling individual residents to resettle assert that staff often attempted to block particular resettlements by deliberately 'instilling fears' in either the person with a learning difficulty, their family or the receiving authorities. This form of sabotage, it was claimed, often occurred in case conferences, where all key stakeholders were present. Mary Lawrenson, for instance, recalled that:

> *You were sitting in a meeting to plan a resettlement. Everyone, like Steve (Mee), would be really positive about what's going to happen, and you'd get staff saying, 'Oh no you can't have that male with a female, they'll just abuse them'. Or – 'No you can't have him near a busy road he'll just run on the road and get run over and then that'll be that.' Just instilling fears I suppose in the receiving authorities that this is just too much.*[22]

Similarly, Steve Mee remembered attending a case conference which involved 'one charge nurse who is mentioned by lots of clients as a rough man'. On this individual's ward,

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[20] My emphasis.
[21] Hansard, April 27th 1989 quoted in Kanjilal, G. C. (1989). "The role of the consultant in mental handicap." Psychiatric Bulletin **13**(12): 705-706.
[22] Mary Lawrenson, Interview September 9th 2009.

was somebody who used to go outside and smash up garden furniture. That was his way of venting his anger. And at this meeting the family were there and it was a resettlement that clearly could go very, very wrong. And this particular charge nurse said, with the family there, 'He'll resettle over my dead body. Because what he needs is acres of ground to run around in. He needs things to smash up. And if he goes and lives in a small house and they won't have people like me and my staff who know about these things, they'll have unqualified people and so he mustn't go.' And I was in the position, I said, 'Well he will be going somewhere and we have to make sure we get it right.'[23]

Mee then recalled walking back with the family to their car,

and one was in tears, saying, 'We don't know who to believe and that particular charge nurse has had him for a long time and seems to do alright.' Now I didn't say what I could have said, 'Well the only reason he's going out smashing up furniture is because he's living in a hellhole.'[24]

Underpinning the vulnerability experienced by relatives could be a sense of indebtedness, as implied in an extract from a letter written, on the cusp of closure in late 1995, by a mother to RAHLOF:

> It will be a sad day when the 'Royal Albert' closes its doors. I am sure so many parents, like myself, owe the hospital, and staff, a debt we can never repay, for their care of our children, over so many years.[25]

In his narrative, Mee recollected attempting 'to reassure' the family, and,

this guy went out (of hospital) and in no time at all he'd calmed down. Mum actually rang me to thank me... She said it was the first time she'd ever seen him relax.[26]

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[23] Steve Mee, Interview February 18th 2008.
[24] Steve Mee. Ibid.
[25] Anonymised extract from a letter written by a parent to the League of Friends, November 1st 1995.
[26] Steve Mee, Interview February 18th 2008

This transformation, it was claimed, was achieved despite the endeavours of somebody who was very powerful in the place 'actively trying to undermine things'.[27] According to Mee, there was a rumour that this 'sabotage' extended to the actual day of the resettlement:

> *The social worker who ended up taking this fellow down to resettle reckoned that the charge nurse had been winding the guy up, and to get him into the car and down there he had to be tranquilised. So that was his welcome to the community, arriving in the car. It was a fact he was tranquilised but I don't know to what extent you could say he'd been deliberately wound up. You couldn't could you really? But that's what the social worker thought because she'd been to see the guy the day before and he'd been alright.*[28]

However, without condoning such alleged behaviour, from the perspective of the nurse, here portrayed as the 'villain', it can be argued that he had little formal influence over this particular resettlement. It went ahead despite his knowing the individual resident 'for a long time', and who, according to a family member, seemed 'to do alright'. Added to this, Mee himself intimated that it was potentially a very challenging move. He himself had genuine worries about the resident:

> *Part of me thought how entrenched is that behaviour (smashing up furniture) going to be. Is it all going to go tits up? We had no idea at all really.*[29]

Also, as argued in Chapter Five, the strong drive to contract the hospital was facilitated by a hegemonic approach espousing community care. The political framing of the contraction dialogue meant that individual voices of resistance were heard but not allowed to impact. In such an environment, as referenced in other organisational settings (Benyon 1978; Jermier, Knights et al. 1994), it is perhaps unsurprising that

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[27] Steve Mee, Interview February 18th 2008.
[28] Steve Mee, Ibid.
[29] Steve Mee. Ibid.

shop floor workers resorted to what the Unit General Manager described as 'little bits of mischief'. In a telephone interview, the nurse in question expressed strong critical views of resettlement policy, claiming that 'the politics stank'. He suggested that those advancing a community care agenda knew that he did not believe it was right for some clients to leave, so their resettlements would be organised when he was 'on holiday'.[30]

Other members of staff provided clues as to why nurses may have had passionate concerns regarding the transfer of care from hospital to community. For example, a ward manager talked of a process with clients, in which 'we would just hand him over... to the person who was coming in from the receiving area.'[31] However,

> *I found with some of them you'd say, 'Such and such has got quite challenging behaviours.' And they'd sort of be going, 'Yeah. Right.' You know you get this attitude, this rather arrogant attitude of, 'We're going to change everything'. And of course it backfired in a lot of cases because some of the guys were quite violent, they could be quite disruptive, destructive as well you know, pulling doors off and all sorts, fingers behind electrics and whatever, you know.*
>
> So after they left the Albert did that continue to happen in their new setting?
>
> *I don't know, basically. Because once they'd gone they'd gone. It's just there was some feedback, particularly of the guy they brought back, tried to persuade to stay, there was some feedback from the receiving areas but of course their agenda was not to see that it was failing, to show that it was failing, you know, their agenda was to show that it was a success, 'Oh yeah B——'s been all right'. You know. B—— might have ripped the bloody light fittings out but B—— has been all right, you know!'*[32]

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[30] Charge Nurse, Interview January 28th 2009.
[31] Ward Manager (Male), Interview August 2nd 2009.
[32] Ward Manager (Male). Ibid.

Although this was the perspective of a member of staff who had strong criticisms of aspects of resettlement policy, elements in his narrative are echoed by those with a more sympathetic attitude. The Unit General Manager, for instance, in a tongue in cheek manner, suggested that:

> *Most of the feedback I got was positive from people that left, but maybe people were trying to encourage me to do the job I was doing. Who knows! (Laughs) You never know what goes on behind the scenes... 'Ring David Jordison up and tell him that you're really happy now that you've been resettled.' (Laughs)*[33]

A former charge nurse, Tony Dennison, worked over a number of years with a handful of young people with high support needs. He described developing very close relationships with those in his care, even though he was supportive of their moves out of the institution. However, like the ward manager quoted above, he recalled issues arising because of the sceptical attitudes of community-based workers:

> *And the care staff they appointed came along and spent some time with us on the ward and read the notes and got to know the person. And then it was evident when they moved out that they disregarded most of what we'd said.*[34]

In contrast to the memory of the ward manager, Tony Dennison's assertion was supported by specific information regarding the individual after he had left the Albert. According to the nurse, the former resident had cerebral palsy which meant that at night his arms and legs could go 'anywhere', so:

> *What we did for him at night we put cot sides on his bed. So he didn't hurt himself we put padding on them... and he slept fine. What they decided was that cot sides were a form of restraint. They wouldn't be having them at all and they'd put some pillows for him to fall on to when he fell out of bed! So I wasn't happy with that! And sure enough the poor chap did fall out of bed and eventually they*

[33] David Jordison, Interview June 12th 2009.
[34] Tony Dennison, Interview September 1st 2009.

did review and they did put cot sides on with padding on. But we told them and they decided that we were institutionalised, didn't know what we were talking about... At one review... I was really annoyed that he'd fallen out of bed and yet I'd told them. I asked them why they'd ignored us. The person in charge of the staff team, at a fairly low level, said it was, 'because he came from an institution and we thought there might be institutionalised thinking there. So we wanted to get rid of all regimes and treat him as an individual.' 'We put those regimes in place having tret him as an individual and found out his needs.' 'Well we realise that now.'[35]

As explored in Chapter Seven, resistance to aspects of community care could embrace a multi-faceted weltanschauung, of which one part included anxieties about the well-being of people with learning difficulties. However, with regard just to that dimension, these extracts, particularly the latter one, indicated the dangers in applying a hegemonic ideology, which could be reduced to that of bricks and mortar: 'institution' is bad; 'community' is good. Such concerns were noted elsewhere in the United Kingdom at the time (Jackson 1988). These observations do not condone the remembered behaviour of the charge nurse in Steve Mee's narrative, but they do offer insights into why some staff had frustrations with the resettlement process.

Attribution of intention on the part of some staff to sabotage resettlements was theorised by Mary Lawrenson, who argued that:

I still firmly believe that anything that happened to a person with learning disabilities in the Royal Albert was all about the staff. So if you got in a meeting some staff saying, 'Harry doesn't want to leave', that's because the staff had made them think that they don't want to leave or they haven't given them the benefit of the choice or the experience. It's all about informed choice isn't it?

[35] Tony Dennison, Interview September 1st 2009.

And I don't ever believe that anyone who lived at the Albert would genuinely say, 'I want to still live here,' once they knew what the alternative was...[36]

In the wider literature it was noted by a research interviewee in a report on Iowa, although relating to community staff, that the latter

> have set up individuals for failure, with the result that many are forced to return to an institutional setting (Enbar, Morris et al. 2004:50).

Traces of the sort of staff intervention intimated above are evident in memories of people with learning difficulties themselves. A former Royal Albert resident who left in the early-to-mid 1980s recalled that:

> *It was a Wednesday I think and everybody (Royal Albert staff) was saying, 'I wouldn't leave. I wouldn't leave'. And they got a fright when I did leave.*[37]

These staff, according to this woman, 'didn't like me'. She remembered that they 'pushed' her to do things that she did not want to do, such as having a bath at a certain time, or tidying her room or making her bed. However, she was determined and told them, 'I'm going to leave', despite many staff saying that this would not happen. There was a 'very nice' member of staff, however, who told her, 'You'll leave all right ——. You've got the brains up here.' This individual left 'eventually' but felt that nobody helped her leave, they let her go in 'rags and tatters ... old clothes'.[38] In a similar fashion, Mary Ball, when leaving Gogarburn Hospital in Edinburgh, recalled being confronted by negative staff expectations:

> *One of the staff said to me when I did get out of hospital, 'You'll no' last a day.' See if they were still there today I would say, 'I've been out mair than a day'... There were a lot of them on my back, but I got through (Ingham 2003:114).*

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[36] Mary Lawrenson, Interview September 9th 2009.
[37] Former Hospital Resident (Anon), Interview May 28th 2009.
[38] Former Hospital Resident (Anon). Ibid.

In both these accounts the tellers, while recognising the disruptive impact of staff attitudes, turn their tales into heroic ones: they overcame the odds and, in Mary Ball's words, 'got through'.

Mary Lawrenson's assertion that, with reference to residents, 'staff had *made* them think they don't want to leave' does, however, resonate with studies elsewhere. Kelley Johnson, when closure was announced at an Australian institution, noted the way that one or two of the women on a locked ward were adversely affected by the anxieties of staff:

> Joyce said happily: 'Hilltop's gone, so I'll be going home.' N. (staff member) said: 'No, you won't be going home, Joyce. You'll have to live in a community house with lots of people you don't know.' Joyce looked anxious and walked away (Johnson 1998:88).

The content of such a message, exacerbating understandable fears of the unknown, is not dissimilar to that attributed to the charge nurse in Mee's testimony, quoted above. Johnson also recalled another member of staff saying to Jodie, one of the residents:

> 'You don't want to leave us and go into the community do you?' Jodie said 'No' (Johnson 1998:88).

Likewise, Dave Spencer, a core member of the Resettlement team for most of the rundown period, referenced staff who expressed doubts about individual resettlements. He suggested that direct expressions of resistance, exemplified by the extracts quoted above, had a redeeming feature:

> *If people were actively saying, 'I don't think this will work', and they would say so in meetings, and talk to families and say, 'Well I know that everybody is telling*

you how wonderful it is going to be but actually in my view it is not going work for your son or whatever', you could deal with that and that is kind of honest.[39]

More problematic, however, for resettlement procedures were when staff would deliberately withhold pertinent information, so,

after people had moved on and something had happened - they'd say, 'I told you that would happen, that has happened before'.[40]

Spencer recalled,

talking to a group of staff explaining about the process and saying we are moving on to your wards next and this is what is going to be happening. And I said, 'If anybody says that to me afterwards I am going to be reporting you for keeping information back. Because the whole process is built on the premise that if we give people the amount of support that they need at the times when they need it then they can live anywhere. And if you are denying us the information that says he needs this kind of support at these kinds of times then it is not going to work is it? And it is not us that is suffering it is them.' There was a bit of bloody mindedness, 'Well go on make it work but I am not having anything to do with it.' But by and large that was as much as it got. There were a few meetings that you'd turn up expecting a nice friendly chat with a family and realise that somebody had been feeding them a line about how someone has been neglected or abused.[41]

The assertion that on occasion hospital staff kept information back is echoed elsewhere in England in the 1990s. Collins argues that 'several resettlement officers' at other learning disability hospitals claimed that 'quite often' attempts were made to deliberately 'sabotage' resettlements by withholding crucial pieces of information until 'the eleventh hour' (Collins 1993:50). Moreover, Spencer's belief that staff were capable of 'feeding a

[39] Dave Spencer, Interview April 3rd 2009
[40] Dave Spencer. Ibid.
[41] Dave Spencer. Ibid.

line' to families resonates with a Royal Albert social work document, written in 1990, which stated that,

> Lancaster based families ...are bombarded with negative images of resettlement by members of the local community (some of them present and former hospital staff) (RAH 1990).

Furthermore, at that time, the Social Work Team was especially concerned about the remaining years of the organisation's existence, because,

> our increasingly vulnerable resident population will be left in the hands of those staff holding out for redundancy, awaiting their pensions and/or actively opposed to resettlement. The latter group have always attempted to sabotage resettlement plans, often by mis-informing and/or dis-informing relatives (RAH 1990).

Client conferences, referenced in Chapter Four, were pivotal to the decision making process regarding the resettlement of people with learning difficulties from the Royal Albert. The operational process of these meetings hinged upon multi-disciplinary working, in which 'no individual profession would hold sway'.[42] However, a 1985 internal Social Work Team paper entitled 'Problems of team work at the Royal Albert', as well as the oral testimonies of one or two of those involved in resettlement at that time, claim that consultant psychiatrists,[43] fuelled by a mistaken notion of their 'pre-eminence' employed a range of strategies to undermine such a collaborative ethos (RAH 1985). One of the social workers, Gudrun O'Hara, recalled in an interview that:

> *You had somebody there having a case conference, the final one for resettlement. The consultant finally turns up and he says, 'I don't agree with it. There's something wrong with that man, he can't go out. He has to stay in*

[42] Steve Mee, Interview February 18th 2008.
[43] The use of the epithet 'consultants' does not necessarily signify that *all* the consultants either engaged in, or agreed with, the actions being recounted. For further explanation of this point please see Chapter Five, Section 5.2.7.

hospital.' And you think, 'Oh God!' All your work and everything, and parents and everything else. And you find out he has an enlarged prostate. There's no reason why he has to stay in hospital. I mean the man moved out and they had a very good time.[44]

Such a memory, emphasising the attempted final veto by the consultant, fits with the assertion of the 1985 social work document that:

> Non-medical decisions have been taken unilaterally and against the advice of colleagues who have carried out the major responsibility for working with a particular resident .

Also in Gudrun O'Hara's recollection her comment that 'the consultant *finally* turns up' suggests that he had not been party to previous consultations and negotiations. This theme of absence, as a deliberate strategy to hold up proceedings, is present elsewhere in the same document, as well as in other oral testimony. Steve Mee, for instance, recalled that during the 1980s:

> *Deciding who went and when they went would all be multi-disciplinary ... So they (the consultants) stayed away from those meetings.*[45]

And the 1985 social work paper likewise claimed that consultant psychiatrists 'subverted the team approach' by,

> absenting themselves from a client conference and then refusing to accept the conference decision (RAH 1985).

Sometimes, it was argued, this absence occurred during the meeting itself with the consultant,

> walking out of a client conference when the discussion takes a turn (he) does not agree with (RAH 1985).

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[44] Gudrun O'Hara, Interview June 22nd 2009.
[45] Steve Mee, Interview February 18th 2008.

On other occasions, according to the social work perspective, the 'subversion' was expressed in more subtle ways. Endeavouring to assume control of the client conference, for example, was one of these:

> After the Chairperson of a client conference has already summarised the conference decisions the consultant will list them again as if to suggest he has the final word and has the responsibility of accrediting or legitimising the decisions (RAH 1985).

In addition, there were occasions, it was alleged, when the consultant would engage in,

> the ostentatious perusal of medical notes when other members of the conference are speaking – and when (he) eventually emerges from the medical notes he makes a contribution which does not connect with the previous discussion (RAH 1985).

This accusation, along with the others mentioned above, led the author of 'Problems of team work at the Royal Albert Hospital' to conclude that, because of the behaviour of the consultant psychiatrists, 'client conferences have been battlegrounds'.

8.2.3 Resettlements

Steve Mee recalled that, during the mid 1980s, this subversion extended beyond the client conferences themselves. Consultants, he argued, as touched upon in Chapter Five, used their control of a resident's medical notes to stall a resettlement. The forwarding of this documentation to the appropriate community GP was an essential bureaucratic requirement, without which the resettlement of a person with a learning difficulty could not proceed. *But*, Mee claimed,

> *in order to register with a GP the consultants had to release their medical notes, and they wouldn't. And they would say they would and a year later – and in some areas GPs said they weren't going to accept anybody else on their books. I know that happened in Rochdale for example, wouldn't have anybody else on*

their books unless the notes went ahead of the person and the consultants just wouldn't play ball with that. And that was, that became a sort of preoccupation of mine chasing up the notes, trying to work out how to get them to release them. And they would say they were going to and then wouldn't, or say they had sent them. They'd say that and the GP must have lost them, all that sort of stuff.[46]

Issues with the release of medical notes seemed to be a feature of resettlement elsewhere in England, one researcher suggesting that:

> By retaining records hospitals retain some element of control over people, just as they seek to continue to control their living conditions and activities (Collins 1993:66).

However, as in the case of delays with the resettlement policy document, the executive leadership exerted by David Jordison at the Royal Albert was, according to Mee, instrumental in changing this state of affairs, and paving a way for easier resettlements:

> *... they (the consultants) didn't want to be told when they were going to be releasing the notes. And that was one of the issues, from my memory anyway, that became something we explicitly argued in the resettlement meeting and Jordison ended up saying, 'No it will happen. Region say it will happen', and Region were the employers of the consultants, it wasn't the hospital so, their employing body wanted this to happen and that's sort of, I think that's the way he argued it.*[47]

Viewed from the perspective of the consultants in the Royal Albert, however, even that attributed argument of the Unit General Manager may have been problematic. According to a 1977 professional directive from the Royal College of Psychiatrists:

> The Consultant is responsible to his employers in all matters *except* clinical professional standards and responsibilities... (RCPsych 1977:6). [48]

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[46] Steve Mee, Interview February 18th 2008
[47] Steve Mee. Ibid.
[48] My emphasis.

Nevertheless, as intimated in Chapter Five, the over-riding impression is that, as the years of contraction unfolded, it was the will of senior management which prevailed.

8.3 Informal Avenues of Resistance

Those advocating resettlement in the early years of the 1980s recalled encountering scepticism, and ridicule, enunciated directly by staff in everyday organisational settings. Mary Lawrenson, for instance, a young student nurse at the time, remembered being inspired by the Jay Report of 1979 (Mitchell 2003):

> *It was like this kind of light came on for everybody. It said that people shouldn't be institutionalised, they should be out in the community.*[49]

However, although this document, offering a radical critique of learning disability nursing, led to animated discussions in the School of Nursing,

> *it wasn't happening on the wards that discussion... And you had young inexperienced people like me going out and trying to fly the flag for this change of philosophy and the older staff just laughing at you saying, 'You must be mad. You think (so and so) is going to live in a house.' And it was like this, 'Don't be stupid', kind of thing.*[50]

As with the wards, similar views, it was claimed, were voiced in the organisation's staff social club. Eric R., in the years following the Jay Report, was involved in the resettlement of residents who, according to some of the other nursing staff, were 'the most disturbed' young people in the Royal Albert. This male nurse, who had qualified in the late 1970s, recalled that,

> *I did like a pint, so I used to go to the club every night where I was guaranteed to see somebody I knew in their social time. We didn't talk about work that much, but people did express in loud voices what their opinion was of community care. 'What a load of shite Eric! How are you going to get - and they*

[49] Mary Lawrenson, Interview September 9th 2009.
[50] Mary Lawrenson. Ibid.

used to reel off the name of someone who was very dirty or difficult to care for - who's going to live next to such and such? Who's going to -?' That's where that kind of opinion was mostly expressed, probably under the influence of alcohol as well! And it was a popular view to express in the Social Club anyway. Nobody wanted to believe in community care.[51]

A feature of some angry outbursts at the time, claimed Steve Mee, is that they were 'personal'. He recalled that:

I'd just started as the Resettlement Co-ordinator. And it was quite an odd experience actually 'cause with my role came quite a lot of personal threat and aggression. I think part of the problem is that people in institutions like that... the limits of their line of authority are what they can see... (So) a lot of people thought resettlement was my idea and, 'You're not going to get your way about this, 'cause the government aren't supporting it.' I remember one person saying.[52]

On another occasion Mee recounted that a case conference had decided to go ahead with the resettlement of a resident, although such a move was vehemently opposed by a member of nursing staff. The anger of the latter, it was claimed, spilled over:

I got a personal threat from this charge nurse after the meeting. It was very direct, almost along the lines of: 'We know where you live' sort of threat'.[53]

In addition, Mee remembered that after he had left and was working 'on the community side in Lancaster District', he was confronted by a member of the Royal Albert staff over job prospects:

Several people were applying for jobs who realistically they'd been anti-resettlement all the way through ... And again that got personal a couple of

[51] Eric R., Interview August 11th 2009.
[52] Steve Mee, Interview February 18th 2008
[53] Steve Mee. Ibid.

times. I remember being shouted at in a pub once. Bloke saying, 'Unless you drank in the right pub, unless your face fitted you weren't going to get a job.' I suppose people think that don't they? [54]

Although there was no evidence for this at the Royal Albert, it has been alleged that a resettlement officer at another institution in the north west had their car tyres slashed.[55]

8.4 External Avenues of Resistance

On occasion, arenas and bodies external to the organisation were important loci or avenues for the expression of oppositional voices. An analysis of documentary data reveals the formal involvement of a number of outside agencies. The National Development Team, for instance, after its damning report of 1979, referenced in Chapter Four, revisited the hospital in 1984. Whilst there it met with the League of Friends, who were able to enquire about the future of their relatives, resident in the institution, as well as plans for the organisation itself.[56] Likewise, in 1989, the league, as referenced in Chapter Seven, called upon the local MP to advocate on their behalf regarding the proposal to adapt the Royal Albert into a 'community village'. Furthermore, throughout the 1980s and 90s members of the District Health Authority and the Community Health Council raised questions, often on the back of visits to the Royal Albert, about aspects of the institutional rundown.[57] Recurrent themes in the meetings of these watchdog organisations, as reported in the local press, included concerns about lack of adequate community resources, over ambitious resettlement rates, living conditions at the Albert during rundown, and community facilities for those residents perceived as having 'challenging behaviour'.[58]

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[54] Steve Mee, Interview February 18th 2008.
[55] Conversation with Duncan Mitchell, March 14th 2009.
[56] *Minutes of the Visit of the Development Team for the Mentally Handicapped*, March 1984.
[57] Lancaster Guardian: July 6th 1984; February 2nd 1990; June 14th 1991; September 17th 1993; March 4th 1994; May 19th 1995.
[58] Lancaster Guardian, July 14th 1995.

However, the oral testimony indicated that voices of resistance emerged in a more informal, spontaneous manner at a neighbourhood level. One of the Royal Albert senior managers recalled that:

> *The house that I live in was originally owned by social services... Before I came into the area social services wanted to buy it to put people with learning disabilities in it. And a person who lived further down the street, who worked at the Royal Albert, and was a union steward, protested, didn't want people with learning disabilities, people who she works with all day, living down her street. And I moved into it! I've always considered that to be an irony. I don't know what she thought of that!*[59]

On another occasion the involvement of a nurse who was 'against community care' was, according to Hopkinson, instrumental in fomenting successful resistance by the local neighbourhood. He recalled that:

> *We wanted to resettle a couple of people into a house in one area of Lancaster and there was a protest from the neighbours... It came to our attention that they had heard that some people from the Royal Albert were going to be resettled into an empty house, in their cul-de-sac. They didn't like it. So we arranged to meet them... We had a meeting in somebody's house in that street... We listened to what they were saying. I was quite appalled actually when I realised that there was a member of my staff there, who lived in that street. I still feel very angry about that, it was one of our very first resettlement attempts into Lancaster, after the pace of resettlement increased. And it was very obvious that she was against community care. She didn't want it to happen in her street, she told her neighbours about it, and that was the reason why we had this protest.*[60]

[59] Geoff Hopkinson, Interview May 1st 2008.
[60] Geoff Hopkinson, Interview May 1st 2008.

This could be construed as an instance of 'opinion leadership' which, unlike the examples quoted in Chapter Five, worked against a change agenda (Rogers 2003). The nurse had influence within her own neighbourhood system, and as Rogers argues:

> Influential persons can lead in the spread of new ideas, or they can head an active opposition (Rogers 2003:27).

A former charge nurse who remembered this particular incident, suggested that 'all the people in this drive got a petition to stop it, and they stopped it.'[61] Geoff Hopkinson intimated that it was purely by chance that the member of staff,

> *had got wind of it. So I can only imagine that she must have been very, very close to the people, you know the residents who are going to move into that house. She must either have worked on that ward or knew somebody who worked on that ward who said that a house was being identified down her street for these residents.*[62]

Given the level of resistance, it was felt that withdrawing was the best option for 'the clients' who could be,

> *up against it right from the very beginning. The neighbours could well not be supportive. And we didn't want them to be made to feel uncomfortable, so we found somewhere else for them.*[63]

Elsewhere, in North America for instance, alliances between parental groups and trade unions were recorded as being effective in profoundly disrupting institutional closures (Enbar, Morris et al. 2004; Malacrida 2006). In the case of the Albert it was asserted that this experience resulted in a change in resettlement procedures; from then on there would be no consultation with neighbours because when,

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[61] Malcolm Alston, Interview May 19th 2009.
[62] Geoff Hopkinson, Interview May 1st 2008.
[63] Geoff Hopkinson. Ibid.

anybody... moves into a house somewhere, you don't consult with the neighbours and ask them if I can come in, you just go in. So that's what we decided to do.[64]

Although the rationale is couched in 'ordinary living' terms, the roots of this managerial response, as intimated here, could also be construed as resting in the politics of expediency.

8.5 Impact of Resistance

Although the impact of resistance is difficult to assess with any degree of accuracy, a number of salient observations can be made. Recalcitrant staff, including consultants, as identified earlier in the chapter, were claimed to have effectively undermined resettlement processes at different times. It was also intimated that short-staffing issues[65] could be exacerbated by the direct actions of employees. One former male nursing officer, for example, asserted that, when faced with what they regarded as unacceptable practices during the rundown period, members of senior staff would leave. In his interview, he recalled that an experienced nursing officer reported dangerously low nursing levels to a senior manager:

And the boss said to him, 'Get away with you. You don't know what you are talking about.' And the man was silent for a moment and then he said, 'If I don't know what I am talking about now I never will.' And turned round and walked out.[66]

As an outcome of this disrespectful exchange, the teller recalled that the senior staff member, 'took an early retirement'. Such an action was given added weight by the latter's impeccable credentials:

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[64] Geoff Hopkinson, Interview May 1st 2008.
[65] Lancaster Guardian, June 14th 1991.
[66] Nursing Officer (Male), Interview July 23rd 2009.

He was one of the strongest and most-liked characters in the whole hospital. One of the most trustworthy able men that you could meet.[67]

In this account, the failure of communication on the part of a senior manager resulted in an act of defiance by a key member of nursing staff. It was implied that the latter's leaving worsened the provision of hospital care.

Oral testimonies of those implementing change indicated that on occasion deeds were executed in order to prove a point to detractors of resettlement. Spontaneously referenced, for instance, by a number of interviewees was a deliberate decision early in the 1980s to move people out who were viewed by many staff as being impossible to resettle. Mary Lawrenson recalled that her line manager Steve Wade,

said to me, 'Look Mary the resettlement programme is starting but they (critical staff) are saying that we can't resettle people with challenging behaviour, because they're too difficult and it won't work. What are we going to do about it?' I remember Steve and I sitting down and saying, 'Well what we'll do - I mean its mad now thinking about it - We're going to take the five most challenging people in the hospital and we're going to put them in ordinary housing and make it work, and prove to them that it can work.' [68]

Importantly this extract highlights that it was not just about moving people out of hospital, it was about showing staff that 'ordinary' living could work. At least one other study referenced such a strategy as being important early on in a formalised process of resettlement (Shumway 1996). Less specifically, oral evidence intimated that managers were extremely mindful of the vulnerability of change agendas to damaging criticism.[69] The investment by managers in staff training, meetings, involvement with RAHLOF, as well as the local press, suggested that the need to keep various stakeholders on-side

[67] Nursing Officer (Male), Interview July 23rd 2009.
[68] Mary Lawrenson, Interview September 9th 2009.
[69] David Jordison, Interview February 15th 2008; Steve Mee, Interview February 18th 2008.

required a considerable investment of time and energy. In the case of one hospital, for instance, it was intimated that:

> The management has remained committed to resettlement into the community, and has expended considerable time, energy and resources on dissuading some relatives and staff from pursuing a village[70] campaign (Collins 1992:21).

Significantly, the outcome of 'the need to do this has inevitably slowed down the general progress of resettlement plans' (Collins 1992:21). Although problematic to discern the degree to which the broader sentiments of such a statement resonated with the Royal Albert, it does hint at a covert dimension to the impact of resistance.

8.6 Conclusion

Discussed here and in Chapter Seven, has been the presence of individuals during Royal Albert contraction who were critical of the dominant community care rhetoric. Like proponents of the latter, however, these voices of resistance espoused a privileged ethical position in relationship to people with learning difficulties. Senior managerial testimonies marginalised these alternative perspectives and their impact upon rundown. Although there was little evidence of a coherent and sustained collective resistance, these chapters intimated that at a micro-organisational level an intense political and ethical conflict was enacted. Chapter Nine examines the personal meanings which were entwined with the viewpoints of those positioned on either side of this struggle.

[70] See Chapter Seven.

CHAPTER NINE

MEANINGS OF CHANGE

9.1 Introduction

This chapter examines the ways in which stakeholders, particularly staff, made sense of the organisational rundown of the Royal Albert. It will address the research question:

> *What meanings did Royal Albert rundown have for implementers and resisters of change?*

The primary emphasis here, especially in contrast to Chapters Four, Five and Seven, is not on the *rhetoric* of change, but on how individuals, in their oral narratives, attempted 'to recreate reality *poetically*' (Gabriel 2000:31). In other words, how these actors in the contraction narrative made sense of the changes *for themselves*. Analysis indicated that there was a critical difference of meaning between on the one hand the change agents and those who resisted the rundown agenda. Particular members of middle management implementing change presented narratives infused with a sense of epic struggle and redemption. In contrast, those individuals with a greater institutional identity narrated a sense of loss and tragedy. The latter group emphasised deindustrialisation as much as deinstitutionalisation. This dichotomy of meaning between advocates and opponents of hospital rundown, for instance, resonates with a study into the impact of a car factory closure in Wisconsin. It is asserted that:

> For blue collar workers, the closing of the auto plant represented the end of an era. For white collar workers, however, the plant closing was seen as progress (High 2004:4).

However, as intimated in this chapter, for stakeholders of whatever persuasion the years of Royal Albert rundown were emblematic of acute personal emotional investment.

9.2 Redemption

The argument propounded in Chapter Five was that during the 1980s and 1990s student nurses were fast-tracked into the Royal Albert's middle management to push through organisational change. In Gramscian terms these individuals were described as *intellectuals*, providing vital moral and intellectual leadership in a radically changing political landscape. Weaving through their narratives were themes of institutional injustice and collusion, rebellion, recruitment as agents of change, and ultimately redemption and liberation.

9.2.1 Injustice

Underpinning the oral testimonies of Dave Spencer, Mary Lawrenson, and Steve Mee was a critical consciousness regarding the appropriateness of institutional care for *anyone* labelled as having a learning difficulty. Although Mee, for instance, was an instrumental figure in the Resettlement Team at the Royal Albert, he first encountered an institutional setting as a care assistant at Turner Village in the late 1970s. In a narrative which critiqued oppressive elements of congregate living he pinpointed his very first day at the Colchester-located hospital as being an initiation into the injustices of this system of care. He arrived on a ward for men, and was shocked to discover that control of residents by staff, often with the support of other residents, was enacted with high levels of physical violence:

> *One man (a resident) who managed to slip away was literally chased and rugby tackled down, taken back to the ward and the charge nurse kicked him and thumped him from one end of the ward to the other. And I'd probably been there a couple of hours at that point. 'What the fuck's going on here. What's this?' And he said, my first lesson ever in learning disability, he says, 'What you've got to realise lad is no brain, no pain. Unless you treat them like this you'll never get 'em to do what you want 'em to do.' And he says, 'He actually won't feel it like you or I would.'* [1]

As with observations made about women in an Australian institution's locked ward, this extract epitomised a taken-for-granted negative discourse of learning difficulties in which the men were 'othered'; such a viewpoint legitimised abusive and degrading behaviour (Johnson 1998:78). Similarly, Dave Spencer at the Royal Albert in the late 1980s recalled a conversation with the hospital dentist who was refusing to give residents an anaesthetic for tooth extraction because,

[1] Steve Mee, Interview September 22nd 2005.

'Where there is no sense there is no feeling. We won't be bothering with any of that nonsense.'[2]

After his initial encounter, Mee recalled that he continued to witness abuse, even being taught by the charge nurse how to hurt someone without leaving any visible signs. As a young man new to this institutional world he remembered his moral dilemma:

I kept thinking maybe he's right, maybe this is how it needs to be, because I'd never been in anything like that in my life before.[3]

After five weeks, however, the Resettlement Co-ordinator 'went with my first instincts and reported it and had another member of staff support me on it.'[4] Very clearly through this story, in which he gives voice to the charge nurse, Mee has *actively* positioned himself on the side of the resident; his 'instincts' indicating that the practices on this ward were wrong.

However, the implication that hospital residents were the victims in a tragic institutional narrative was given a more sinister twist in the oral testimonies of Mary Lawrenson and Dave Spencer. The latter argued, in contradiction to an oppositional perspective,[5] that it was institutional, not community, care which contributed to the premature death of people with learning difficulties:

We just didn't have deaths of people that had been resettled for years. Every now and again you would be going to a funeral of somebody that had once lived at the Royal Albert; it would be few and far between. Whereas when you worked at the Royal Albert all the time the funeral director's car was never away from the front drive.[6]

In an impassioned interview, Lawrenson echoed these sentiments. She asserted that:

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[2] Dave Spencer, Interview April 3rd 2009.
[3] Steve Mee, Interview September 22nd 2005.
[4] Steve Mee. Ibid.
[5] Discussed in Chapter Seven.
[6] Dave Spencer, Interview April 3rd 2009.

When I worked at the Royal Albert there weren't many people who had physical care needs... But in these days people are surviving a lot longer ... So just an observation there weren't that many people with physical care needs in institutions probably because they didn't live that long 'cause the medical practice wouldn't treat them - I think that was one of the things I remember, having arguments about people who were ill at the Royal Albert not having access to good medical treatment for cancer, for heart problems, things that we would expect to be treated for.[7]

Furthermore, in the same interview, she appeared to be almost caught unawares by the poignant memory of the negative impact of the Royal Albert on the quality of life for some of the younger people with whom she worked:

The wards I didn't like working on were the children's wards, you know because that particularly upset me. You'd - (pause) - still upsets me now - You'd be on a ward (...) and there'd be about 30 boys, a third of them maybe under 16 years old, some of them even under ten years old, and them just sitting around, just being bewildered, you could see they were institutionalised, just in shock I think personally. And they would get bullied by the staff and the big boys on the ward. I can remember P— and some of the other lads from when they were about 10 years old, A—, D—, they were all around as children when I was a student nurse. I can remember D— coming in from home, S— when she came from home - they were 14 year old girls... Having a particular persona, a personal identity, and six weeks later they were drugged up, they were in institutional clothes, they'd lost that sense of individuality and I think they became mentally ill just because they were there. Throughout my career I tracked people like S—— and D—— and P—— and I know what happened to them. D——'s dead, P——'s

[7] Mary Lawrenson, Interview September 9th 2009.

dead. They're younger than me and it was just the life they led didn't care for them really. [8]

Mary Lawrenson was visibly upset as she remembered what had happened to these individuals, some of whom she was involved with for a number of years. Moreover, as emphasised in her overall narrative, these comments were linked to a simmering resentment against 'the system' (her term) which allowed such things to happen.

Running through these extracts from Steve Mee, Dave Spencer and Mary Lawrenson's interviews was the theme of an institutional system of care, which, either through the agency of individuals or in a more impersonal systemic manner, traumatised people with learning difficulties. The latter were viewed as the tragic victims, with the institution cast in the role of villain.

9.2.2 Collusion

A key element in the narratives of these three former members of Royal Albert middle management, however, was an admittance of their own collusion in an institutional system which victimised people with learning difficulties. Dave Spencer summarised the paradox:

I mean you were doing things that you knew weren't right. You were doing them because the alternative was that things wouldn't get done at all. It might be being done in a slapdash and uncomfortable and difficult way like lining 15 blokes up and they are all sharing the one set of bath water but the alternative was that nobody would get - Well if you said that, 'This is ridiculous. I am not doing it.' Nobody would have a bath. Well at least they had got a chance of being at least semi-clean and a bit more comfortable.[9]

[8] Mary Lawrenson, Interview September 9th 2009.
[9] Dave Spencer, Interview April 3rd 2009.

Mee also recalled a similar rationalisation of institutional care, in his case providing him with the impetus to continue working as a care assistant. An Essex University graduate, he remembered taking the job, referenced earlier in the chapter, simply because it was the only one available at the job centre. He recalled that he 'didn't think I'd be sticking it for very long.'[10] However, having witnessed, what he described as, cruel practices on his very first day he decided to remain:

> *I think it was partly political motivation (to stay) because I'd done sociology at university, and I couldn't see what job you would do that wouldn't be supporting the status quo; I couldn't see what I could do that was politically acceptable. But I remember the actual conversation I had with —— (partner) at the time was, 'There's a group of people here who are below any level of politics' - as I understood it then – 'that were just being treated like shit, being treated like animals. And you don't have to do very much to make it better, and at one level you're not supporting the status quo.' And she said, 'Well you're still supporting the institution and perpetuating that.' But it didn't feel like that. It felt like, 'Well it's going to be there anyway.' Not very sophisticated political idea but that was the motivation, 'There's something I can do here. And I don't have to question what I am doing here particularly.'*[11]

Here Steve Mee used an inner dialogue to highlight a broader debate about complicity, embracing both a critique and a justification for involvement in institutional care. Later in the same interview he suddenly recalled a specific moment of professional compromise, which occurred at the Albert. On one of the male lock-up wards although residents had their own clothes labelled, in practice:

> *which clothes you ended up wearing was pot luck. So yes they did have their clothes but it never ended up as people wearing their own clothes.*[12]

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[10] Steve Mee, Interview September 22nd 2005.
[11] Steve Mee. Ibid.
[12] Steve Mee. Ibid.

However if the charge nurse, Steve Hothersall, was on duty:

> *He used to insist that people wore their own clothes, but you see this is where my standards weren't up to scratch 'cause I remember trying to sort it some days and there'd never be a full set for everybody. And I ended up thinking, 'Oh fuck it, they're only clothes. So as long as they more or less fit.' So I did that.*[13]

Likewise, Mary Lawrenson was critical about aspects of institutional care, but confessed that early on in her nurse training in the late 1970s she was 'complicit with the system', having been 'indoctrinated' into the clinical model.[14] However, she along with Mee and Spencer, narrated their professional involvement in the Royal Albert as being one in which they had the opportunity, as change agents in later years, to redeem themselves. Whether this was true for all staff, with similar views, is debateable: one former nurse was reported as having been very traumatised by his collusion, these feelings only emerging in an acute form after the closure of the Albert.[15]

9.2.3 Rebellion

Alongside admissions of complicity with the 'bizarre'[16] institutional system, both Mary Lawrenson and Steve Mee positioned themselves as rebels who fought back. Such a rebellious identity can be construed as an integral element in a narrative sense-making process. As one researcher argues:

> organisational storytelling allows people to try out and develop identities for themselves (Gabriel 2000:129).

However, although Gabriel suggests that in doing this 'the pleasure principle prevails over the requirements of veracity and accuracy', other narrative analysts are more circumspect. Ezzy, drawing upon the work of Ricoeur, asserts that the creation of an

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[13] Steve Mee, Interview September 22nd 2005.
[14] Mary Lawrenson, Interview September 9th 2009.
[15] Conversation with Steve Mee, January 29th, 2009.
[16] Steve Mee, Interview September 22nd 2005.

identity through narration is a mixture of historical 'fact' and fiction (Ricoeur 1991; Ezzy 1998). Such a viewpoint is summarised thus:

> Narrative identity is ... historically grounded but "fictively" reinterpreted, constructed by an individual but constructed in interaction and dialogue with other people (Ezzy 1998:246).

In their narrated rebel identities both Lawrenson and Mee bear out this relationship between actual events, their interpretation and the importance of an inner dialogue.

Running through his narrative, and already touched upon, is that, whether at Turner Village or at the Royal Albert, Mee reported colleagues for abusive practices. In the stories of his time at the Essex institution he intimated that he was constantly rubbing up against the authorities through comments such as '*again* I got in hot water with the Sister' and 'I was challenging - I wouldn't accept it, *as usual*'.[17] This theme was echoed in a more collective manner when narrating his early career experiences on one of the male lock-up wards at the Albert. In his interview he distanced himself from the,

> *idiot staff on there, thugs really. And they weren't doing the blatant hitting but there was all the shouting and verbal abuse, herd treatment and - There was still one guy doing the old thing ... of, 'Oh they don't know any different.' So he put dinner, pudding and custard all in one dish.*[18]

This contrasted with other staff:

> *Absolutely excellent people (who were) fantastic - and there were these thugs. Like oil and water really. And it just depended who the majority was on a shift as to what sort of shift it was.*[19]

[17] Steve Mee. Interview September 22nd 2005. My emphasis.
[18] Steve Mee. Ibid.
[19] Steve Mee. Ibid.

Often, around the humanisation of daily routines, he described a constant battle between these 'two bunches of staff'. In this struggle, Mee aligned himself with those 'on the hopeless hippy side'.

Similarly, in her narrative, Mary Lawrenson presented herself as someone, as a student nurse, who was prepared to speak out against injustices in the dominant institutional culture. In one anecdote, in which she questioned the judgement of the ward sister, she recalled being 'sent off the ward for being insubordinate'. On another occasion, there was,

> *a charge nurse who told me off for wasting my time talking to people instead of getting the laundry done. We used to get reports at the end of our placement and he wrote in my report that I wasted a lot of my time talking to people and not doing the jobs I was supposed to do. They had a little box on the bottom that you could write a comment and I wrote that this charge nurse was lazy, that he wasn't fit to run his ward, and that somebody should look at his practice. And I remember it causing this furore. It had gone into the School of Nursing that a student nurse was questioning the practice of a charge nurse. Nothing happened about it, but I got a lot of satisfaction that he wrote about me, and I wrote about him. But that's as far as it went, nothing - I was never ever given any feedback about whether anything would change or not.*[20]

In this extract Lawrenson constructed a narrative in which she displayed solidarity with the residents, and 'othered' the charge nurse, who was 'lazy' and incompetent. This ethically fuelled story is consistent with key twin themes of her overall professional narrative: individuals with learning difficulties had a right to be treated as people first and foremost; and that she would stand up to anyone, regardless of status, for what she

[20] Mary Lawrenson, Interview September 9th 2009.

thought was right – which included her professional integrity. As a young student nurse, this assertiveness resulted in her being viewed as

> *a troublemaker and the longer I was there the more I was seen as a troublemaker.*[21]

However, implicit in the oral testimonies discussed here is that these two rebels at this point in the early 1980s were estranged from the institutional philosophy of care. In the light of this, the unfolding of their respective narratives hinged on unexpected and dramatic plot twists.

9.2.4 Recruitment

Mary Lawrenson and Steve Mee asserted that during their nurse training, or not long after completion, they decided to leave the Royal Albert. For the former student nurse, she recalled that:

> *I didn't want to support people with learning disabilities. I wanted to be a general nurse. But because I couldn't get in I had an option of doing my training at the Royal Albert and then doing another year after the end of it. What I decided was that I liked the clinical nursing. I loved it. I worked on the Medical Ward. And I wanted to be a staff nurse on (the Medical Ward) when I qualified because (after a year) I was going to do my general nursing. I wanted the uniform. I knew all about drugs and procedures, I could save somebody's life.*[22]

Underlying this intent however, and resonating with the outcome of her challenge to the charge nurse, was a strong sense of impotence:

> *It never dawned on me that you should actually try and challenge the system 'cause it was too big. I knew it wasn't right the way people were being treated,*

[21] Mary Lawrence, Interview September 9th 2009.
[22] Mary Lawrence. Ibid.

but I just felt that I couldn't do anything about it. And if the senior managers weren't going to do anything about it, what could I do?[23]

Likewise, Mee did not see a future at the hospital:

I'd gone from Barlow (Ward), where I thought, I am going to look for teacher training. I really don't want to be a ward charge nurse, really don't want that at all. To go on to Welch (Ward) thinking, I really don't want to do this at all, this is an awful job.[24]

These extracts implied that not only were these self proclaimed rebels on the margins of the organisation they were close to disappearing out of sight. Yet, within four to five years both were at the institution's heart, in middle management positions implementing a hospital rundown agenda. Their respective narratives endeavoured to explain this radical shift in their professional fortunes, in doing so, suggesting that a degree of providential intervention prevailed.

Early in her post-qualifying year Mary Lawrenson recalled that:

A sister's post came up and I thought, 'What shall I do?' Because I had only just qualified. I was 21, I'd had three months experience as a staff nurse and these sisters' posts came up. And I thought, 'Well it's going to be another year before I go to do my general, I'll earn a bit of money and I'll be a sister.' That was all it was. 'I'll become a sister.' I remember putting in for a job. And in our (student nursing) group there were three of us put in for jobs and we all thought we were being a bit cheeky but we went for it anyway.[25]

Because of lack of experience she was offered an acting sister's post. However at this point her narrative revealed the seeds of an epic twist:

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[23] Mary Lawrence, Interview September 9th 2009.
[24] Steve Mee, Interview September 22nd 2005.
[25] Mary Lawrenson, Interview September 9th 2009.

But I was told to report to Jim Bow and Steve Wade about where I was going. And I thought, 'Well why do they want to ask me that? I want to be acting sister on the Infirmary Ward and I'm good.' And I remember sitting there and Jim saying, 'Right Mary you've not got enough experience to be a sister but you're going to be an acting sister and you're on Mr. Wade's section.' I knew straight away that he didn't have the Infirmary Ward. My heart just sank, I could feel it. I looked at Steve and he said, 'Come and see me tomorrow and I'll show you where you're going'. And I said, 'But the Infirmary Ward isn't on your section.' He said, 'You're not going to the Infirmary Ward, you're coming to one of my wards.'[26]

In this tale the protagonist, the young female nurse, with a *sinking heart* is being called out of her comfort zone; her expectations for seeing out her time at the Albert had been radically undermined. Her youthful exuberance in 'being a bit cheeky' had led to unexpected consequences, and an emotional response:

I actually burst out crying and I said to Jim Bow,' I don't want to go on that section. I want to be a nurse on this – ' And Jim Bow said, 'Oh pull yourself together woman! Go and see Steve Wade in the morning.' So all night I remember talking to my partner, saying, 'Oh I've got myself in a right problem now, because I don't want to go on there and yet I've got this promotion.' I worried about it all night long.[27]

The full extent of the 'right problem' in this epic narration was revealed in graphic form the following morning. Mary Lawrenson went to see:

Steve Wade, and he said, I'm going to put you on ———. Which was the lock-up men's ward. They'd never had a female sister up there, ever. I remember thinking, 'You must be mad'. I remember saying to him, 'You think I'm going on –

[26] Mary Lawrence, Interview September 9th 2009.
[27] Mary Lawrence. Ibid.

——?!' He said, 'I'm going to show you round now.' I'd never set foot on ——. And he took me up there and it was the locked doors. I could see through the window pane, there were men in the nude, there was a lot of screaming going on. And we walked on the ward, it stank, there was a seclusion room almost as you came on to the ward... There was no furniture, it had all been smashed... And there was a guy laying in the corridor, nude, wrapped around the radiator. And Steve Wade said to me, 'Right Mary. You're appalled by this. I'm putting you up here to do something about it. If you're appalled by it, do something about it. I said, 'Look at that guy there he's just in the nude.' He said, 'Well that's why I'm putting you here. You're going to do something about it, or you'll have to leave and do something else.'[28]

The senior member of staff, in this gendered narrative, had thrown down the gauntlet. The choice was to pick it up 'or you'll have to leave and do something else'. This prospective challenge pushed Lawrenson's courage, identity and career plans to the limit. She remembered that:

I went home and cried again. I thought,' I'm not going on there. I can't wear my uniform and be a nurse.' And I went back to see Steve to say, 'I'm not going, I can't hack it.' And he said, 'This is about making lives better for people and we haven't got many qualified staff in this hospital who want to do it. Now if you're up to anything I'm challenging you to do something about it. Have a think about it.' So anyway the ego got the better of me in the end and I said, 'Right I am going to try it.' And that was actually the making of me. Because I went up there as a young acting ward sister. It was all male staff, they were all the big boys. They were all about two foot taller than me.[29]

In this alien and threatening landscape her narrative unfolded to illustrate how it was 'the making of me'. She had been *chosen* to play a special role in changing the culture

[28] Mary Lawrence, Interview September 9th 2009.
[29] Mary Lawrence. Ibid.

of the organisation: to become a leader rather than a rebel. Importantly, as discussed in Chapter Five, and in contrast to her experiences of being 'a troublemaker', she was given 'power to make changes' to a system 'that just isn't right'.[30] Although admitting that her 'ego got the better of me', the overall tone of this story is one of selflessness; a moral tale. In making sense of this period in her professional life, Mary Lawrenson identified herself as a *reluctant* hero (Gabriel 2000:73-77), who sacrificed the more comfortable option of general nursing. She had little doubt that she would be 'good' at the latter, but opted to remain at the institution and help make 'lives better for people (with learning difficulties)'.

This emotional narrative of promotion represented a leap from rebel to leader, and symbolically, as discussed in Chapter Five, recruitment as an intellectual in a hegemonic change process. After a period on the lock-up ward, Lawrenson remembered that she was given the responsibility of setting up a new assessment unit:

> *I had a hand-picked group of staff who didn't want to be complicit with the system and we were at Lathom House (Assessment Unit) for three months before it opened doing training.*[31]

At this point her narrative intersects with that of Mee, who became one of the staff on this unit. This represented a pivotal point in his career testimony, pinpointing the 'inspirational' management of Mary Lawrenson, who had instigated a culture in which,

> *people were treated with respect, rights were recognised, individuality, everybody had meals together - it was the first time ever that I had been anywhere where everybody ate together... It felt like a proper job somehow, like we were doing something.*[32]

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[30] Mary Lawrence, Interview September 9th 2009.
[31] Mary Lawrence. Ibid.
[32] Steve Mee, Interview September 22nd 2005.

From this experience Mee concluded that 'I can do something here (at the hospital)'. He progressed to become the first Nursing Process Co-ordinator with a hospital wide remit of introducing individual care plans; after which he was appointed Resettlement Co-ordinator. So from being on the cusp of leaving, like Lawrenson, he was recruited, and *empowered*, to implement the changing agendas of those years. This provided him with purpose and meaning, resulting in a career in learning disability services.

9.2.5 Liberation

Typified by Mary Lawrenson's story of recruitment into the challenging atmosphere on a male locked ward was the theme that, for herself and other newly appointed leaders, these years represented entry into an unknown and frightening organisational landscape. She reflected that in introducing changes,

> *there was some blind faith that treating people as people would actually prove that was the way to do it, and it was but you didn't know it at the time. It was a risk because actually if it hadn't worked what would people have said?*[33]

Likewise, for Steve Mee, these years represented,

> *a very, very intense period. I've always preferred working in places at times like that ... We'd no idea really whether it would work or not and all of us involved at that stage had a passion for doing it, the dislike of the institutions, and that was across the board... It was a very invigorating atmosphere to work in, and a great sense of solidarity amongst people.*[34]

The implication was that there was no map for this huge organisational change, and so 'blind faith', 'passion' and 'solidarity' were prerequisites for progression. However, for Mee the intensity and unknown nature of the quest were both 'very invigorating' and desirable.

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[33] Mary Lawrenson, Interview September 9th 2009.
[34] Steve Mee, Interview September 22nd 2005.

Although qualifying later than Mee or Lawrenson, after the formalisation of key change systems were embedded, Dave Spencer encapsulated the exhilaration of hospital rundown for these young professionals. Like the other two, his narrative embraced an inner struggle as to whether to stay in an institution which he thought was 'weird and not nice'.[35] However by the time he had qualified in 1985, 'people (senior managers) were saying, "No it isn't always going to be here"'; so he decided to stay and assist with the Royal Albert's demise. His excitement then hinged on the transformational impact of change on individual hospital residents. In his narrative, as with those of his colleagues, people with learning difficulties assumed agency, switching from victims to heroes. He recalled that:

> *I thought at the time that it was fantastic... I would say to people, 'Look treasure this... The Royal Albert has been here all these years and people have come, worked, gone home, retired, died and it has just been the same as it was before they went. We are going through a massive social change, it is dead exciting and you are seeing people come to life almost and that is a privilege.' And it was. And I used to say, 'It won't happen again'.... It was kind of a hidden world, like releasing people into a bright new - It sort of sounds a bit pretentious, but it was really, really exciting to see. And I was particularly privileged as were a few people in that particular sphere.*[36]

Implied in this extract and elsewhere in his testimony is the sense that people moving out represented acts of liberation: residents were 'com(ing) to life' by being released, by being freed. In the process of entering the 'bright new (world)' of the community, Spencer proclaimed, in an animated fashion, that:

> *It was fantastic to see people so excited about new possibilities. People had decorated their own house and it would be horrible but they had done it themselves and were so thrilled with it and you would think, 'Oh that colour is*

[35] Dave Spencer, Interview April 3rd 2009.
[36] Dave Spencer. Ibid.

going to give me a migraine in a minute'. But people were learning about, 'Well actually those two colours don't go together but I will go and get another colour tomorrow and repaint it.' And they can do that. You couldn't have done that on –– Ward. It was very, very exciting. People used to tell me to shut up about how much I enjoyed my job![37]

These extracts reinforce the notion, as suggested above by Mee, that those directly involved in leading the changing agendas of these times remembered it as 'an invigorating atmosphere'. Furthermore, an additional nostalgic dimension appears to be present in Dave Spencer's testimony in that times of such professional excitement are gone for ever (Gabriel 2000). His remembered dialogue warns colleagues that the time of 'massive social change... won't happen again' that they need to 'treasure' it. He continued to re-emphasise such a sentiment, later in his interview recalling that:

I knew that it wasn't going to go on forever but it was thrilling really to be part of seeing that time and time again people feeling like they had been given a new lease of life or in some cases the first lease of life.[38]

The message conveyed by Dave Spencer was that, through the resettlement process, he was energised by the realisation of dreams for people with learning difficulties. This is exemplified particularly through his almost apocalyptic story of one specific individual, which occurred after,

I got the chance of working on the Flats, I could see where I might fit in, helping people move on and move out. And as soon as I started really, I realised that was where the excitement was, in that buzz ... you would see people drive off to a new life somewhere. And I have probably told you this story before but not on tape about T–– disappearing... Somebody in their wisdom had decided that part of being prepared for life in the community meant that T–– had to have

[37] Dave Spencer, Interview April 3rd 2009.
[38] Dave Spencer. Ibid.

some teeth, because he had them removed like a lot of people, particularly people with Down's Syndrome... The National Health all-purpose one-size-fits all NHS teeth are rattling round in his head and he hated the things and they did make him look ridiculous with this enormous set of teeth that didn't fit his head and he couldn't talk, he couldn't eat with them. So he had to take them out to eat, take them out to talk. And somebody from the social work department had said, 'To fit in he will have to have a set of teeth... If you see T—— around and he hasn't got his teeth in can you remind him to put his teeth in.' So everywhere he went somebody was saying to him, 'T—— put your teeth in, T—— put your teeth in.' Anyway, as his sister was driving him out of the hospital grounds and we were all stood there to wave goodbye to him, the window came down and a set of false teeth came flying out of the window into Ashton Road. It was brilliant! I got that kind of buzz. And then I used to go and see people in the flats and the houses that they were moving into, checking to see whether people were still happy... And the number of different ways I got told to fuck off and, 'You can stuff it and you know what do you want us to do with your bed at the Royal Albert, you can shove it up your arse.' And it was brilliant! I used to get the same kind of buzz and realise that there was nothing quite like it really.[39]

Using an epic-comic narration, Spencer conveyed the buzz gained from his involvement in the liberation of people with learning difficulties from an institutional environment; ultimately they had the agency, not the professionals. In fact it was the latter who were the fools in this tale, with former hospital residents having the last laugh, or the final word. The *exhilaration* of liberation is conveyed by the symbolic description of the point when 'a set of false teeth came *flying out* of the window into Ashton Road'. The mantle of rebel had passed from those workers, like Spencer, who had critiqued institutional

[39] Dave Spencer, Interview April 3rd 2009.

care, onto people with learning difficulties. Such a narrative represented a vindication of a professional decision to stay.

Steve Mee, the first Resettlement Co-ordinator, also recalled one individual, who, on behalf of his three friends, took the initiative in organising resettlement meetings:

> *I remember K— in particular as well as introducing all of the others and saying that they all wanted to go together, he took some control of the agenda as well. So when things were brought up he decided when enough had been said. I remember him doing that a couple of times, 'Shall we move on?' It was that sort of thing. I can't remember his exact words. 'Oh that's enough of that!' I think he said. ... 'Cause it was my responsibility to get the meeting – I sent out a letter to everybody and messages coming back, 'K—'s already invited me.' I remember that. 'Are you coming to my meeting?' And it really did matter to them. They really did want to leave the hospital.*[40]

As with Dave Spencer's narrative, the satisfaction here is that, in contrast to an institutional regime, the person with a learning difficulty was in control. Moreover, the collective energy, and momentum, of such a state of affairs was highlighted elsewhere in Dave Spencer's interview:

> *When we did have provisional discharge, it was called, and people would come back for a meeting to say, 'No, I am happy...' They would go and visit people they had been living with previously and tell them what life was like outside, and that they get their own room and they get their own this, and they could watch what they wanted to on the telly, and they could eat what they wanted. And there were queues forming of people saying, 'I want some of that. That is what I would like.' I mean even down to a lady knocking on my door, and she was 97,*

[40] Steve Mee, Interview July 7th 2007.

and said, 'Are you the man that is in charge of getting out because I think I have been here long enough?' And she was 99 when she left.[41]

This, along with the other resettlement stories quoted, *emphasised* autonomy, empowerment and exuberance, rather than the 'rightness' of SRV, as explained in Chapter Two. Importantly, it was implied that, by stepping back, the professionals were able to be supportive and effective. The liberation narrative embraced hospital residents *and* the member of staff; the latter being freed from the taint of past collusive practices.

However, in contrast to these tales of liberation narrated by members of the Resettlement Team, direct-care staff recalled a sadness when young people with learning difficulties moved out of the Royal Albert. Their narratives can be construed as primarily romantic, with the residents the object of this love (Gabriel 2000). Almost akin to a parent as their child flies the nest, these staff wanted individuals to leave, but were equally sad at having to end their day-to-day involvement with them. In his narrative, for instance, Eric R. recalled the emotional wrench of the departure of children with whom he had developed a close relationship. Because of an anomaly in qualifications required, he was unable to leave the Albert and go with them. This,

disappointed me quite a lot because I had a really good relationship with two of those three boys who ended up going to that place, and I was quite hurt and upset when they went, so I cried you know 'cause I felt that strong about them and I was upset that they had gone out of my life.[42]

A similar sadness was recounted by Tony Dennison, who remembered that:

We didn't argue against them being seen as a priority for resettlement, it seemed right that they should go and have a better life in the community.... I can remember waving them off actually, when those young lads were collected and taken off to Preston it was like getting rid of my own kids in a way, because

[41] Dave Spencer, Interview April 3rd 2009
[42] Eric R., Interview August 11th 2009.

I stood on the steps of Sturton Lower and waved and cried! Little friends. Because I'd know them from about '87 so I'd known them five years - lovely little kids.[43]

Such an emotional story by this former charge nurse is not surprising given his overall narrative which, as with Eric R., was one of dedication to those he supported. Also Tony Dennison's discourse was, quite matter of factly, one of equality: these residents were 'kids', similar to his own.

Further complications were added to the liberation narratives of resettlement officers by the tellers themselves. In their interviews, Dave Spencer and Steve Mee suggested that their power to make a difference may, on occasion, have been inadvertently used to the *detriment* of people with learning difficulties. In his interview Mee intimated that, as the push to close the hospital intensified during the later years of rundown, the resettlement focus had 'got past the people who had come knocking on the door'. During the late 1980s, and into the 1990s:

we were getting to the sort of more anonymous people in the hospital who wouldn't have understood the notion (of resettlement) and we had no idea who their friends were and what their links with family were... (And) when somebody can barely communicate with you how do you ever find out what they want.[44]

These sentiments were echoed by his colleague:

We just knew that there were people with significant friendships, relationships. There were people who were important to them that we would never know about because you couldn't, they wouldn't be written down anywhere. There would be people who had grown up together and they mightn't see each other for months at a time but they would see each other going past on the way to an occupation centre and they might nod or say hello or acknowledge each other in whatever

[43] Tony Dennison, Interview September 1st 2009.
[44] Steve Mee, Interview February 18th 2008.

way they did or they could and nobody would know how important knowing that person was still there or still safe, or whatever, still alive how important that was to people. And we did spend a lot of time agonising, myself and Steve Mee, about how can we ever find out if we are splitting up a lifelong friendship or a really significant relationship, or that we have not uncovered a relationship that people aren't comfortable with: the vocal person in the relationship is saying, 'He is my friend. I really like him. I want him to come and live with me.' And he is not saying anything and everybody is saying, 'Isn't that nice – ah.' And it turns out that it is an abusive relationship and we didn't know it. We had to just kind of reconcile ourselves to the fact that we were doing our best to find that out...[45]

The 'agonising' referenced here reinforces the point made by Mee that workers, such as those involved in resettlement, were 'life architects' for people with learning difficulties; integral to the sense-making of these change agents was a recognition that they were vested with enormous power.[46] At times, as illustrated earlier, the latter constituted a vital constituent element in an epic tale of redemption. However, as these self-critical extracts indicate, equally this power was viewed as a *potential* contribution towards a tragic narrative, especially in relationship to the most vulnerable members of the institutional community. The only redeeming feature was, according to Spencer, that at least 'we were doing *our best*' to establish whether harmful relationships existed between residents.

However, these reservations about their interventions notwithstanding, the narratives of Mary Lawrenson, Dave Spencer and Steve Mee overall can be construed as ones in which they were given the opportunity to redeem their own complicity in, what they regarded as, a system of harm not care. In doing this there are strong suggestions that they displayed what Rogers identifies as a necessary quality for pushing through

[45] Dave Spencer, Interview April 3rd 2009.
[46] See Chapter Five: 5.2.5 Recruitment.

change: 'venturesomeness... a desire for the rash, the daring and the risky' (Rogers 2003:282-3). Furthermore, their recollections tally with a description of others involved in an epic struggle during the 1980s in the United Kingdom. Adeney and Lloyd record some of the miners active in the national strike of 1984-5 as saying that they

> had clearly enjoyed the experience: they had lived at a pitch, physically, intellectually, morally even, which they could not expect to emulate...(Adeney and Lloyd 1986:7).

9.3 Loss

Integral to a managerial perspective, as outlined in Chapter Five, was that an *unfortunate* consequence of the organisational contraction of the Albert was that it resulted in 'casualties'. However, Gordon Greenshields, former Chief Executive of the North West Regional Health Authority, the key change agency for the Albert, emphasised that these were *inevitable*. He theorised that:

> *When you have change there'll always be casualties... That's life. I think the NHS is no different from any other organisation. If you want to achieve change you've got to get the right people in the right place at the right time, with the right sort of support if you want to achieve the results. It doesn't matter where you are. I mean I've been through mergers in the private sector - Deloitte's and Coopers... That was a blood bath. You think two accounting firms coming together, 'This will be very genteel. Well let's have sherry together.' Jesus Christ! The knives were out everywhere. That's where you begin to see ruthlessness really and you've got to understand it and work with it.*[47]

Along with references to a cut-throat business culture, this extract, with its 'bloodbath' metaphor, presents deinstitutionalisation as a military conflict. The implication is that in either of these arenas, for both combatants and civilians, they are inevitable casualties

[47] Gordon Greenshields, Interview December 16th 2009.

and so why not in the case of hospital closure; the 'NHS' after all 'is no different from any other organisation'. Unsurprisingly, and in contrast to the overall heroic narrations of change agents, this meant that many oral testimonies relating to the contraction of the Royal Albert were imbued with a sense of loss, and of tragedy. These remembered accounts emanated primarily, but not exclusively, from those staff who were critical of aspects of the ethos or practice of rundown.

9.3.1 Loss of Meaning

As examined in Chapter Seven, voices of opposition highlighted the loss of life and relationships for people with learning difficulties, contributing to a tragic deinstitutionalisation narrative. For some hospital residents, according to one interviewee, there could be an additional poignant dimension. After nearly an hour into a measured account of her time at the Royal Albert, Bernadette Hobson, former Voluntary Services Co-ordinator, suddenly recalled a particular incident:

> *I went into the (Royal Albert) office one day and an old woman had died and her possessions were on the desk. And it was a black plastic bin liner and in it - oh and it still makes me weep - and there was a plastic flower and a plastic hand bag and about three little jewels, and that was the end of her life, she'd been there all that time - terrible.*[48]

At this point in the interview Bernadette was tearful, but equally determined to make the point that this experience was instrumental in her wanting to do something to rectify this sense of a life without meaning.

> *I thought they can't all leave this hospital and actually say, 'My life's wiped out.' 'Cause a seventy, eighty year old and say, 'That's what I've got. I've come out of this and people are saying to me, 'You're in a rotten place and you've to go out into the community.' Because what it's actually saying is your life is negated. So*

[48] Bernadette Hobson, Interview August 26th 2009.

I thought, 'Can't have this. We need to do something to give people histories here, to recognise it and say, 'You have done this and you have done that.' Particularly the old ones who had been there quite a time.[49]

Triggering these sentiments was the sense of someone's life being reduced to paltry items in a black plastic disposable *rubbish* bag. The latter, in other institutions as well, was often seen as symbolising the impoverishment of institutional life. Jean Collins exemplifies such a perspective, quoting a community support worker who said,

> after twenty, thirty of forty years people walk out of hospital clutching a black bin-bag containing the whole of their life history (Collins 1993:79).

For Bernadette Hobson, such concerns resulted in *her own* professional life being given added meaning by setting up a reminiscence project, which involved residents and, as discussed later, hospital staff.

9.3.2 Loss of the *Good Old Days*

Pervading interviews of former members of Royal Albert staff, and implying a profound disquiet with the all encompassing contraction of the hospital, was a nostalgic yearning for an institutional past. In this form of narrative sense-making this past has:

> irrevocably gone; it is part of a 'world we have lost'. In organisational nostalgia, the past is frequently separated from the present through *a radical discontinuity*, a symbolic watershed, which cannot be undone (Gabriel 2000:173).

In the case of those remembering the Albert, 'the present' can be understood as beginning with the vigorous implementation of organisational downsizing during the 1980s. Moreover, and indicating the value of a study of nostalgia for this research, Gabriel argues that:

> Nostalgia is not a way of coming to terms with the past (as mourning and grief are), but an attempt to come to terms with the present (Gabriel 2000:183-4).

[49] Bernadette Hobson, Interview August 26th 2009.

So, in other words, nostalgic recollections can provide insights into how people *felt* about hospital rundown, rather than necessarily providing a plausible historical account.

Brian Illingworth, whose father and sister also worked at the Albert, was a porter from the late 1970s until the mid 1990s. In his testimony he yearned for an earlier time in his employment, prior to the acceleration of contraction, when the hospital 'emptied out'. He recalled what it felt like as the portering staff dwindled from a team of twelve down to just himself and one other, working opposite shifts:

> *I used to like the days when we were all there... It just wasn't same because all biggest part of people that you'd known, that you were used to, they just slowly went until you were just going round seeing to a few here and there - to me that was beginning of the end... There was good days at the Royal Albert wasn't they? And they was. It was the sort of place at one stage when it was all running, all the departments and everything were there, you sort of worked your own system out with your job and you looked after all these different folk on the wards and what not and got on with everybody, it were grand. I used to look forward to getting up in the morning and going to work, and I can't honestly say that now, 'cause with job I'm on now I'd sooner see back of it.*[50]

For Brian Illingworth the rundown of the hospital incurred a personal cost. When he said, 'It was the beginning of the end', in many ways he was referring to the end for him of a meaningful working life, an important element of which was having a fulfilling role in which he 'looked after all these different folk'. He emphasised such an impression through his negative assessment of work now; and later in the same interview he said, 'I'm on the heap now'. Conversely his nostalgia for the Royal Albert was further articulated a few months after the interview. At that point he spontaneously stated that,

[50] Brian Illingworth, Interview September 8th 2009.

'I'd go back there like a shot if things could be as they were.'[51] The demise of the Royal Albert, and its personal consequences, was viewed as a seminal turning point in this man's life.

Hinted at in Brian Illingworth's recollection, but made more explicit by Mrs Creed was the suggestion that the 'old days', prior to its contraction, were 'good' for all at the institution: staff and residents. As already cited in Chapter Seven, this former nurse recalled the concerts, the films, the holidays available to patients and that everybody, including the staff, got on with each other in 'one big (happy) family'. Mrs Creed was adamant that:

> *I loved it. To me it was my life. It was hard when I had my babies, but I stuck it. I'd do it again. I'd do it again.*[52]

The nostalgic potency of this testimony is given particular emphasis because elsewhere, in her interviews, she referenced instances where patients were unhappy, and where staff did not 'gel'.[53] Like Brian Illingworth there was a poignant desire to return to this imagined past. Moreover, this nostalgic recollection hinged upon the concept of family. This accords, as Gabriel argues, with other organisational research:

> The image of the organisation as a family seemed to be at the heart of many nostalgic feelings (Gabriel 2000:175).

Similar to Mrs Creed, a male nursing officer recalled that the Royal Albert was 'like a family but that was dissipated as the hospital broke down, as it was dismantled.'[54] The significance lies in the use of a human metaphor to illustrate what the hospital meant to him and a mechanical one, arguably more impersonal and distant, to describe its rundown.

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[51] Conversation with Brian Illingworth, January 21st 2010.
[52] Mrs Creed, Interview June 17th 2009.
[53] Mrs. Creed. Ibid.
[54] Nursing Officer (Male), Interview March 11th 2009.

In his interview the nursing officer, just referenced, developed this image of family, aided by other nostalgic constructs. Similar to Steve Mee, he had worked at another learning disability institution prior to the Royal Albert. However, unlike this other hospital, he recalled that the Royal Albert

> *had a tremendous reputation. It was internationally famous before the National Health Service took it over, it was considered to be a world class example of how to deal with handicapped people... They'd become very good at it, and they'd become very excellently self regulating. They'd found rules that worked and stuck to them.*[55]

In a testimony critical of, and mystified about, aspects of contraction and resettlement, this extract accords with a feature of nostalgic narrative identified by Gabriel. The latter observes that:

> In contrast to chaotic and organisational rules and procedures of the present, the organisation's golden past is seen as one of order and reason (Gabriel 2000:181).

However, the crucial attribute of the Royal Albert was that it used to be,

> *more of a family place. There were some people when I first went to work there whose parents and grandfathers had actually worked there and they had a tremendous family feeling in the place. And if you were in any trouble, sorrow, need, sickness or any other adversity to quote the church ... if you went to the Matron or the Medical Superintendent or one of the senior nursing assistant matrons (nursing officers) they would treat you as a member of the family and say, 'Right what can we do to help you?'... It worked really until the Matron and the Medical Superintendent retired, I think, and after that it tended to thin out because unfortunately the quality of nursing officers was altered. The quality of nursing officers when I first started was tremendously high... They were people*

[55] Nursing Officer (Male), Interview March 11th 2009.

who had been charge nurses or sisters for a long time... knew everybody - knew their names, their ages, what was wrong with them, what was likely to be wrong with them. If a sister rang up, 'I've got little Johnny so and so on such and such a ward and he's got a bit of a temperature and I don't know why. And there's something else the matter with him as well.' The nursing officer might say, 'Oh yes he had pneumonia 14 years ago, didn't he?' Or something like that, you know.... It was more than personal knowledge, it was care and affection as you have in a family. And that disappeared as we got newer, less experienced nursing officers.[56]

As with Brian Illingworth, and interviews with a former clinical psychiatrist and Chief Engineer,[57] important to this memory is that in the past the hospital was an informal, caring and altruistic place; in other words, an idealised family. In the nursing officer's account this was further embellished by reference to the maternal and paternal figures at its head. However, although the retirements of the Matron and Medical Superintendent marked a significant point in the family's fortunes, its break up was ultimately linked to the 'dismantling' of the institution.

The use of nostalgia, as illustrated here, can have an important role in organisational accounts, as long as it is perceived as a critique of the present, rather than a historical account of the 'good old days'. Such a perspective accords with Steven High in his deindustrialisation research. This Canadian oral historian has been 'interviewing displaced industrial workers about job loss since the mid-1990s.' He identifies, in North America terminology, 'smokestack nostalgia'. There are inherent dangers as a historian, High argues, in taking displaced workers' nostalgic accounts as a true reflection of what actually happened in the mill or factory. In his view:

[56] Nursing Officer (Male), Interview March 11th 2009.
[57] Dr. Prasad, Interview August 12th 2009; Mr S Webb, Interview August 28th 2009.

> Nostalgia empties out history of meaning and, ironically, serves to de-politicize the past. Nostalgia invokes the past only to bury it alive (High 2004:4-5).

However, as with Gabriel, he implies that nostalgia has a place, because oral historians

> must work on both the factual and narrative planes, as well as on the past and on the present (High 2004:5).

The narrative extracts of former Royal Albert staff examined here if identified as *essentially* nostalgic provide a valuable insight into sense-making. Implied in the stories are powerful antagonistic feelings about changes in the later years of the organisation, in which the tellers felt marginalised. As suggested by Gabriel:

> Individuals who are too disillusioned, too inquisitive, too rational, or simply too old to 'buy' the organisation's own ideal, to internalise it... may create an alternative ideal, one built around not galvanising utopias for the future, but around the warm and loving reconstructions of the past (Gabriel 2000:187).

These nostalgic discourses provided an alternative voice in the overarching deinstitutionalisation narrative of the Albert.

9.3.3 Loss of Employment

In a tragic discourse, examined in Chapter Seven, people with learning difficulties were regarded as the victims of organisational rundown. However, as the above discussion on nostalgia intimates, an additional thread woven into this deinstitutionalisation narrative was one relating to deindustrialisation. In the 1980s, as neo-liberal and monetarist policies took hold, large scale primary and manufacturing industries were decimated in Lancaster, across the UK, and further afield (Adeney and Lloyd 1986; Fevre 1989; Chatterley and Rouverol 2000; White 2001; High 2005). From this perspective, and reflected in the oral testimonies, the Royal Albert, along with other institutions, was just another workplace being downsized. Similar to the closure of

factories and mines, it was the paid workforce who could be viewed as casualties of such an organisational change.

The most obvious effect of hospital contraction was loss of employment. In 1982, the organisation employed 631 nurses as well as a range of other staff, employed in trades, ancillary work, administration, management, and professional roles; it was a massive organisation (DHSS 1985). By late 1995, months before closure, it was reported that:

> The RAH has said goodbye to more than 500 staff, with 50 being redeployed elsewhere in the trust. Some 20-30 work for other trusts, 50-60 with social services, while 100 have taken other employment or further education. Dozens decided to take retirement while more than 100 are estimated as still redundant. The RAH currently employs around 170 staff though not all are permanent.[58]

The suggestion in this extract that the hospital 'said goodbye' personalises the institution, echoing a deindustrialisation study which suggested that, in their narratives, former workers perceived the mill as 'an actor' (High 2004:6). In the instance of 'the Albert' the journalist's sentiment, as evidenced in a series of rundown reports, was indicative of an underlying sympathy for the hospital.[59]

As the employment statistics imply, not everyone who left the Royal Albert found employment. Part of the issue for direct care staff was that, as Geoff Hopkinson, the nursing services director, remembered saying:

> *We've got about 600 staff at the hospital and only 200 staff, shall we say, will be required for the Lancaster service.*[60]

Moreover, unlike some other institutional closures, hospital staff were not given privileged status as regards work (Johnson 1998; Enbar, Morris et al. 2004). Although

[58] Lancaster Guardian November 17th 1995.
[59] Lancaster Guardian: June 2nd 1995, November 17th 1995, February 23rd 1996.
[60] Geoff Hopkinson, Interview July16th 2009.

the oral testimonies indicate exceptions to this, the general rule was that community staff were recruited on merit. In practice, particularly as rundown gathered pace during the 1990s, some staff discovered that they were rejected as suitable candidates for working in non-hospital settings.[61] What the contraction meant for ancillary staff at the Royal Albert is partly summarised by the Secretary of the Hospital Shop Stewards Committee:

> *There was a lot of demoralisation... There was a lot of worry about what they're going to do, where they are going to find some other employment... There weren't the factory jobs, they were all closed in the early days of Thatcherism, well in the early 80s in the main, Storey's went and Williamson's went, all those other great employers so they were as worried as hell about where and how they were going to be able to make a living once they left the Albert... Once they left the hospital they were no longer members of my union (NUPE) branch obviously... Quite a lot I'd see people in town and they'd collar me about this that and the other. And some people would say they'd managed to find a job here or there, and other people I'm sure never did get jobs.*[62]

Implied in this testimony is that in the 1980s, the Royal Albert merely represented another local large employer, all established during Victorian times, that was being downsized (Warde 1981; Urry 1986; White 2001). In this sense the hospital's demise was deeply embedded in a deindustrialisation and neo-liberal discourse, reflecting the drive to privatise public services (Hughes and Lewis 1998).

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[61] Geoff Hopkinson, Interview July16th 2009; Tony Dennison, Interview September 1st 2009; Mary Lawrenson, Interview September 9th 2009; Steve Mee, Interview February 18th 2008.
[62] M.J. Kiernan, Interview September 23rd 2009.

Like other large employers in Lancaster, such as Storeys, Williamsons[63] and Lansil (White 2001), the contraction of the Royal Albert signified a radical break in the cycle of employment of families at the organisation. A ward manager, for instance, whose mother also worked at the Albert recalled that:

> *All our wives worked there and I got married, and you may have heard of the big families there, there was the B—— , the biggest family there, and the R—— that was us and of course when I married my wife, she was one of the B —— so we joined up the two biggest families there! You had to be very careful who you slagged off there because – 'That's my cousin!' 'That's my brother'!*[64]

These sentiments are not dissimilar to those emanating from an oral history study of workers at Sturgeon Falls, a Canadian paper mill, which eventually closed around the turn of this century. This study suggests that:

> The connection to the mill ran deep in many families. These bonds were so deep that interviewees frequently referred to themselves as 'mill families' in their oral narratives (High 2004:10).

In that instance this family link was associated with security of employment and an almost closed shop to outsiders. While the latter did not appear to be the case at the Royal Albert, the institution did offer longevity of employment.

Through family connections, Tony Dennison decided that being a nurse at the Royal Albert was an attractive proposition. Starting as a cadet nurse in his teens in the 1970s, he remembered that:

> *It seemed at that time it would be a very secure job. I went into it thinking, 'Well that'll be me for life then'.*[65]

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[63] Ironically, the founders of Storeys and Williamsons had been benefactors of the Royal Albert when it was a charitable institution Alston, J. and E. Roberts (1992). The Royal Albert Hospital: Chronicles of an era Centre for North-West Regional Studies, University of Lancaster

[64] Ward Manager (Male), Interview August 2nd 2009

[65] Tony Dennison, Interview September 25th 2005.

Similarly, this sense of anticipated security was evident in a dialogue between two former nurses, Beryl-Ann Foxcroft and Lesley Alston. The former recalled that after she married,

> *I wanted a secure career really and a secure future. And as it happened with the changes that came it wasn't as secure as I – because people went to the Royal Albert and I think they thought this is a job for life –*
>
> *Lesley: Yeah, yeah. Oh yes, definitely.*
>
> *Beryl-Ann: - you know, 'We're secure here', you know, but times change.*[66]

It was with a resigned air that this latter sentiment was uttered, suggesting that she had had to accept her fate and get on with her life. The promise of life-long security had disappeared with the rundown of the organisation.

As with other themes, there is a hint of a resonance with the experience of workers who underwent mill closure. In his Canadian study, High notes that:

> A profound sense of loss permeated the oral testimonies. Marcel Boudreau, like many others, once thought that he had a job for life: 'I can remember lying in bed and wondering what the hell I was going to do.... When I got hired in the mill I was told by the guys that were working there that 'this was a job for life' (High 2004:13).

In connection with the Albert, this 'profound sense of loss' was intimated by Mrs Creed. After nearly 50 years of nursing service, she remembered being almost inconsolable after leaving the hospital, only coming to terms with this when it finally closed.[67] Likewise, one of the other nurses recalled that:

> *There was some people dealt with it (closure) really badly. I know one guy went working into the community, he'd been a staff nurse there, and he used to go back. And they put all these iron railings, all these big barriers around the site to*

[66] Beryl–Ann Foxcroft and Lesley Alston, Interview June 5th 2006.
[67] Mrs Creed, Interview June 17th 2009.

keep people out, and he used to go back sneaking in there, walk around the place, closed down. He couldn't handle it, you know. And he had to be retired on stress and anxiety grounds in the end – bad news, so it affected some staff really badly.[68]

A sense of grief on the part of staff was documented in relationship to an institutional closure in New Zealand:

> Many staff admitted they were grieving for the residents, the loss of friends, and the loss of a workplace (Gates 2008:31).

In these staff narratives, whether from a Canadian paper mill, or an institution in New Zealand or England, it was the workers who constituted the victims.

9.3.4 Loss of Community

However, the Royal Albert represented more to the workers than merely a place where they earned their living, and were guaranteed security of tenure. One of those enthusiastically implementing organisational change at the Albert in the late twentieth century highlighted the importance of the hospital for staff as a *community*. Such an assertion accords with High's (2004) research into deindustrialisation in Canada. Long service workers, in particular, emphasised 'strong attachment to the industrial workplace and to workplace communities' (High 2004:4). In the case of the Albert, Mary Lawrenson remembered that:

My colleagues in my student group became my best friends, my very best friend now is somebody that I did my training with and we as a group, because we were all women, grew up together.[69]

Partly echoing the theme of families, already mentioned, Mary Lawrenson went on to say that:

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[68] Ward Manager (Male), Interview August 2nd 2009.
[69] Mary Lawrenson, Interview September 9th 2009.

We had the Social Club so we went to the discos together, a lot of us met partners through work, I didn't because I already had a partner then, but we grew up together with various people, got married to other people in the service.[70]

However, when she became a manager she withdrew from aspects of this social side because,

I always had a view that if you were going to be a manager you had to make tough decisions. You couldn't socialise with the staff as well, didn't work... (So) I lost that social contact because I was a manager and I made that decision but that social camaraderie was very important to people who worked at the Royal Albert.[71]

She concluded that the high degree of 'social camaraderie', which included involvement in pantomimes and shows, was,

one of the reasons they (staff) felt bad about the hospital shutting 'cause they lost that social contact, and the social club was the hub of it all, and the discos that went on.[72]

Beryl-Ann Foxcroft, in her interview, implied that this social contact was expressed amidst working routines. As a mother of small children, she found it 'exhausting' working nights, but this was offset at times by,

the camaraderie and the laughs we used to have, at the night sister's expense sometimes. You know we used to laugh and giggle and play tricks, not at the detriment to any of the clients, I mean they'd probably be asleep and settled. And we'd creep around the corner on Siviour you know, and say, 'Pssst, Are you coming for a natter?' And we'd sit on the steps listening out for sister. Then

[70] Mary Lawrenson, Interview September 9th 2009.
[71] Mary Lawrenson. Ibid.
[72] Mary Lawrenson. Ibid.

when we heard the door at the far end clank we'd all scatter off, you know. But we did have a laugh. We did.[73]

Others, besides former staff, conveyed a sense of a lost feeling of community. On the occasion of the final League of Friends meeting, for instance, an active parental member of the committee wrote to its secretary:

> For the first and last time in 27 years I am unable to attend LOFRAH AGM and send my apologies. Our committee has been unique in the ties of friendship uniting us, is forged by our mutual understanding of the concern we each feel for our particular relative, our sympathy with each other's problems and our wish to do as much as possible for the welfare of all the residents. It has not merely been "nice to know you" it has been a heart-warming experience for which I am grateful.[74]

However, the concept of community is not unproblematic (Mooney and Hughes 2001). One commentator who critiques its 'romance' describes it as being constantly invoked as an,

> unequivocal good, an indicator of a high quality of life, a life of human understanding, caring, selflessness and belonging (Joseph 2002:vii).

Such a sentiment resonates with the extracts highlighted here, but equally a critical discourse was evident in relationship to the Albert. In the interview with Beryl-Ann Foxcroft and Lesley Alston, for instance, they also recalled divisions and mistrust between night and day staff.[75] Similarly, the staff club, heralded above as the heart of the staff community, was the scene of an internecine conflict in 1978 between those for and against people with learning difficulties being allowed to drink there. Aired in the local press, and referenced by one of the oral history interviewees, this incident

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[73] Beryl–Ann Foxcroft and Lesley Alston, Interview June 5th 2006.
[74] Letter (Anonymous) November 1st 1995.
[75] Beryl–Ann Foxcroft and Lesley Alston, Interview June 5th 2006.

provoked an intensity of conflicting viewpoints amongst club members.[76] Developing this latter observation about exclusivity, one former nurse suggested that the staff community had powerful *institutional*, in her eyes, reactionary components. The nurse claimed that:

> *The hospital was run for the staff when I first went there and they didn't want that to stop, did they? They got overtime. They drank on duty. And at Christmas they had parties and the people they were supporting weren't involved in those parties. All sorts of bad things were going on.*[77]

One specific example of a 'bad thing' related to the requisition of residents' money for sweets. This occurred on a ward, recalled by others as well, that was notorious for its dehumanising environment:

> *The clients used to have what was called provisions. They had spending money but it was never given to them, the staff bought things for them. We had a hospital shop so you ordered the basket of provisions, and it was massive baskets of sweets. And I remember walking on (the ward) and the charge nurse throwing the sweets all over the day room, where the clients were, half of them in the nude, there was faeces everywhere, and the clients running to get them like animals actually, they were treated like animals. And the staff laughing about who was going to get something and who wasn't. But only about a third of the basket was given out, the rest of it went to the staff and they put it in their lockers and they took it home.*[78]

This extract clearly charts not only financial exploitation, but more general abuse of a duty of care, epitomised by the appalling living environment. In the same interview, moreover, the nurse alluded to the sexual mores which operated amongst some members of Royal Albert nursing staff:

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[76] Malcolm Alston, Interview May 19th 2009; Lancaster Guardian: February 17th, 24th, March 3rd, 10th, 17th 1978.
[77] Anonymised extract from a research interview.
[78] Ibid.

You could see nursing officers who came, who had relationships with married nurses and it was the downfall of them really, I believed it anyway in terms of integrity, but it happened and that's what happens in a big institution like that.[79]

Such an observation was repeated by other former staff,[80] including the specific intimation that senior male nurses sometimes exploited their position with younger female ones. The implication is that, whether related to financial or sexual gain, certain members of staff were able to abuse their power and status. This could have provided them with a strong investment in the status quo, and a sense of loss, which went beyond feelings of mere camaraderie.

9.4 Avenues of Expression

Organisational rundown, as illustrated both in this chapter and Chapter Seven, generated a multiplicity of meanings and emotions for Royal Albert staff, families and residents. The extent to which formalised structures were available at the time to support staff emotionally through this change is unclear from the data, other than references to an NHS in-service counselling service being set up in the early 1990s. However it was suggested at a Community Health Council meeting that this was under-used because the culture of the NHS was about *coping*.[81]

Although limited in scope, the research evidence intimated that other ad-hoc opportunities for emotional expression did exist. In the early 1990s, as discussed earlier, Bernadette Hobson, the Voluntary Services Co-ordinator, initiated a reminiscence project.[82] Involving residents, this was also very much directed towards staff, to help them remember and grieve:

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[79] Anonymised extract from a research interview.
[80] Gudrun O'Hara, Interview June 22nd 2009; Mrs. Ann M. Wilson, Interview November 17th 2009; Anonymised extract from a conversation (prior to the research) with a former nurse.
[81] Lancaster Guardian May 10th 1991.
[82] Lancaster Guardian June 7th 1991.

I think it was a very healing thing - for nurses as well to sum up what their lives had been, it helped it to close, it helped it to say, 'No, we are going'.[83]

In the year or two immediately preceding the closure the local press referenced two other events in which reminiscence, or storytelling, played a role. In December 1994 there was the final staff dance held in Winmarleigh Hall, the symbolic venue at the institution, since Victorian times, for dances and concerts. More than 250 people attended, with the organiser commenting that:

> It was an excellent opportunity to meet old friends and reminisce. Many staff were pleased to be able to see people they had worked with in the past. Many had left years ago.[84]

During the following year a Royal Albert story-telling project was carried out. Although the primary focus was upon the reminiscences of residents, the project involved staff, and represented a collaboration between the hospital, Lancaster's adult education college and the local professional theatre company. The culmination was a multi-media dramatisation, performed publicly in the autumn of 1995, which, according to the local press, portrayed the Albert 'as a living breathing community and not just bricks and mortar.'[85]

In addition to these *intermittent* reminiscence opportunities, a 1990 hospital social work document intimated that social workers offered ongoing therapeutic support to staff:

> Over the years, members of the Department have offered advice and counselling to individual staff members informally on a great variety of personal problems. Since morale amongst hospital staff is becoming lower, as the date for closure draws nearer, it is likely that this need for personal support will

[83] Bernadette Hobson, Interview August 26th 2009.
[84] Lancaster Guardian, December 9th 1994.
[85] Lancaster Guardian, October 27th 1995.

increase, in spite of the recent development of a staff counselling service within the Health Authority (RAH 1990).

The need to recognise the psychological needs of direct care staff working with people with learning difficulties is emphasised by one counselling service in the south of England. Writing on the behalf of Respond, O'Driscoll implies that deinstitutionalisation processes took little account of the emotional needs of staff who, as a consequence, were left feeling angry and resistant to change. He concludes that:

> The management of change and organisational transitions depends upon our ability to articulate the process of grieving as well as exploring and understanding our unconscious feelings and attitudes towards people with learning difficulties (O'Driscoll 2006:19).

The hegemonic approach, explicated in Chapter Five, along with research data references to staff demoralisation and shortages,[86] cast doubt upon the degree to which such an articulation took place during the years of Royal Albert contraction.

9.5 Conclusion

Focussing primarily on staff memories of Royal Albert rundown, the picture painted here has been one comprising multiple meanings and emotions. For those staff enthusiastically implementing a deinstitutionalisation agenda these years were framed in terms of exciting and intense professional development, in the midst of which some degree of redemption, for earlier collusive practices, can be construed as having been achieved. However, set against this are the meanings, invariably ones of tragedy and nostalgia, generated by staff who were at times bewildered and resistant to an all embracing organisational rundown. For this latter group of employees the closure had

[86] Geoff Hopkinson, Interview July16th 2009; M.J. Kiernan, Interview September 23rd 2009; Mrs. Ann M. Wilson, Interview November 17th 2009; Ward Manager (Male), Interview August 2nd 2009; Lancaster Guardian: April 4th 1986, December 12th 1988, April 7th 1989, October 13th 1989.

as much in common with processes of deindustrialisation as it did with deinstitutionalisation; it was indeed 'the end of an era' (High 2004:4).

CHAPTER TEN

CONCLUSION

10.1 Introduction

This concluding chapter summarises and discusses core facets of the research. Initially the focus is on the key questions articulated earlier in the thesis. The chapter then reflects upon the methods employed by the study, followed by a consideration of the research journey itself. Finally, there is a review of potential avenues for further study.

10.2 The Research Questions

Focussing upon institutional closure as a core facet of deinstitutionalisation, I chose the rundown process of the Royal Albert Hospital in the north west of England as a case study. I asked two overarching, and linked, research questions: *How did the Royal Albert contract? What did the rundown of the Royal Albert mean for key stakeholders?*

10.2.1 How did the Royal Albert Hospital contract?

Examined in Chapters Four through to Eight, this query was broken down into three sets of sub-questions: *What were the external pressures shaping the rundown of the Royal Albert Hospital, Lancaster in the late twentieth century? How did managers implement Royal Albert rundown?* And regarded as one line of enquiry: *What were the viewpoints of those who resisted the closure of the Royal Albert? How did they express their resistance?* Each of these areas is considered in turn.

10.2.1.1 What were the external pressures shaping the rundown of the Royal Albert Hospital, Lancaster in the late twentieth century?

Deinstitutionalisation and rundown tensions

This study highlighted the point that tensions inherent in the drivers of deinstitutionalisation as a national policy translated into pressures upon the institutional contraction of the Royal Albert. The literature review identified the interplay between forces driving the move towards deinstitutionalisation in the late twentieth century: the impact of campaigns; ideas and ideology; hospital scandals; and political economy. As examined in Chapter Four, the findings indicated that, with the exception of campaigns, these elements were all mirrored at the micro-level of Royal Albert contraction. Critical external reports, for instance, forced improvements in living conditions, capital investment and a radical shift in the nurse training curriculum away from the medical model. The ideas of normalisation were transmitted by the North West Regional Health Authority (NWRHA) with its adoption of the *Model District Service* in 1983, reflected at the Albert in the appointment of a senior manager infused with these ways of thinking. The introduction of IPP for all residents and PASS training for staff ensued, as well as the establishment of a Resettlement Team promulgating a model of community care reflecting the values expressed in the *MDS*. Furthermore, and depicted particularly in

Chapter Four, political economic pressures stemming from the NWRHA pervaded the contraction process. Outcomes of these included internal movements for residents as wards closed, and a more ruthless emphasis on targets, with an increased pace of rundown in the last four years of the hospital. Particularly in these later years, oral and written testimonies from both advocates and critics suggested that, despite their best efforts, those managing resettlements occasionally had to make compromises. One of the procedural casualties of these years, for instance, was the removal of a probationary period for those who had moved out. In addition it was claimed that some residents were moved into wards in psychiatric and general hospitals, friendship groupings were undermined, and that stop-gap measures were adopted as accommodation was prepared.[1] Overall these research findings add to those studies which problematise aspects of hospital rundown (Collins 1992; Johnson 1998; Bigby and Fyffe 2006). However, under-represented in previous research is the sense of how those managing change experienced and dealt with the pressures outlined above. The managerial discourse running through this thesis, and elucidated particularly in Chapters Five and Six, helps to provide insights into tensions, particularly between 'cost' and 'the needs of people with learning difficulties', inherent in the change process.

Political economic pressures

Ultimately considerations of political economy rather than the needs of people with learning difficulties determined the pace of closure of the Royal Albert. By the early 1990s in England and Wales, as outlined in Chapter Two, some analysts at the time suggested that the programme of deinstitutionalisation was running into serious problems because of fiscal issues involved in closing hospitals (Collins 1992; Felce, Grant et al. 1998). Although large long-stay institutions, such as Starcross and Darenth Park, had shut, many more were still open with little sign of impending closure (Korman

[1] Mrs. Ann M. Wilson, Interview November 17th 2009; Dr. Prasad, Interview August 12th 2009; Dave Spencer Interview April 3rd 2009.

and Glennerster 1990; King 1991). The case of the Royal Albert, in its regional context, provides key insights into how a reforming agenda was translated into actual closure by early 1996.

Discussed in Chapter Four was the assertion that by the late 1980s the deinstitutionalisation programme in the north west (as elsewhere) was faltering largely because of the logistical and financial issues associated with the transfer of funds from the NHS to the local authority. The development of community services was predicated predominantly upon the release of monies from the institutions as they contracted, with the ultimate prize being the generation of capital from the sale of hospital estates. However, for the Royal Albert, oral testimonies and documentary evidence suggested that economies of scale linked to the downsizing of wards, continued investment in institutional infrastructure, heated negotiations over the dowry for each resident, as well as care with resettlement processes, were all undermining the fulfilment of NWRHA's need for financial solvency (NWRHA 1989).[2] Ironically, on the local authority side the neo-liberal agenda of the Thatcherite government had imposed rate capping, limiting their ability to create funding streams (Wertheimer, Ineichen et al. 1985). In 1989, as argued in Chapter Four, in the midst of this fiscal crisis the NWRHA asserted the priority of hospital closures, including the Royal Albert (NWRHA 1989). This would be achieved primarily by health releasing monies through bridging finance thus enabling deinstitutionalisation to proceed. Increased targets for resettlement were set to achieve the closure of the Albert by at least early 1996. Contrary to management rhetoric, the 1990s witnessed the bureaucratic imperative of contraction as the *ultimate* determinant of the pace of resettlements, not the needs and rights of people with learning difficulties. This is significant when assessing why Royal Albert closure was realised, when other contractions nationally faltered.

[2] David Jordison, Interview February 15th 2008

Affordability rhetoric

Contested in the literature, and raised in Chapter Two, is the degree to which deinstitutionalisation was pursued as a policy goal because it was thought to be a cheaper option than retention and essential upgrading of the large long-stay institutions. Although it was beyond the scope of this study to analyse the minutiae of government policy, its findings do present a pertinent perspective on this issue. As discussed in Chapter Four the NWRHA's seminal 1983 document, the *Model District Service*, intimated that the move away from institutional towards community care was an economically viable, and cheaper, alternative. However this contrasted with the oral testimonies of Royal Albert change agents who claimed that the support offered by community services was always going to be more expensive than the segregated and congregated model. One former manager, for instance, used this assertion as proof that the closure of the Albert was predicated upon values not cost considerations:

> *Everyone knew that it was going to cost more money so therefore it was about values and not money.*[3]

However, as argued earlier, the importance of the claims of *MDS* may rest in their *rhetorical* significance. It is possible to argue that, in times of fiscal stress, the NWRHA had to convince the district health authorities, the government, and the critical nursing unions that their idealistic aspirations were economically viable.

10.2.1.2 How did managers implement the rundown of the Royal Albert Hospital, Lancaster?

Leadership qualities

The research findings indicated that the change agency NWRHA exerted enormous adverse pressure upon the implementation of rights based agendas at the Royal Albert.

[3] An anonymised extract from a research interview.

Even staff antagonistic to the all embracing contraction agenda suggested that local managers had their hands tied by the demands of 'higher echelons'.[4] However, in their own oral testimonies, senior managers presented a narrative in which they claimed agency, including ethical manoeuvrability. As pinpointed in the literature review, first hand managerial accounts are under-researched, so the findings examined in this thesis contribute important insights to an understanding of the dynamics of rundown. In the case of the Royal Albert the interviews with both the former General Manager and Director of Nursing Services, as documented particularly in Chapters Five and Six, were interlaced with tales of *resistance* to externally driven political economic pressures.[5] These stories partly support the view that because of their 'independence' general managers 'were not worried by what their political bosses might say' (Korman and Glennerster 1990:63).

In their seminal work on the closure of Darenth Park the authors assert that:

> Unit general managers became key figures. Though a great deal turned on the capacity of the particular individual involved, in many instances it created clearer lines of responsibility (Korman and Glennerster 1990:27).

The oral and documentary data on the Royal Albert provides significant support for such claims. As referenced earlier in the thesis,[6] the testimonies of various members of management and staff, as well as that of the General Manager himself, all attest to the impact of David Jordison in providing efficacious organisational leadership. However, and recognised by Jordison, the oral histories depicted the considerable leadership contributed by other individuals who constituted the body of senior and middle management at the time. Importantly, and under-represented elsewhere, through memories this study *illuminates* the recalled dialogues, interactions and incidents which

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[4] Male Ward Manager, Interview August 2nd 2009; Conversation with Nikki Riley, July 4th 2011
[5] David Jordison, Interviews February 15th 2008, June 12th 2009; Geoff Hopkinson, Interviews May 1st 2008, July 16th 2009.
[6] See Chapters Five and Six.

make up a nuanced narrative of leadership. The analysis emphasises the myriad ways in which individual 'capacity' was expressed by senior and middle management; the ability to lead rested on more than power of position (Baldwin and Williams 1988). Overall the oral testimonies at the core of the research offer critical insights into how the rundown was managed.

Embracing complexity

A powerful overarching theme of the thesis is that the years of Royal Albert contraction represented a highly complex task, comprising a range of interconnected human, logistical, political, and economical variables. This re-inforces the important contention, borne out by other studies highlighted in Chapter Two, that social policy *implementation* is a 'messy' business. However, this study's oral history findings evidence the relative inexperience of senior and middle managers in organisational change management. Their backgrounds were predominantly therapeutic or of management on a much smaller scale. Management interview data provide 'more history' (Frisch 1979); they suggest that the 'right' values, strength of personality, a willingness to learn rather than any expertise in change management were the attributes which would bring about the contraction of the Albert. These observations constitute important, and little documented, insights into the human and professional dimension of closing a large long-stay institution for people with learning difficulties in late twentieth century UK.

Hegemonic leadership

Unlike some other institutional closures, the lack of guaranteed employment for staff forcibly displaced by the rundown of the Royal Albert did not result in collective resistance. Certain clues as to why this was the case may lie in matters beyond the scope of the study, such as the financial details of individual redundancy or early retirement packages, or, more broadly, Lancaster working class and NHS politics. However, the findings do provide a partial explanation. Management at the Royal

Albert, whether unwittingly or not, employed a hegemonic approach combining persuasion and coercion to enlist staff, family and public support. In making and supporting this argument, detailed in Chapter Five, the thesis makes an innovative contribution to the research on institutional closures.

Significantly, the thesis has unpicked the otherwise under-researched ethical dimensions of a hegemonic approach in the closure of a large long-stay institution. In contrast to other studies, this research has evidenced the political, rather than therapeutic, attributes of normalisation/SRV. These ideas provided an *overt* ethical framework to those charged with the task of implementing the immensely complex rundown of the Royal Albert. Normalisation/SRV could be construed as offering the moral glue of 'rightness' which held together the disparate and, for some, unwelcome strands of change. Analysis of the managerial oral history testimonies reveals how these philosophies legitimised institutional contraction through contributing a critical conceptual language, the taken-for-granted 'rightness' of change, and with SRV the 'rightness' of closure, as well as a body of work which informed student nurse and professional training. However, the findings discussed in Chapter Five suggested a more hidden, and less well documented, ethical dimension to the contraction of this hospital. Infused with the 'rightness' of normalisation/SRV, the oral histories of senior and middle management indicated that they *legitimised* institutional contraction by discrediting the viewpoints of those who questioned facets of the ethos and practice of Royal Albert rundown. This thesis has developed this point to situate the ethical positioning of Royal Albert senior and middle management within a *hegemonic* framework. This is definitely *not* an argument which doubts the ethics, principles or compassion of individual managers who prosecuted change. It is one, however, propounding that in terms of organisational *politics* there was a pervading and intricate hegemonic weltanschauung which marginalised critical voices and constituted an

essential facet of downsizing. Such a research perspective provides insights under-represented in other studies of institutional closure and deinstitutionalisation.

10.2.1.3 What were the viewpoints of those who resisted the closing of the Royal Albert? How did they express their resistance?

Valid critical perspectives

The findings of this study intimate that those individuals critical of elements of Royal Albert contraction were expressing tensions which resided at the core of the process. Chapter Four pinpointed conflicting pressures which shaped institutional closure at the Royal Albert. Overall the research indicates that the exigencies of political economy were present throughout the rundown period, although their impact was particularly apparent during the final five or six years. This assertion is in contrast to the hegemonic rhetoric of change agents which emphasised the engine of Royal Albert closure being driven *predominantly* by the needs, and rights, of people with learning difficulties. Entwined in this weltanschauung, and highlighted earlier in the thesis and in this chapter, was a complexity of ethical perspectives which 'othered' critical voices. The net result was that those who resisted the changes of these years were discredited; they did not present a cogent viewpoint in the contraction narrative.

This research, however, has suggested that elements in a resistance viewpoint represented a *valid* perspective on the rundown of the Royal Albert. As discussed in Chapter Seven, critiques highlighted issues associated with political economy, concerns over those people with learning difficulties regarded as the most vulnerable, the degree of choice possible in the process, collective as opposed to individualised living options, and the professional benefits accruing to those staff who promoted change. The findings, including the oral histories of those *implementing* change, intimated that these themes were prevalent both during and after the process of downsizing. They did not

comprise the whole story of the last 10 to 15 years of the Albert's existence, but were an *integral* part of it. This with the odd exception (Gleeson 2010), as highlighted in Chapter Two, is a historical perspective lacking from the research literature; as such the findings of this study offer an 'anti-historical' account (Frisch 1979).

Micro-politics of resistance

Gleeson, discussed in Chapter Two, argues that the small scenes of moral and political struggle associated with institutional closures are in danger of being lost forever (Gleeson 2010). In this *under-researched* area, the findings of this thesis retrieve the micro-political elements of resistance within one organisation. Oral histories, along with organisational documents, provide 'more history' (Frisch 1979) by illuminating the myriad acts of resistance associated with the contraction of the Albert. Data analysis reveals a web of informal and formal avenues through which individuals expressed their dissatisfactions about hospital contraction. These micro-political acts, examined in Chapter Eight, provide a historical narrative which has frequently been passed over by other researchers. As referenced in the literature review, there are one or two exceptions to this trend, but generally the nature of resistance has either been unpicked or seen in terms of overtly political collective actions.

Summary

This section has covered the component parts of the overarching research question: *How did the Royal Albert Hospital contract?* Using oral histories primarily of former management and staff, supported by a selection of documentary evidence, the findings have suggested that there was an intricate amalgam of ethical and political factors in the contraction of the Royal Albert. Integral to this blend, and emblematic of deeper tensions within the policies and practices of deinstitutionalisation, was a conflict between critics and implementers of change. Managing this discord was crucial to

hospital closure and was achieved through the adoption of a hegemonic approach by those managing the change.

10.2.2 What did the contraction of the Royal Albert *mean* for key stakeholders?

In Chapter Two it is argued that missing from the research literature overall are studies illuminating the multiple and rich meanings that institutional rundown had for both change agents and those staff and relatives who expressed resistance. This thesis, based largely upon narrative, dialogic and thematic analysis of oral histories, provides insights into these areas. The contention, illustrated in Chapter Seven, is that for individuals critical of the rundown of the Royal Albert those years represented a sense of loss and bewilderment. Their feelings were resonant of workers undergoing deindustrialisation. In contrast, for some change agents the contraction offered opportunities for redemption, and an exciting and intense involvement in transforming the lives of people with learning difficulties. As documented in Chapters Five and Seven, either side of this divide could construe the other's sense-making as being *merely* about career or job self-interest. The oral histories examined in this study depict a far richer interpretation, and one which is largely absent from existing research.

10.3 Research Methodology

Oral history methodology was pivotal to this qualitative research. In turn, both the choice of interviewees and the analysis of their oral data relied heavily upon a polyphonic approach, designed to elicit a diversity of voices involved in the closure process of the Royal Albert. Reliance upon remembered accounts, supported with limited documentary data, at times meant that establishing the *precise* chronology of the event was problematic. However, it was possible, by triangulating data, to identify a sufficient authentically sequenced account. Moreover, any gaps in this area were more

than adequately compensated by the insights gleaned from the oral, and documentary, evidence.

The interviewees provided a rich, nuanced multi-voiced *human* account of organisational change. In using their testimonies to depict institutional rundown, Frisch's concepts of 'more-' and 'anti-history' proved invaluable. The dynamics, challenges, relationships, personalities, conflicts, emotions and perspectives of Royal Albert contraction were illuminated through the memories of key stakeholders. In their interviews individuals told not only their own stories but in their inner dialogues revealed the viewpoints of others (Schrager 1998). Furthermore, individual testimonies were then compared with others to add to this kaleidoscope of voices. A critical outcome of this approach was 'more history'. At an organisational level, facilitated predominantly by oral historical testimony, this thesis provides fresh insights into the complex human dimension of the rundown of a large long-stay institution for people with learning difficulties.

Importantly, however, the polyphonic oral historical methodology has offered an 'anti-historical' narrative of institutional contraction. Through an analysis of the oral testimony, aided by reference to documentation, it was possible to acknowledge and explore a counter-community care viewpoint. Interviews with former managers, for instance, revealed inconsistencies in the rundown process. Arguably such revelations would be less forthcoming in a more formal, deliberately constructed statement. Additionally, amongst those critical of facets of Royal Albert contraction perhaps it was safer, and easier, to express these views years after the event, especially when no longer employed by the NHS. Oral history interviews could offer what Gabriel defines as an 'unmanaged space' where,

all kinds of organisational controls (including ideological, administrative, spatial and technical) are evaded, dodged or side-stepped... (Gabriel 2000:125).

Alternative voices generated in such an arena challenged orthodoxies regarding deinstitutionalisation. In amplifying and examining these largely hidden perspectives, provided through oral testimony, the research offered an 'anti-historical' account. This enriched the narrative of Royal Albert rundown, and of research into institutional closures in general, through enabling a rigorous consideration of acts and viewpoints of resistance.

Inextricably linked to a historical reconstruction of institutional rundown were the meanings this dramatic event had for those involved. Oral historical testimony, situated within a polyphonic framework, and assisted by dialogic, thematic and narrative analytical tools proved invaluable in explicating the ways in which individuals made sense of the downsizing of the Royal Albert. In their inner dialogues, for example, interviewees provided clues as to their values, ethical positioning, their relationship to the Albert, to its closure and to people with learning difficulties. Devices such as tragic or epic narratives, moreover, revealed as much about respondents' own perspectives as they did about any 'objective' historical truth. Aided enormously by the oral historical evidence, the study was able to illustrate, to an extent largely absent from existing literature, the multiple-meanings evoked by the contraction of a long-stay institution for people with learning difficulties.

10.4 Research Journey

Informing the choice of the Royal Albert Hospital rundown as a case study were my own links with the institution as it contracted during the 1980s. As discussed in earlier chapters,[7] being an insider, albeit to a limited extent, was a mixed blessing for the

[7] Chapters One and Three.

research. Overall, however, revisiting the event as a historian rather than as a participant was an illuminating experience. Delving deeper into the research presented the possibility of standing back and re-examining attitudes held both by my younger and older selves. Such a process was exemplified by attempting to hear the perspectives of those critical of deinstitutionalisation, especially since, at the time, I would have adopted a dismissive attitude towards these individuals. Endeavouring to make sense of the event in a dispassionate manner helped me see that the move to community care was riddled with anomalies. Many of the latter, despite the best intentions of those implementing change, had little to do either with the needs of people with learning difficulties or those supporting them. An awareness of this state of affairs *partly* fuelled the anxieties and anger of those resistant to the policies and practice of deinstitutionalisation. Furthermore, although the study has not undermined my belief that many practices in long-stay institutions were physically and emotionally abusive, it did highlight the profound and complex relationship many members of staff, families and people with learning difficulties had with the hospital. As a researcher, rather than as an adult educator, this understanding has complicated, and deepened, my perspective on this organisational transition. It does not signal agreement with all the attitudes encountered in the course of the research, but has reaffirmed the notion that a humane process of change needs to find ways of engaging diverse needs and viewpoints in a genuine dialogue.

10.5 Avenues for Further Research

Further light could be shed on the tensions impacting on Royal Albert contraction, particularly those which stemmed from the conflicting pressures of cost and human need, by a closer examination of actual resettlements. Drawing on oral histories and documentary material this would embrace the voices of *all* those involved, including people with learning difficulties, at that micro-level. This attention to the detailed ethical

and political dynamics associated with particular individuals moving out of the Albert may provide additional valuable and informed insights into themes raised in this study.

This research, however, has raised broader ethical and political issues meriting attention. These relate both to institutional closures and the wider field of organisational change. The contraction of the Albert was imposed upon the organisation, and enthusiastically adopted by some, less so by others. The lack of zeal of the latter was bound up with concerns for people with learning difficulties, a critique of contraction politics and ideologies, and with the profound meanings, for both staff and families, that association with the institution held for them as a place. Was it right that these voices were marginalised both in policy creation and in its implementation? Are there ways of generating and implementing change which embrace a polyphony of viewpoints, and enable a genuinely democratic dialogue? There is clearly an important place in the scope of these questions for people with learning difficulties. However, that is not the prism through which this research has viewed institutional closure. Furthermore, it is through recognising and considering the legitimacy of the viewpoints of others that this thesis complicates the ethical narrative of contraction and prompts questions worthy of investigation.

Salient lines of further enquiry hinge upon a more profound understanding of viewpoints. To recap, this study has touched upon the importance of sense-making by key stakeholders in the organisational change associated with an institutional closure. It has implied that at the heart of the disparate weltanschauung of individual managers, and members of staff, were narratives, and inner-dialogues, through which they interpreted their involvement in such a tumultuous service transformation. Enmeshed in these narratives was a complex multi-layered mixture of ethics, dialogue, identity, emotion and meaning. The research, however, has also intimated that proponents and

opponents of institutional closure became encamped on either side of a moral divide, across which it appeared to be very difficult to reach and *fully* acknowledge alternative viewpoints. Integral to this polarisation, from a managerial perspective, was that institutional closure was predicated upon a taken-for-granted stance, ethically infused with normalisation/SRV, of what was best for people with learning difficulties. This uni-dimensional positioning effectively marginalised critical voices; it did not recognise, or embrace, the diverse *subjective* realities experienced by those at the heart of that organisational change. However, this thesis merely touched upon, for instance, the consequences of such a state of affairs for the lives of people with learning difficulties. Overall, the findings of the study indicate that further research is needed to investigate the nature, significance, acknowledgement and *impact* of sense-making upon the mission of institutional rundown, and the well-being of its key stakeholders. In other words, the primary focus would rest upon the multiple ways in which way people imbue their world with meaning. This emphasis would build upon, and, particularly with its innovative application of oral history, contribute towards studies which have recognised the central importance of story-telling, and moral viewpoints, in the political and ethical life of organisations (Gabriel 2000; Reissner 2004; Conroy 2009).

In concentrating upon the case study of the rundown process of a single institution the thesis has provided a rich account of organisational change, embracing a polyphony of perspectives. However, this has meant a more restricted assessment of the respective influence of differing elements than may have been possible with a detailed comparative study (Rolph 2000; Tilley 2006). Attempts were made to 'benchmark' (Tilley 2006) the contraction of the Albert with other research but were limited by the lack of comparable in-depth studies. A multi-case study approach has the potential to make tacit issues explicit (Reissner 2004). Evaluating the impact, for instance, of Royal Albert leadership on its rundown is difficult without an analysis of similar phenomena

elsewhere. Likewise, investigating political and ethical issues, pinpointed here as warranting further study, could be assisted by focussing upon the change processes at other large institutions, or non-therapeutic organisations.

10.6 Conclusion

Focussed upon a case study of a single institutional rundown, this study has depicted 'the kerfuffle'[8] of learning disability social policy implementation during the later years of the twentieth century. Analysis of oral history testimony of key stakeholders in the contraction of the Royal Albert Hospital, Lancaster revealed a messy, intense organisational change infused with a powerful ideological rhetoric. A polyphonic approach enabled the thesis to embrace a wealth of diverse viewpoints, some of which complicated and questioned a dominant and oversimplified community care narrative. Constructs, and examples, adopted from organisational, political, deindustrialisation and oral historical studies, as well as those specific to the social history of learning disability, enhanced and underpinned the study. The latter, furthermore, was enriched by the employment of a mixture of thematic, dialogic and narrative analytical tools. Ultimately the value of the thesis lies in the insights into institutional contraction generated by this eclectic fusion of methodology and voice.

[8] Dave Spencer, Interview April 3rd 2009. Also see Chapter Five.

Appendix i: List of Abbreviations

CMH	Campaign for the Mentally Handicapped
COHSE	Confederation of Health Service Employees
DHSS	Department of Health and Social Security
GNC	General Nursing Council
IPP	Individual Programme Planning
LDHA	Lancaster and District Health Authority
MDS	*Model District Service* (NWRHA)
NDT	National Development Team
NHS	National Health Service
NUPE	National Union of Public Employees
NWRHA	North West Regional Health Authority
PASS	Programme Analysis for Service Systems
RA	Royal Albert (Hospital)
RAH	Royal Albert Hospital
RAHLOF	Royal Albert Hospital League of Friends
RCN	Royal College of Nursing
RMN	Registered Mental Nurse
RNMS	Registered Nurse Mental Subnormality
SPSP	*Shared Proposals for Shared Problems* (NWRHA)
SRN	State Registered Nurse
SRV	Social Role Valorisation
VIA	Values into Action (previously CMH)

Appendix ii: Brief biographies of oral history interviewees[9]

Alston, Malcolm

Interview: September 13th 2005; May 19th 2009

Born 1940
Royal Albert Charge Nurse (before and) during late 1970s until 1992: managed the **Independence Training Unit** (preparing residents for leaving hospital, including finding them outside employment) in 1980s; and ran the **annual summer camp and the Pathfinders**, the Royal Albert equivalent of an adult Scout Troop.
[Started at the Royal Albert in 1964; and qualified as a Registered Nurse, eventually attaining Charge Nurse status.]

Alston, Lesley

Interview: June 5th 2006

Born mid 1950s
Royal Albert Night Sister during 1980s until c.1993; **Royal Albert Deputy Team Leader** c.1993 – 1996 (present on last day).
[Royal Albert Cadet Nurse 1971-73; Student Nurse 1973-6, qualifying as a Registered Nurse; becoming a Staff Nurse then Sister.]

Charge Nurse

Interview: January 28th 2009[10]

Born late 1930s
Royal Albert Nurse, then **Charge Nurse** late 1950s to 1990s.

Creed, Mrs. E.

Interview: March 21st 2007; June 17th 2009

Born 1925
Royal Albert Nurse, then **Staff Nurse** 1949–1990s.
[Initially employed as Matron's Assistant, then eventually becoming, through service, a State Enrolled Nurse i.e. Staff Nurse; Night Nurse from c.1964 to retirement in 1990; then into 1990s was a bank nurse at the Royal Albert.]

Dennison, Tony

Interview: September 20th 2005; September 1st 2009

Born 1956.
Royal Albert Charge Nurse 1980s: worked with profoundly disabled young people (on Graham House and Sturton Lower).
[Started at the Royal Albert in 1973 as a Cadet Nurse; qualified as RNMS 1977; qualified as RMN 1979; late 1980s – Qualified Assessor in Clinical Practice as well as Diploma in Nursing; left Royal Albert in 1992; 1994 BA in Applied Social Sciences.]

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[9] For an explanation of abbreviations please see Appendix i.
[10] This was a telephone conversation.

Dewhirst, Bob

Interview: June 9th 2009

Born 1948
Royal Albert Staff Nurse, then **Charge Nurse** early to mid 1970s; **Nursing Tutor** at Royal Albert School of Nursing mid to late 1970s; 1980s **Royal Albert Senior Nursing Tutor** (head of nurse training in learning disability and mental health); 1980s **National Exam Moderator** (GNC).
[Qualified as: RMN c.1969; SRN c.1971; RNMH c.1972. Late 1970s: Senior Nursing Tutor at Turner Village, Colchester[11].]

Dunkeld, Jenny

Interview: August 12th 2009

Born 1949
Royal Albert Nurse 1964-74 (**Cadet Nurse; Student Nurse; Sister**)
Deputy Manager of Pointfield Hostel (Lancaster) for children with learning difficulties 1974-76; **Officer in Charge of Riverview Hostel** (Lancaster) for adults with learning difficulties 1976-92.
[A Lancashire Social Services Inspector of Care Homes 1992-2008.]

Former Hospital Resident (Anon)

Interview: May 28th 2009

Royal Albert Resident c. 1950s – early 1980s. She left prior to the setting up of the formal multi-disciplinary Resettlement Team.

Former Hospital Resident (Anonymous)

Interview: May 12th 2009; May 28th 2009

Royal Albert Resident 1940s – early 1980s. She left prior to the setting up of a formal multi-disciplinary Resettlement Team.

Foxcroft, Beryl-Ann

Interview: June 5th 2006

Born 1953
Royal Albert Staff Nurse (Nights) late 1970s to 1995.
[Cadet Nurse at Lancaster Moor Hospital 1969-71; office work 1971-76; 1976 started at Royal Albert; 1978 qualified as State Enrolled Nurse with people with learning difficulties.]

Greenshields, Gordon

Interview: December 16th 2009

Born 1946
Finance Director NWRHA 1983-4; **Chief Executive NWRHA** 1984-6; **National Finance Director NHS** 1990-93.
[Qualified as an Accountant; early career in Local Authority and Housing; from 1976 in NHS, initially Lothian Health Board as Assistant Director of Finance, then Director of Finance in London based HAs until 1983; from 1986 a Partner in Price Waterhouse Coopers, from where seconded to NHS Financial Directorship.]

[11] Turner Village was a large long-stay institution for people with learning difficulties

Hobson, Bernadette

Interview: August 26th 2009

Born 1947

Royal Albert Clinical Psychology Administrator (after initially employed as Secretary) 1978 to late 1980s; **Royal Albert Voluntary Services Co-ordinator** late 1980s – 1994.

[Whilst at the Royal Albert studied successfully for an Open University degree in Psychology; then after leaving the hospital acquired a Masters in Public Health at Manchester University; became an Higher Education Lecturer in Psychology.]

Hopkinson, Geoff

Interview: May 1st 2008; July 23rd 2009

Born 1940

Royal Albert Divisional Director of Nursing Services 1983-95: responsibility for services at the hospital and in the Lancaster District.

[Worked in NHS learning disability nursing since 1962: Student Nurse, Staff Nurse, Charge Nurse at Balderton Hospital, Newark 1962-72; Nursing Officer, Earls House Hospital, Durham 1972-76; Senior Nursing Officer, Stoke Park Hospital, Bristol 1976-81; Senior Nursing Officer, Prudhoe Hospital, Northumberland 1981-83. Retired from NHS in 1995.]

Illingworth, Brian

Interview: September 8th 2009

Born 1951

Royal Albert Porter 1978 - 1995

[When joined the Royal Albert his father worked there as a porter, with his sister, and future brother-in-law employed as nurses. In 1995 transferred to Lancaster Moor Hospital, where worked, with a short period of unemployment, until he was laid off in the late 1990s when the main site was closed.]

Jordison, David

Interview: February 15th 2008; June 12th 2009

Born 1949

Royal Albert Unit General Manager 1986-92; General Manager of Mental Health Unit c.1987-1992; **Chief Executive Lancaster NHS Priority Services Trust** (Learning Disabilities, Mental Health, Community Services) 1992 – late 1990s; then Chief Executive, Bay Community NHS Trust; retired 2003.

[BA Geography at Leeds University; qualified as an accountant with Coopers and Lybrand in Sheffield; then short period as an accountant in industry; NHS Assistant Treasurer in Northumberland; NHS Deputy Treasurer, North Tees; NHS Deputy Treasurer in South Wales, prior to arrival at the Royal Albert.]

Kiernan, MJ

Interview: September 23rd 2009

Born 1950
NHS Lancaster Branch Secretary of NUPE 1980 - c.1996; **Lancaster Hospitals Joint Shop Stewards Committee Secretary** 1982 – c.1996; **NUPE National Committee member** 3 years during 1980s.

[Storeman at Lancaster Moor Hospital from late 1970s to c.1996; during 1970s left after 2 years at Lancaster University studying BA in Sociology (major) and Theatre Studies (minor).]

Lawrenson, Mary

Interview: September 9th 2009

Born c.1959
Royal Albert Student Nurse 1977-80; **Staff Nurse**; **Acting Ward Sister** c.1981-3; **Ward Sister** c.1984-5; **Nursing Officer** c.1985 – c1990; then **Lancaster District Manager (NHS and Social Services)** for people with learning difficulties.
[At the time of interview: County Manager of Lancashire County Council Social Services provision for people with learning difficulties.]

McLean, Tom

Interview: September 8th 2008

Calderstones Hospital Principal Nursing Officer from 1972; **Founder Member National Development Team** in early 1970s; **Member of North West Regional Health Authority Advisory Group** for people with learning difficulties (seminal figure in the production of key policy documents throughout the 1980s).
[Student Nurse at Cell Barnes Hospital, St. Albans; Senior Nursing Officer at Stoke Park Hospital, Bristol prior to arrival in the North West in 1972.]

Mee, Steve

Interview: September 22nd 2005; July 11th 2007; February 18th 2008

Born 1955
Royal Albert's first **Nursing Process Co-ordinator**, implementing Individual Programme Planning c. 1984-85; the hospital's first **Resettlement Co-ordinator**: 1985 to c.1991.
[BA Sociology, University of Essex 1976; Started as Care Assistant at Turner Village in 1977; began Nurse Training at latter institution; qualified at Royal Albert in early 1980s; 'fast tracked' to Nursing Process Co-ordinator; left Royal Albert c.1991 to work for Social Services in Lancaster area as a manager of housing into which former hospital residents resettled.]

Morgan, Phil

Interview: March 20th 2008

Born c. 1953.
Royal Albert Senior Nursing Officer 1985-1995: responsible for the design and implementation of the Ward Contraction Strategy; **Acting Divisional Manager** 1995-96: the senior hands-on manager overseeing the final months of Royal Albert closure.
[Started at the Royal Albert in 1969 as a Cadet Nurse; qualified as a Registered Nurse in 1974; Staff Nurse until 1976; Charge Nurse 1976-83; Nursing Officer 1983-85; after Royal Albert closure, became a senior NHS manager in Lancaster and district community services; retired in 2008.]

Nursing Officer (Male)

Interview: March 11th 2009; July 23rd 2009

Born 1930s
Royal Albert Student Nurse, Staff Nurse, then **Charge Nurse** 1970s into the 1980s; **Nursing Officer** 1980s to early 1990s.

O'Hara, Gudrun

Interview: June 22nd 2009

Born 1942
Royal Albert Social Worker 1980 – 1996
[As a young woman had worked with people with learning difficulties in a Rudolph Steiner Home in Switzerland; prior to arrival at the Royal Albert was a Social Worker in the Freeman Hospital, Newcastle; after the Royal Albert continued as a Social Worker in the Lancaster area, working with people with learning difficulties, and their families; retired 2002.]

Prasad, Doctor

Interview: August 12th 2009

Born c.1938
Royal Albert Consultant Psychiatrist 1982 to mid-1990s.
[His leaving was a consequence of the contraction process, being transferred to Lancaster Moor Hospital.]

R., Eric

Interview: August 11th 2009

Born 1957
Royal Albert Nurse 1976 – 1985: **Student**, then as **Staff Nurse** working predominantly with young people and children – including those moving out; 1985-88 **Charge Nurse – Manager of Community Houses** for former Royal Albert residents.
[1990 – present: working for NHS with learning disabled people with high support needs.]

Spencer, Dave

Interview: April 3rd 2009

Born c.1960
Royal Albert Charge Nurse mid-1980s, working with residents preparing to leave hospital; **Assistant Resettlement Co-ordinator** late 1980s – c.1991; **Resettlement Co-ordinator** c.1991 – 1995.
[BA Degree Course in Social Science at Trent Polytechnic in the late 1970s – left prior to completion; qualified at the Royal Albert as a Registered Nurse to work with people with learning difficulties in 1985; 'fast tracked' to Charge Nurse; left Royal Albert in 1995 to take up a post in community services in the Blackpool area]

Ward Manager (Male)

Interview: August 2nd 2009

Born 1953
Royal Albert Staff Nurse early 1980s; **Royal Albert Charge Nurse, and then Ward Manager** (post re-grading late 1980s) until closure.
[Started at Royal Albert in late 1970s; then qualified as RNMH]

Webb, Mr. S.

Interview: August 28th 2009

Born 1925
Royal Albert Chief Engineer 1968 – 88.
[Engineer at Williamson's in Lancaster 1947-67.]

Whitfield, Paul

Interview: October 28th 2009

Born 1940
General Manager Lancaster District Health Authority 1985 – 1992; Chief Executive Lancaster Acute Hospitals NHS Trust 1992 onwards.
[Originally trained in cost accountancy, then from 1959 worked for the NHS in the North West, initially in finance, then as Personnel Officer, Deputy Administrator and Administrator for different Health Authorities, prior to arriving in Lancaster in 1985]

Wilson, Mrs Ann M.

Interview: November 17th 2009

Born 1949
Royal Albert Deputy Administrator 1975-8; **Secretary of the Royal Albert Hospital League of Friends** 1985 – 1995; **Royal Albert Volunteer** 1980s - 1990s.
[Deputy Administrator at the Royal Lancaster Infirmary 1971-75, then promoted to a similar role at Lancaster Moor Hospital[12].]

[12] Lancaster Moor Hospital: a large long stay psychiatric institution

Appendix iii: Timeline of Royal Albert Hospital rundown[13]

Years	Royal Albert Hospital	Regional and National Events
1870	Opened as a charitable institution: Royal Albert Asylum for Idiots and Imbeciles of the Northern Counties.	1913 Mental Deficiency Act
1910	Renamed Royal Albert Institution.	
1948	Lost independent status - incorporated into NHS, as Royal Albert Hospital.	1959 Mental Health Act
1970s	1974: NHS re-organisation: end of Matron/Medical Superintendent; introduction of tripartite consensus management: medical, nursing and administration. Late 1970s: Critical external reports (NDT, GNC, NWRHA) – overcrowding and poor living conditions. GNC withdrew recognition of RA Nurse Training School.	1971: *Better Services for the Mentally Handicapped* White Paper 1979: NWRHA *Planning of Services for the Mentally Handicapped*
1980s	Early 1980s: ad-hoc resettlements increased; GNC restored RA nursing school status. Early to mid-1980s: Individual Programme Planning (IPP) for all hospital residents introduced; RA Hospital Resettlement Team established. 1985: All under 19 year olds resettled. 1986: First RA General Manager - end of tripartite consensus management. Mid-1980s: RA resettlement strategy. 1988: RA contraction strategy.	1983 NWRHA *A Model District Service* - stating *eventual* closure of institutions for people with learning difficulties in region. 1983 *Health and Social Security Adjustments Act*: DHSS benefits could finance resettlement to private and voluntary community accommodation. 1983 *Griffiths Report* – introduction of general management in NHS. 1985: NWRHA *Run-Down of Hospitals for People with Mental Handicap in the North West* 1989: NWRHA/LCC *Shared Proposals for Shared Problems* : Timetable for closure of RA and other institutions in the North West.
1990s	Increased pace of resettlement from RA. 1996 RA closes. New owners: Jamea Al Kauthur Islamic College for girls.	1990 NHS and Community Care Act 1992 Brockhall Hospital (one of three large institutions in North West) closes on schedule.

[13] For an explanation of abbreviations please see Appendix i.

Appendix iv – Royal Albert Rundown Statistics[14]

Year	Numbers	Details
1973	955 residents *399 nursing staff*	
1981		15 residents to Eaves Lane Hospital, Chorley; 9 residents moved to a house in Morecambe.
1982	749 residents *631 nursing staff*	21 residents moved to 7 houses provided by MIND in Preston; residents moved on a trial basis to Blackpool.
1983	750 residents	22 individuals of over 5 years residence moved out; 4 boys to a house in Lancaster; 120 residents now resettled.
1984	721 residents (Including: 75 from Lancaster; 96 from Cumbria; 89 from Blackpool)	27 individuals of over 5 years residence moved out; 9 children under 16 years old remained; 13 residents already moved to Chorley Places for 53 residents at Royal Albert Flats opened in January; NWRHA to provide 12 places p.a. in Lancaster.
1985		40 individuals of over 5 years residence resettled.
1986	Over 600 residents	NWRHA (October) reported no children 'from Region' living in large institutions.
1987	*800 staff*	Since 1979: 270 residents moved to various communities (predominantly North West). 1986-87: 30 resettled (mainly Lancaster area). 28 former residents now lived in Lancaster area.
1988		Lancaster district: 80% of people with learning difficulties already lived in the community; aim by closure (in 2003) 78 RA residents will live in the area; 31 already resettled. RA resident population estimated to be reducing at 35-60 p.a. Rate expected to continue.
1989	506 residents *(March)* 460 residents *(July)* *720 full time equivalent jobs at RA.*	27 residents resettled during the year.

[14] Sources for statistical information: Lancaster Guardian 1984-96; RAHLOF Minutes 1981-95; Hansard (April 22nd 1987); RAH (1988) Ward Contraction Strategy Policy Document; DHSS (1976), The facilities and services of mental illness and mental handicap hospitals in England 1973; and DHSS (1985), The facilities and services of mental illness and mental handicap hospitals in England 1982.

Year	Numbers	Details
1990	411 residents *(November)*	22 residents resettled.
1991	355 residents *(November)*	Dowry a *minimum* of £21,000 but could be £60,000 if 'degree of disability is high'. Since 1984, 12 residents resettled in Blackpool, with another 80 to resettle.
1992	*650 staff*	From April resettlement rate to increase from 25 to 75 p.a. for 4 years.
1994	180-90 residents *(January)* 165 residents *(September)* 141 residents *(November)* *500 staff (January)*	100 job losses were predicted in 1994. Lancaster NHS Priority Services Trust won contract to support 50 RA resettled residents.
1995	65 residents *(September)* 55 residents and 5 wards open *(November)* *170 staff (November)*	In September Lancaster NHS Priority Services Trust won contract to support 21 RA residents, and create 40 new jobs, in Lancaster District NHS, by November, provided support to 41 former residents in 21 'domiciles' in Lancaster District; employed 70 full and part-time staff. RA claimed that between 1983 and 1995 no more than 10 residents returned, and most of those gone back into 'community'. 500 RA staff left by November: 50 redeployed in Lancaster NHS Priority Services Trust; 20-30 worked for other trusts; 50-60 in Social Services; 100 took other employment or further education; 'dozens' took early retirement; 200 members of staff made redundant.
1996	Closed (March)	In total at least 120 residents resettled into Lancaster district.

Appendix v: Interview questions

The ethos of the interviewing approach, adopted in the research, was discussed in Chapter Three. In terms of practicalities this usually translated into two index cards: one with 6-8 stock open-ended questions (see below); and the other with prompts or questions of specific relevance to the individual interviewee. Writing *both* these cards constituted a critical element in preparing for *each* interview. The information on the cards would be minimal, usually written in block capitals, with key text coloured with a highlighter pen. This format was used so that, if necessary, they could be glanced at, rather than followed to the letter. However, the time spent drawing up the cards meant that by the time of the interview I was *au fait* with intended questions or prompts. In the vast majority of interviews, because of this preparation, little direct reference was made to these aide memoirs.

Examples of stock interview questions used in the study:

General/RAH background?

Role/Remit re-resettlement/rundown?

How RAH rundown/resettle? e.g. pace (early/later); creativity; general management; ward closures ...

Impact of rundown? e.g. residents; families; you; other staff

Factors helping/hindering rundown/resettlement? e.g. SRV; staff; community; economics...

Why closure? At what point did you believe it would close?

Is there anything you would like to add?

Appendix vi: Information Sheet

An oral history of the closure of the Royal Albert Hospital: a large long-stay institution for people with learning difficulties.

A PhD Research Project

Nigel Ingham
Faculty of Health and Social Care, The Open University

What is the study?

I am studying the process of closing The Royal Albert Hospital, Lancaster which ended its existence in 1996, after nearly 130 years as a large long stay institution for people with learning difficulties. The decision to close this enormous edifice (in the 1970s home to nearly a thousand residents), along with other NHS hospitals of a similar nature, marked a significant sea change in policy direction, reflecting the growing rhetoric of community care. Explaining and exploring the closure process of the Royal Albert through the narratives of some of those who were involved will be the main focus of my research.

What and who is involved?

This study rests on a number of recorded interviews with former residents, staff (including senior management), families who had relatives in the Albert, as well as key NHS and Social Services decision makers at a district and regional level. Memories, stories and meanings of the closure process generated in these interviews are cross referenced both with each other and other historical sources.

Interpretation of the closure process data ultimately rests with myself as a researcher although participants are encouraged to offer their own insights. The most obvious outcome of this work will be a PhD thesis, but I will be looking to share findings through presentations and articles, as well as ensuring that some of the recorded material - with the permission of those involved - can be deposited in public archives.

My research is has been reviewed and approved by the Open University Human Participants and Materials Ethics

Committee, as well as being conducted in accordance with the Oral History Society's ethical guidelines.

Why is this study important?

By looking closely at the dynamics of one institution for people with learning difficulties, this study provides an opportunity to gain insights into the reality of social policy implementation. More specifically, the research can contribute to an understanding of deinstitutionalisation, a key aspect of late twentieth and early twenty first century social policy which has impacted upon the lives of thousands of people with learning difficulties, their families, staff and local communities through the UK, Western Europe, the United States and Australasia. Importantly the study will actively challenge the marginalisation that people with learning difficulties, and their history, often experience by: placing their stories and concerns at the heart of the research process; and relating the rundown of this particular institution to broader societal and political themes of closure.

Finally the Royal Albert itself has a particularly significant part in the institutional landscape of the United Kingdom. It was one of only five charitable large asylums set up nationally in the Victorian era, purpose built for people with learning difficulties, representing a radical departure from available generic institutional provision. A number of histories have been written about the inception of these voluntary establishments, few, if any, about their demise.

How to get in touch? [15]

My phone number is ------
The best time to contact me is 9-6 Monday to Friday. You can always leave a message and I will return your call.
My email address is n.w.ingham@open.ac.uk

If I cannot answer your questions, then you can contact one of my supervisors:

Professor Dorothy Atkinson
Faculty of Health and Social Care,
The Open University
Milton Keynes MK7 6AA

[15] Selected email and telephone number details removed (here) for reasons of confidentiality.

Dr. Sheena Rolph
Faculty of Health and Social Care
The Open University
Milton Keynes MK7 6AA

Appendix vii: Copyright Form

An Oral History of the Closure of the Royal Albert Hospital, Lancaster

A PhD Research Project with the Open University

Clearance Form[16]

1. I confirm that any items (e.g. photographs, documents, recordings) contributed to ***Nigel Ingham*** belong to me and that to the best of my knowledge, I own the copyright to the items contributed.

2. I give permission for my recorded words, and other contributed items, to be used by Nigel Ingham in his Open University PhD research. yes/no

3. I give permission for my recorded words, and other contributed items, to be kept and/or copied into the ***Unlocking the Past***[17] Archive and agree to their use:

   a. as an educational resource yes/no
   b. for public reference in libraries and museums yes/no
   c. as a source that may be published (including CD Rom) yes/no
   d. as a source that may be published on the Internet yes/no
   e. in public performance, lectures or talks yes/no

I understand that Nigel Ingham will pass on the ***Unlocking the Past*** Archive (with any copyright conditions) to Lancashire County Council public archives and, in the case of master recordings, the North West Sound Archive for permanent long term preservation.

4. Date(s) of any recording(s) _____

5. I do/do not agree to my name being used. If you do agree to the use of your name – how would you like it to appear? _____

Please specify any other restrictions you would like placed upon the use of the material:

_____

_____

Signed_____Date_____

Name (Print)_____

Address_____

_____Tel_____Email_____

Nigel Ingham_____Date_____

[16] Because of restricted thesis margins, this version of the form has a smaller font size, and more cramped layout, than the original.
[17] Referenced in Chapter One, this is a Royal Albert Hospital historical archive: www.unlockingthepast.org.uk

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