MANAGING CHANGE:
THE DEVELOPMENT OF MENTAL HANDICAP SERVICES IN SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY, 1978-88

submitted by Nancy Lincoln Korman
for the degree of Doctor of Philosophy
London School of Economics and Political Science
University of London

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Abstract

This dissertation is an examination of the planning and management issues involved in the implementation of a regional health authority decision to close a mental handicap hospital and reprovide services in seven districts which had used the hospital.

Several features made this project worthy of attention:

it was among the earliest hospital closures;

it involved a very large number of districts and therefore was a complex situation which nonetheless was fairly typical of long-stay hospitals in the London area;

all residents, regardless of degree of disability, were to be given the chance of living in the community:

local authorities were also involved along with health authorities, and this project could illustrate new principles of joint planning.

The project further lent itself to a consideration of the adequacy and accuracy of the academic literature on planning and related activities.

The research focussed on three areas. The first set of issues related to the approaches to planning used by regional officers who had responsibility for seeing the

project through to completion. The Darenth project tested the new NHS planning system which was based on a rational planning model, and found that it could not deliver what was wanted from it. Regional officers created new types of working relationships with districts which allowed progress to be made.

The second set of issues concerned the management of the rundown of the hospital. Aspects of the rundown discussed are: retention and redeployment of staff; physical contraction of the hospital; impact on residents; financing the rundown.

The third set of issues related to joint planning. One of the purposes behind the introduction of joint planning into the NHS was creation of a mechanism to bring about a more appropriate balance of social and health care for people who were currently long-stay patients. But it was not joint planning with local authorities which got these residents out into the community. This study documents some of the reasons why government policy intentions could not be met.

The main findings of this study point to the inadequacy of a model of planning which is based solely on rational process. Policy and implementation interact over time, as ideas and personalities change, as objectives are redefined in light of current circumstances, and as recognition is given to the competition for dominance of objectives of different participants in the planning process.

Table of Contents

List of Tables

List of Figures

Introduction

This dissertation examines the planning and management issues involved in the implementation of a regional health authority decision to close a mental handicap hospital and reprovide services in the seven districts which the hospital served. The research was supervised by Professor Glennerster and carried out under a grant from the then Department of Health and Social Security (DHSS) between 1981 and 1988. The project report has appeared in a book published by the Open University Press in 1990 (Korman and Glennerster, 1990). This dissertation presents a revised version of those aspects of the project for which the author was directly responsible under Professor Glennerster's supervision.

The research process itself had some unusual features. First, it began because of local interest in getting research done on the Darenth project, but it became of much greater interest as time went on, because of the increased attention being paid to the hospital closure movement. Most research has the opposite experience.

Secondly, it is not often that a researcher, especially one on short-term contracts, has the opportunity of staying with a research project long enough to see through a process of change. It is far more usual to work for two years or so producing a snapshot of a particular part of the change process. The experience of working continuously on a project in this case enabled the research to identify the change process and the end results, the impact of personalities, policies and external events. It made possible the production of a coherent and comprehensive narrative of events which was comprehensible to participants and to a wider audience of practitioners, managers and academics.

The research reported in this dissertation excludes that section of the report to the DHSS and the book which dealt with an analysis of the costs of community care, as that analysis was the work of Professor Glennerster.

Acknowledgements

I wish to express my thanks to the many members of staff at Darenth Park hospital, within the health authorities and local authorities and at the regional office of South East Thames Regional Health Authority for having accepted the presence of an outsider in their midst for just over seven years. They showed every courtesy to me and gave freely of their time to the research project.

Thanks are also due to the Mental Handicap Research Liaison Group of the DHSS for having funded the research and to the two research liaison officers, Sara Graham and Jenny Griffin, for their support, advice and interest. Having spent several years observing the research

management system at the DHSS, I can say that for my project, the system worked exactly as intended.

I am especially indebted to Howard Glennerster, Professor of Social Administration, who supervised the research and the writing of the thesis. This thesis represents a third writing about the same subject, and despite this, he has shown steadfast support and encouragement, in addition to just the right amount of constructive advice. Without his deadlines, I would have neither started nor completed the thesis.

Chapter 1

The Policy Scene

This study concerns the closure of a long-stay hospital for people with mental handicap, one of the first to be built specifically for people with mental handicap and one of the first to close. The closure was made possible by the development of new services in the community. Hospital closure was thus not a policy objective; it was expected to occur as a by-product of the development of community-based services. Hospital closures have come to assume a significance, however, because of the resources tied up in hospitals which are essential for the development of community-based services - capital as represented by the buildings and land, revenue as represented by the running costs and expertise of staff in caring for people with a mental handicap.

Services for people with a mental handicap have been developed as specialist services largely in this century, specifically since the 1913 Mental Deficiency Act which recommended separate and special facilities. The current service ideology demands that services for this client group be provided in the community and integrated with generic facilities used by all citizens. This chapter discusses the policy context in which the closure of Darenth Park hospital took place, with a brief review of earlier history.

Creating institutions

Institutions were created very much more rapidly than we are now able to close them. An early landmark in the history of institutions was the 1845 Lunatics Act which made the establishment of asylums by county authorities compulsory, and which had implications for people with mental handicap as well as those with mental illness, as the two were often confused and treated similarly. Jones and Scull provide contrasting interpretations as to why asylums became a statutory obligation.

Kathleen Jones (1960) gives what might be termed a conventional interpretation of the history of mental institutions, emphasizing the humanitarian impulses behind the reform movement leading to the 1845 Act. She cites the reports of the work of the Metropolitan Commissioners between 1828 and 1845 which drew public attention to the conditions in asylums, the impact of evangelical movements and societies for the reform of particular abuses, Parliamentary select committees and scandals as each contributing to the success of the reform movement. Thus, in describing the Lunatics Act of 1845, Jones writes that 'Ashley and his colleagues had roused the conscience of mid-Victorian society, and had set a new standard of public morality by which the care of the helpless and degraded classes of the community was to be seen as a social responsibility' (ibid, p. 149).

An account with a different emphasis is provided by Andrew Scull (1979) in *Museums of Madness*. In this book he argues that the creation of institutions was the outcome of urbanisation and industrialisation of the economy which developed during the first half of the nineteenth century. An economy based on wages required those who could work to do so, and thus a separation of the able-bodied from those not capable of work for the relief of poverty.

At the same time, ideas about lunacy were changing. Lunacy was now seen as a loss of self-restraint and a sense or order, but not a loss of one's humanity. These changes in the values of society were paralleled by the rise of the medical profession. At the beginning of the nineteenth century, the medical profession was involved in the treatment of mentally ill people, but were far from exercising monopolistic control. Gradually doctors successfully promoted themselves as the sole providers of treatment, claiming that mental illness was the outcome of disorders in the nervous system; early detection and treatment would lead to a cure. The treatment proposed, however, was not a particularly medical one. It was the 'moral treatment' devised by Tuke which, doctors argued, would allow them to manage mentally ill people in large numbers, whilst avoiding the brutality and horrifying mechanical restraints which had been the source of public disquiet. With an optimistic faith in moral treatment, it was a comparatively short step for the medical profession to encourage the public to transfer acceptance of workhouse institutions to separate institutions for lunatics.

Thus institutions came to be seen as the acceptable way of coping with people seen as needing to be controlled or to have their behaviour modified. Institutional care was extended from controlling the poor to caring for people with mental illness or mental handicap, physical disabilities, children without parents and elderly people unable to look after themselves. Whilst much of the early literature on institutions was concerned those dealing with mental illness, many of the features of these institutions were common to institutions providing care for other groups, and therefore critiques of mental illness hospitals apply equally to other types of long-stay hospitals.

Yet this is only part of the story. As Parker states in his review of institutional care (1988, p.50), "...just as we need to justify why institutions gained or lost support as remedies for social ills we need to identify the reasons why, once established, some survived in the face of their objective failure to meet their aims."

The new institutions intended for people with mental disorders did in fact fail to meet their objective of providing regimes of treatment conducive to curing its inmates. They were almost immediately overwhelmed by the numbers of people with chronic illnesses referred to them and by local political pressures to keep costs down. Institutions were thus unable to fulfil the ideology of moral care and treatment which had made them acceptable to the public. They continued, because they met other objectives. They provided a place of residence for people who, if contained in workhouses or other types of institutions, would prove disruptive to the operations of those institutions. They took in people for whom there were no alternatives in the community. Further, they came to be seen as catering for the pauper mentally ill who formed 90% of the asylum population. The increase in the number of mental asylums occured at the same time as the number of workhouses was increasing, an indication of the extent to which institutions were felt to provide relief to the community without necessarily giving relief to individuals (Skultans, 1978).

People with mental handicaps were incarcerated with people with mental illnesses; there was little understanding of the differences in these conditions by the public. An early attempt to identify issues particular to the condition of mental deficiency, as it was then called, was the setting up of a Royal Commission on the Care and Control of the Feeble-Minded (1904-1908). This was largely in response to public concerns about alleged promiscuity and delinquency of people with mild mental handicap, concerns which had been stirred up by several studies purporting to trace how mental deficiency had been passed from one generation to another within families, with each generation having many family members who had become public burdens through crime, prostitution or pauperism (Jones, op.cit, p.189). The Commission rejected this view of people with mental deficiency, and instead favoured a more stringent system of ascertainment and supervision which would protect the mentally deficient person, rejecting a policy of sterilization. This report laid the foundations for the 1913 Mental Deficiency Act, which recommended that each local authority establish a 'colony' as a basis for specialist custodial care. This would provide a completely self-contained and segregated environment where mentally deficient persons of all ages could live, train, work and relax with villas for residences, schools, workshops, churches, recreational facilities and farms. World War One intervened to delay the construction of such 'colonies' until the 1920s and 1930s. Thus, many of the arguments used to justify the establishment of mental institutions in the mid nineteenth century were used again to justify the establishment of separate institutions for people with mental handicaps - the need for specialist facilities to control and care for those seen as a danger to themselves and the community.

The period between the two wars saw the rapid expension of specialised institutions for the mentally handicapped. Starting with 2,040 such people in special institutions in 1914, the numbers role to 46,054 in 1939 (Alaszewski, 1986, pp 14-15). By 1961, there were about 61,000 people in mental handicap hospitals. The numbers peaked during the mid 1960s to about 64,600 (Bone, Spain & Fox, 1972).

In 1948, mental handicap hospitals came into the new National Health Service from management by local authorities. Under the 1959 Mental Health Act, people were able to enter mental handicap hospitals as voluntary patients. Hospital records show that as this new status became understood, many inmates simply walked through the gates; self-discharge was not uncommon.

Mental handicap hospitals remained the backwater of the health service; they did not share in the glamour of acute services, they received little interest by psychiatrists who were developing new forms of treatment for mental illnesses (Ramon, 1986). Conditions in several large hospitals were exposed in the national press to be of very low standards and led to a series of public inquiries (e.g. Cmnd.3975, 1969, Martin, 1984). The government's response to this situation was to produce a policy statement, *Better Services for the Mentally Handicapped* (Cmnd 4683, 1971).

The Beginning of Change

Better Services was the government's attempt to change the direction of service development for people with a mental handicap without so undermining existing services that they would further deteriorate before more appropriate ones were available. It set a pattern for policy statements for other client groups (Cmnd.6233, 1975, Cmnd.8173, 1981). The purpose of the White Paper was to begin urging a shift from hospital and health care to community and social/educational care, and at the same time, to offer to those authorities involved in bringing about this shift guidance on the development of new services. It did this by putting forward a 20 year projection of services to be available at the end of this period of time. It forecast a tripling of day places for training or occupation of adults in the community and a ninefold increase in the amount of accommodation for adults in the community (including private and voluntary types of provision). Hospital places for adults were to decrease by half but only by one-seventh for children. That these targets would be difficult to reach could have been realised by comparing what local authorities thought they would be providing in 1972, as forcast in the 1963 Health and welfare plans: 9907 hostel places as compared with 4300 actual places in 1969 (including private and voluntary), and 27,795 ATC places as compared with 24,500 actual places in 1969 (Cmnd 1973, 1963).

Despite the forward look it gave to changes in services, the White Paper nonetheless disappointed some of its audience. It gave little justification for retaining the level of hospital care it recommended, for adults or children, and ignored some of the early evidence which indicated that even those with severe handicaps could attain higher levels of achievement in environments which emphasized growth and development rather than those which were more custodial or passive in style.

Throughout the 1970s, central government continued to focus attention on service developments for people with mental handicaps. Some approaches it used were shared efforts to shift resources to all the "priority" client groups. So, for example, a system of joint finance was initiated in 1976 to pump-prime experiments and develop services in the community provided by local authorities.

These could be funded on a tapering basis for a maximum period of seven years by the NHS (DHSS,1977a). Joint finance was intended to encourage local authorities to do more for the priority groups who were also relatively neglected in terms of community services. Services for people with mental handicaps also were one of the groups highlighted in the new planning system of the NHS begun in 1977 (DHSS, 1976b) which within the DHSS itself was based on a programme budget using client groups as one method of ordering expenditure. Planning guidance for priority services was contained within two elaborate planning documents (DHSS, 1976b, 1977b).

Other measures were specific to the field of mental handicap. In 1975, the then Secretary of State, Barbara Castle, announced the formation of the National Development Group for the Mentally Handicapped (NDG). This group, chaired by an academic adviser to the Department of Health, was to assist the DHSS in policy formation. During the five years of its existence, it produced annual reports, five pamphlets of guidance, a checklist of standards for improving the quality of services, and a report on mentally handicapped people in hospital (NDG, 1976, 1977, 1980). The pamphlets covered topics such as joint planning, an action plan for the development of services for children, school leavers, short term care and day services. After the Group had been disbanded, its final publication appeared, entitled *Services for the Mentally Handicapped - Unfinished Business* which was critical both of policy development and resource allocation as undertaken by central government and local authorities. The National Development Group was disbanded because its demands for service development were beginining to embarrass the new Conservative government which had a different set of priorities.

Alongside the NDG, a Development Team for the Mentally Handicapped (NDT) was established. This team still exists, although it is now called the National Development Team. This is a multidisciplinary group of people, both professionals and general managers, who visit and advise on the development of services being provided by health and local authorities. This quasi-inspectorial function was taken over from the Hospital (now Health) Advisory Service, a body set up in 1969 by the Secretary of State to report directly to him on visits to long stay hospitals for elderly people, people with a mental illness or a mental handicap, another aspect of the government's response the the revelations about conditions at Ely hospital (Kogan et al, 1989).

A new ideology

At about the same time as the NDG and NDT were being established, the Secretary of State also appointed a committee of enquiry into mental handicap nursing and care (Cmnd 7648, 1979). This committee considered in detail the skills required to provide residential care services to people with a mental handicap. The report began with a statement of principles: people with mental handicap, even those with severe mental handicap, should use ordinary community services unless there was a clear recognition that general services could not cope with a special need; the work of professionals should strengthen existing community networks of support rather than supplant them; maximum degree of coordination of services should be provided within and between agencies; people with a mental handicap had a right for someone to intercede on their behalf to ensure they received the services required. The Committee firmly rejected the necessity of hospital care for the numbers envisaged in *Better Services* and argued for ordinary community housing stock as the most appropriate form of accommodation. Equally controversially, it urged that all residential staff regardless of their employing authority, should have a common training and career structure.

The recommendations of the Jay Committee were not accepted by the government until 1981 (DHSS, 1981a) but its report began to give some official recognition to a new philosophy of care based on the principles of normalisation (Wolfensberger, 1972). Further recognition came in a report produced by DHSS officials and the former chairman of the NDG, Peter Mittler (DHSS, 1980). This report reviewed progress towards the *Better Services* targets of service provision by both local and health authorities. It very clearly countered the recommendations of the White Paper for children's residential accommodation, stating that hospitals did not provide the correct environment for children to grow up in and that the targets of residential provision for children by both authorities were too high. For adults, it thought that the total levels of provision proposed was still appropriate although it urged more consideration to be given to the balance of provision between hospital and community, and to a greater range of types of housing such as group homes, satellite homes, lodgings and ordinary housing stock. It strongly supported the White Paper target for ATC places and expressed concern that these might not be met.

It was particularly concerned about difficulties in hospital services. The imbalance of provision remained, insofar as a small number of districts continued to provide care for a very large number of people with mental handicap, whilst about 40% of health districts had no local provision for people with mental handicap. It was concerned also that in recent years, expenditure increases for mental handicap hospitals had ceased, so that future improvements in hospital care would depend on falling numbers of in-patients. It urged that more attention be paid to the declining role of the large hospitals and to ways of getting new services into the community.

The new ideology put forward in the Jay report was given further impetus by the publication of *An Ordinary Life* (King's Fund Centre, 1980) which drew on the experience of the experiments in the use of community facilities to provide all services needed by people with mental handicap in the ENCOR programme, eastern Nebraska. By bringing together the experience of others and putting forward principles of service development that could be easily understood by planners and managers and members of voluntary organisations concerned with people with mental handicap, this publication soon established itself as the standard text for service development, and its title as the shorthand expression for the new philosophy of care.

The government responded to these reports in several ways. First, it issued a circular (DHSS, 1982) offering three year funding for projects designed to provide accommodation in the community for children under the age of 16 in long-stay mental handicap hospitals; this has resulted in a dramatic decrease in the number of under-16s remaining in hospitals. Secondly, services for people with mental handicap were affected by the growing recognition of the difficulties in developing community care, making it increasingly difficult for central government to avoid taking a role in sorting out some of these issues.

Resources

If the policy objective was to develop services in the community then resources had to be channeled there. In the first half of the 1970s the new social services department maintained very high rates of growth, over 17% p.a. in current expenditure for 1972/3 and 1973/4, and just over 13% in the following year (Webb & Wistow, 1986, p.32). These real rates of growth were considerably higher than central government had planned and demonstrated attempts to develop new services immediately after the establishment of the Seebohm social services department. At least one previous study has shown how difficult social services departments found it to plan and manage growth on this scale (Glennerster et al, 1983).

Following the oil crisis of 1973, central government became increasingly concerned to contain inflation by imposing limitations, and then severe limitations, on public (including local government) expenditure. Social services departments thus faced a slowing in their rate of growth, although during the remaining years of the 1970s this did not amount to cuts in real expenditure levels; that occurred only in the late 1980s (Evandron et al, 1990). Yet, as Webb and Wistow point out, resourcing policies of the 1970s undermined community care. The reduced rate of revenue growth in the second half of the decade was insufficient to both meet the revenue consequences of earlier capital schemes and sustain development of new community services. The allocation of a general grant to local government provided no guarantee that any increase intended to promote community care would in fact reach social services department; it was left to each local authority to decide its own pattern of expenditure. And, even if extra funds reached the social services departments, there was no guarantee that it would be used for community care services or for the client groups for whom it might be intended (Webb & Wistow, 1986, p. 33).

At the same time, health authorities were beginning to move towards a faster rate of development of community based services. This made social services feel uneasy. Their own funding was inadequate (and recognised as such by the DHSS in its 1980 review of mental handicap services) to bring about a shift in the balance of services between hospital and community. The movement of health-run services into the community was making additional demands on local services for support to the NHS residential provision - day care places, social work support, use of adult education places. The inability of the NHS to legally transfer funds to local authorities (other than joint finance funds) was placing a major limitation on the development of community care and became a source of complaint to central government.

The government's response to this was a consultative document on different means of effecting such transfers (DHSS,1981b), and two years later a new policy on revenue transfers (DHSS, 1983). The consultative document began with two sentences indicating a much greater commitment to community care than had been exhibited before:

> Most people who need long-term care can and should be looked after in the community. This is what most of them want for themselves and what those responsible for their care believe to be best.'(DHSS, 1981b, para.1.1)

The new policy of funding community care made it possible for district health authorities to make annual grants to local authorities or voluntary bodies for as long a period of time as they provided services for people moving out of hospital. Payments could now be made for education and housing services as well as for social services care. Joint finance arrangements were improved to allow funding of projects to last for 10 years at 100% funding, with an additional three year tapering period, for projects helping to take people out of hospital. A series of pilot projects were also funded (up to £16m) by the government, with evaluation by the Personal Social Services Research Unit of Kent University, to experiment with ways of developing new styles of services for people coming out of hospital (Renshaw et al. 1988).

The new opportunities presented to statutory agencies by these changes in funding were quickly seized upon. There was an immediate boost given to the use of ordinary housing as the basis of residential provision for people coming out of hospital, thus allowing authorities to base services on the 'principles of normalization'; this alone gave impetus to 'ordinary life' as the dominiant philosophy of service provision. Many of these homes became registered care homes, allowing residents to claim higher DHSS allowances. When joined with the government's more generous funding of non-statutory residential places for elderly persons, there was an immediate impact on the social security budget; the Audit Commission estimated that the cost of supporting private residential care had increased from £200m in 1984 to £500m in 1986 (Audit Commission, 1986). The new funding arrangements also made it possible for health authorities to develop their own discharge plans without consultation with their local authorities; they could now work directly with housing associations to set up residential schemes. Many became involved in consortium arrangements with local authorities housing associations and voluntary bodies, although most of the housing being planned and provided was for people coming out of hospital.

Emerging Problems

The *Care in the Community* circular resolved at least one of the financial problems, how to transfer funds for people coming out of hospital into the community. But many other problems remained, and the second half of the 1980s saw several reports outlining the various difficulties being experienced which made progress in developing community care much slower than expected or desired.

Local authorities' concern about being by-passed has already been mentioned. A further problem was that once clients moved into an area, they could made demands for additional services but local authorities (health or social services, education or housing) were not funded for any extra provision. This was becoming quite an issue in particular localities of England, such as the south coast, which was attracting many private residential homes. The provision of day services was another issue which received considerable attention in these areas, with newspaper stories about clients being locked out of their homes during the day, wandering the streets because they had nothing to do.

A further voice of disquiet about the way community care was being developed came from the Select Committee on Social Services of the House of Commons in its report on community care (House of Commons, 1985). The Select Committee supported community care but not 'on the cheap'. It also argued that community care could not be provided overnight - there was a need for a slow and thoughtful development of a wide range of facilities and services and considerable preparation of the public to accept people with differing degrees of disabilities in their midst.

The committee expressed concern about the emphasis ("obsessive concentration", para. 24) being placed by government on the discharge of patients from hospitals. It argued that no hospital should be closed before all necessary community facilities were in place for those being discharged and for those who would otherwise have sought hospital admission. A further recommendation was that no patient should be discharged without an individual care programme covering all the needs that individual had. ment on mental health services (DHSS, 1989).

The committee also had comments about the balance of care provided by health and local authorities. Although it did not wish to see people stay in hospital unnecessarily and therefore accepted that in the immediate future, health authorities would have a significant role in residential services, in the long-term, it thought local authorities should take on responsibility for all community residential care. Joint finance was 'played out' as a means of transferring funds from health to local authorities; mental handicap services were seen in general as underfunded and understaffed.

An exception to these difficulties occured in Wales, with the publication of the all-Wales strategy for mental handicap services (Welsh Office, 1982). The intention behind this document was to ensure that all local authorities in Wales eventually had comprehensive services for people with mental handicap. The Welsh Office took a direct hand in bringing together local and health authorities to produce community based service plans and to provide transitional funding to allow new services to develop locally. No other part of Great Britain had such a helping and guiding hand from central government in this policy area.

A major review of the current problems found in implementing community care was produced by the Audit Commission in 1986. It reviewed services for people with mental or physical handicaps, mental illness and elderly people, in particular arrangements for long term care. The report gave legitimacy to some of the current concerns about the failure to develop community care; it showed that problems lay at structural and financial allocative levels rather than local political and administrative functions. In particular it cited the peculiarities of the ways funds were distributed to the NHS and local authorities; the restraints placed on local authority expenditure which penalised authorities for expanding community services; the lack of bridging finance to allow services to be built up; and the perverse effects of a social security system which allows benefits on the basis of location and type of service rather than needs of clients.

The Commission recommended administrative changes designed to remove some of the impediments to developing community care for the three principle client groups. For people with mental and physical handicaps, local authorities should be made responsible for long term care, except for those whose handicaps were so severe as to require medical supervision. For people with mental illness, the NHS would retain the lead responsibility, but would either purchase appropriate social care from other agencies or would be joint budget holders with social services. Long term care of elderly persons would be provided by a manager who controlled a single budget to which both health and social services would contribute. In these ways, the structural problems in providing community care and overcoming the obstacles of past service traditions could be overcome.

The Commission's final recommendation was that a further 'high level' review of these issues be undertaken to consider these and other possible options and to consider ways in which community care could be delivered to individual clients. The Commission produced another report exclusively on services for people with mental handicap, which more or less looked to a more integrated service approach (Audit Commission, 1987).

Clarifying responsibilities

The high level review of community care was undertaken by Sir Roy Griffiths, a special adviser to the DHSS (DHSS, 1988). He took seriously the Audit Commission's warning that it was no longer tenable to ignore the present difficulties lest the emerging emphasis on residential as opposed to community care become entrenched as the new model of care. His terms of reference were:

> "To review the way in which public funds are used to support community care policy and to advise [Secretary of State] on the options for action that would improve the use of those funds as a contribution to more efficient community care." (para.2)

The Griffith recommendations at last provided the radical rethink of service responsibilities and funding pointed to as needed. Griffiths' analysis of the problems involved were summarised in paragraph 9:

> "At the centre, community care has been talked of for 30 years and in few areas can the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand bheen so great. To talk of policy in matters of care except in the context of available resources and timescales for action owes more to theology than to the purposeful delivery of a caring service. This is not an argument in itself for more resources. The intention is that policy and resources should come into reasonable relationship, so that we are clear about what community care services are trying to achieve and so that leadership and direction to those providing services can be given."

Major changes were proposed for local authorities. They were to become strategic planners of community care services and the assessors of need for social care of its residents. Provision of services was to be encouraged to be undertaken by voluntary and private bodies rather than local authorities. Funds were to be transferred from the social security budget currently funding residential care to local authorities who could use those funds to provide domiciliary and community based care, and residential care if apropriate. All clients would receive the same housing and income support benefits so there would no longer be a financial incentive to use residential care. Local authorities were to produce and publish annual community care plans so its residents could have a clearer idea of what was available. The role of health authorities was limited to providing appropriate community health services. A new role of community carer was to be developed, so that one person would provide the basic range of personal and practical care needed to maintain someone at home.

This report received mixed reactions. It obviously addressed what had been seen as the main difficulties in developing community care in the past - split responsibilities, funding from different sources - but it clearly upset health authorities in that it focussed very much on social care in the community but not on the difficulties of providing community health services or of coordinating these with social care. Nonetheless, with some modification in the mental health area, these recommendations were accepted by the government in a White Paper *Caring for People* which was published in November 1989 (Cm 849).

Conclusion

This brief review of the national policy environment in which the closure of Darenth Park hospital took place illustrates many of the themes to be discussed in succeeding chapters.

It began with the publication of *Better Services for the Mentally Handicapped* in 1971, the first attempt to give official support for the development of community-based services on a much larger scale than before. This theme was carried through by critical reports by the HAS and NDT on hospital services and by the increasing acceptance given to principles of normalisation as the basis of service provision, which eventually led to local authorities being given the prime responsibility for services for people with learning disabilities in *Caring for People* in 1989. The heme of deinstitutionalisation is taken up principally in chapter two.

A second theme relates to ideas about planning. *Better Services* gave central government a strategic role of identifying a model of service and issuing guidance in the form of normative levels of provision for local health and social services authorities to follow. Coordination between services provided by these bodies was to be achieved by joint planning mechanisms. The history of this period shows that neither of these approaches achieved the shift in the balance of care desired by government. In the end, the DHSS began to gain some of its objectives by providing incentives to the statutory authorities to take up its priorities whilst accepting that the model of care it had identified was no longer the one wanted by field authorities. The theme of planning approaches is taken up in chapters 5, 6 and 8.

Even changes in the approach to planning were insufficient to achieve the government's objective of community-based care. *Caring for People* had to unscramble some of the complex arrangements of responsibilities and funding which had grown up in the past, preventing cooperation when the will to cooperate was present. Chapter 12 discusses how *Caring for People* might affect the issue of hospital closures.

Chapter 2

Arguments against institutions

During the second half of the 19th century, Victorian Britain created a series of institutions to provide care for people suffering from mental illness and mental handicap. The quality of care found in these institutions may have been poor, but they did represent an improvement over the arbitrary and cruel treatment of individuals in private unregistered madhouses which preceded the public institutions.

Now, in the second half of the 20th century, all this is to be reversed. Institutions are seen to be bad places, which harm rather than help their inmates. Deinstitutionalisation is being taken up with the same fervour, rhetorical conviction and lack of evidence that one imagines institutionalisation received in its time.

The past forty years have seen many criticisms against mental institutions - those treating mental illness and those treating mental handicap. There are differences in the problems found in these two types of institutions, but there are also many similarities, particularly at the organisation level. The attacks on institutions, by academics, professionals and the media, have all contributed to the development of an ideology that all instituions are wrong. Indeed, in the 1970s and 1980s there were many examples of different types of institutions closing; even the prison service began to develop non-custodial services. This chapter considers some of the arguments against mental institutions and the backlash against these arguments. The Darenth project exhibited both these trends.

Legal criticism

Direct assaults on institutions, and mental hospitals in particular, began in the early 1950s. One of the earliest was based on a legal argument: *50,000 Outside the Law* (NCCL) rekindled fears about wrongful detention which had in the previous century led to a legal process of certification for people with mental illness.

This pamphlet now argued that mentally subnormal people lacked some of the legal safeguards against wrongful detention available to people with mental illness, and that the methods of testing young people for mental deficiency failed to distinguish temporary backwardness from permanent deficiency. Conditions in mental deficiency institutions created a 'vested interest' in retaining people rather than releasing them; patients often did work which would otherwise require additional paid staff and hospitals took on commercial work without adequately paying patients. The pamphlet demanded a revision to existing law to prevent such conditions from continuing, and contributed towards the setting up of the Royal Commission on Mental Health in 1954.

Sociological studies of mental hospitals

Academic researchers began to pay attention to the state mental illness hospitals from a sociological stance, starting with several studies carried out in America (Stanton & Schwarz, 1954; Belknap, 1956; Dunham & Weinberg, 1960). These studies focussed on the interpersonal relationships among the various staff groups employed at the hospitals and between staff and patients, and the ways in which these affected the prime objective of the hospitals - the care or rehabilitation of patients. What they found was an organisational structure within the hospital geared towards custodial care rather than cure or rehabilitation:

> considerable shortage of professional staff of all types within hospitals to carry out treatment programmes, which led to cynicism about their jobs and their roles within hospitals;
>
> because of these shortages of staff, the treatment and management of patients was determined by the ward attendants, the least well-trained of all staff;
>
> the extreme shortage of trained social workers resulted in poor links being maintained between the patient and his family, and among the family, the community and the hospital, so that patients who might have been able to be discharged were left in hospital;
>
> the social class differences between professional

staff, especially doctors and attendants, led to attitudes of suspicion, avoidance and hostility, resulting in considerable barriers to communication; the differences between the formal and informal structures and objectives of hospitals were displayed most clearly at the ward level. The official duties of ward attendants, for example in Southern State Hospital (Belknap), were to clean the ward and attend to the physical needs of the patients; what the research revealed was that due to understaffing (the hospital had 4800 patients and 600 staff) the ward attendants spent their time supervising the work done by patients who did the cleaning of the ward, washing and feeding of other patients and other tasks officially belonging to the ward attendants. For this reason, what seemed to be a confused mixture of patients on the wards was seen to relate to the need to have an adequate number of 'mild' mental patients to help on wards. The prime needs of the attendants were for order and control, and these tended to override the needs of patients.

Another study by Greenblatt, York and Brown (1955) described how several hospitals had changed their regimes to produce therapeutic environments, underlining the importance of social rehabilitation as a key factor in the discharge process of mental illness hospitals. Mental hospitals came to be seen as preventing rather than providing treatment. This study and those mentioned previously pointed to the importance of gaining the cooperation of the patient in achieving his own recovery and of modifying the hospital environment so that it was more responsive to client needs than to organisational demands. These studies attempted to find ways of making hospital care more effective; only one author, Belknap, challenged the ideology of hospitals: "the failure of reform was to ask whether a large-scale, centralised and partly self-sufficient institution is in fact able to function effectively in the treatment of the mentally ill" (op. cit., p.205).

Clinical critiques

Similar issues came to be raised in England by Barton (1959) who was among the first to see 'institutiional neurosis' as an illness, brought about by a lengthy stay in a hospital. The main symptoms of this illness were an unwillingness to take responsibility for oneself and to leave hospital at all. This concept was later taken up by Wing & Brown in their study of institutionalism (1970).

Raising institutionalism to the status of a disease gave the condition it denoted a higher status than would its recognition on sociological grounds alone. It was important that clinicians themselves began to recognise that a person with a mental illness or mental handicap could be made worse, not better, by hospital care. It helped to begin to draw a line around the original mental illness or handicap so that a person could be seen as more than the illness; their personality and human needs remained and demanded respect.

By the end of the 1950s and early 1960s "progressive" thought in psychiatric services was rapidly moving away from the hospital base towards the community. *Trends in the Mental Health Services* (Freeman & Ferndale, 1963) brought together many of the leading exponents of community mental health services and reproduced some of the more influential articles. In their introduction, the editors noted that "there is at present a period of tremendous upheaval, in which a system of care which has grown up over more than a century is being largely discarded" (ibid, p.x).

Other clinical studies were undertaken at the MRC Social Psychiatry Research Unit, focussing on services for people with a mental handicap but following the same trend of community orientation found in contemporary thought about mental illness services. These studies tended to be critical of hospitals for what they did and for what they could do but didn't.

O'Connor and Tizard (1956) reviewed studies relating to the ability of low dependency patients in hospital to work in ordinary employment situations. They described a series of experiments with hospital patients (some of which were carried out at Darenth Park) showing how rehabilitation services could be considerably better than those currently provided. Their comments on training opportunities in hospitals highlighted how poor rehabilitation services were:

~most patients were given occupational activity rather than employed on work of value to the community;

~the work undertaken in hospitals had almost no relation to the kinds of jobs done on licence outside the hospital;

~equipment used in workshops was obsolete;

~little contact with commercial firms, so it was hard to place trained patients;

~training situations were devoid of incentives;

~too little attention was paid to selection and training of supervisors and training staff;

~inadequate supervision of patients on licence or in daily service.

The conclusion of this study argued that a far more effective service could be provided for the group of mentally handicapped people which would enable them to lead productive rather than dependent lives.

Further studies by Tizard (1961, 1964) looked at the service needs of children with a mental handicap and their families, and how services in the community could be organised to meet these needs. Tizard noted in particular the ways in which attitudes towards residential care had changed after the Second World War and how the disadvantages of institutions had become increasingly apparent - their geographic remoteness; their intellectual remoteness from advances in medicine, education and psychology; the difficulties for families in keeping in touch with the child in hospital, and other arguments. In particular, Tizard stressed the importance of size and its relation to the quality of service provided.

Studies of institutions by sociologists/social administration

The frontal assault on the underlying ideology of institutions was made by Goffman (1961). Goffman's work, an analysis of the social structure of institutions and relations between inhabitants and staff, created a prototype of a total institution. This was defined as 'a place of residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (p.11). The central feature of a total institution was said to be 'a breakdown of the barriers' found in ordinary life normally separating the place to live, the place to work and the place for recreation. Further, four characteristics of the operation of a total institutions was cited:

> all aspects of life for the inmates carried on in the same place and under the same single authority;
>
> 'each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and are required to do the same thing together';

> 'all phases of the day's activity are tightly scheduled';
>
> 'the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution' (ibid, p.17).

Academic social administrators began also to take an interest in conditions in a wide variety of institutions and their effects on the inhabitants. These studies concluded that these institutions failed to achieve the objectives established for them and in the process of this failure dehumanised their inhabitants.

First was Townsend's surveys of local authority, private and voluntary institutions for elderly people in England and Wales (1962). His purpose was to describe the conditions found in institutions, and how elderly people lived in them. Townsend did not argue that no elderly person needed institutional care; he did claim that a significant proportion of elderly people then in institutionsal care had been admitted because of social factors rather than physical needs: homelessness, unavailability of domiciliary support services, financial insecurity, general lack of social resources, of friends or family networks. Over half of new admissions, he said, were physically and mentally fit to lead independent lives.

What was so striking about his study were the descriptions of conditions in the homes - the management regimes, the social isolation of the inmates, their loss of occupation, the physical poverty of the environment, the loss of decision making by the elderly person about his or her present life or future. Although not all institutions were rated as poor, the overall portrait presented was grim.

At the end of the 1960s, an influential piece of social research was published, which followed Townsend's in method and substance but was concerned with institutions for people with a mental handicap. *Put Away* (Morris, 1969) presented a depressing picture of meagre and inappropriate conditions. Two thirds of the hospitals studied were housed in pre-1900 buildings. Only a minority of patients seemed to need hospital care: 64.6% of the patients had no physical handicap, 65% were able to dress and feed themselves, only 12% were severely incontinent. The isolation of these hospitals affected staff as well as patients, and the shortage and lack of recognition of the value of specialist staff in education, occupational therapy and psychology, meant that only a small number of patients received any benefit from being in what was supposed to be a specialist service provided by hospitals. The stark contrast between the life led by patients in hospitals and that led by the majority of adults in the community was due to the loss of family contact, the lack of activity for so many of the patients, the crowded living conditions, the treatment of residents by staff as if they were children. Even in voluntary homes, which were rated more highly than hospitals on standards of physical environment, the author claimed to have found few examples of rehabilitation or training.

A later study was concerned with the care offered to mentally handicapped children in institutions (King, Raynes and Tizard, 1971). The researchers set out to examine how different environments found in residential care influenced the way in which children were brought up, by comparing in detail the organisation, staffing structures and patterns of daily activities in two local authority children's homes, a large paediatric hospital with long-stay wards and a mental subnormality hospital. Their conclusions supported many of the types of criticisms made of long-stay institutions, based on the extent to which environmental factors hindered the approach to child-oriented management practices. They claimed that they were not arguing against size of institution as such, but against the ways in which size tended to be associated with other factors which worked against the interests of children, such as separation from the community because residents were drawn from a large area, separation from family for the same reason, problems in recruiting and retaining staff, a greater tendency for centralisation of organisational procedures within large instituions, and the ways in which development of skills in childhood was hampered by institutional practices and attitudes.

Similar criticisms were made by Oswin (1974) in her study of weekend activities offered to handicapped children living in three different types of institutions. These research reports were demonstrating that it was possible to raise severely mentally handicapped children in ways similar to those for non-handicapped children of the same mental age, and that handicapped children benefitted from opportunities to do 'normal' activities.

A more recent study of Booth (1985) examined the extent to which dependency of residents in local authority old people's homes was induced by the regime of management of the home. He attempted to look at whether regimes induced dependency because of poor practice or whether an institutional setting was necessarily harmful to people no matter what type of management style was used. The study he directed examined 175 homes in four local authorities over a two-year period of time. Despite finding differences in the 'ethos of regimes' (liberal to restrictive), the outcomes for residents seemed not to vary according to regime; he concluded that "sociologically, the differences between regimes must, in light of this study, be seen as a veneer that decorates the massive uniformity of institutional life. . . underneath lies the same crushing panoply of controls over lives and doings of residents" (ibid., p.206). Even 'liberal' regimes do not avoid the negative effects of institutionalism. "This study obliges us to face up to the fact that the only sure way of limiting its [residential care] harmful effects is to stop admitting people who, given the chance, could manage with other kinds of support" (ibid., p.209). Similar conclusions were drawn by Willcocks et al (1987).

Scandals

Scandals have played a key role in the development of social policy in many fields and care provided in institutions is an area which has had considerable attention. An early report by Barbara Robb (1967) repeating various accounts of what went on in geriatric units based on what she was told by nurses, relatives of patients, and others. Callous indifference to patients, exploitation, rough handling, removal of glasses, hearing aids, dentures and other indignities, were portrayed as customary practice.

Sans Everything preceded what became a series of reports of inquiries set up to investigate allegations of ill treatment or poor treatment in a variety of long-stay institutions. Starting with the revelations about Ely Hospital in 1969 (DHSS, 1969) and continuing to the report on Normansfield in 1978 (DHSS, 1978), a catalogue of failures at all levels of service provision and service management were revealed to the public (Martin, 1984). In his analysis of reports by Committees of Inquiry into nineteen hospitals, Martin cites common features of the conditions found in those hospitals which more or less mirrored the sociological studies of hospitals in the 1950s: geographic and professional isolation; abandonment of patients by their communities; lack of support towards staff by managements; failure of leadership among all professional groups; poor interaction and cooperation among professions; shortage of resources; 'corruption of care' - subversion of prime objectives of the hospital to preservation or order, quiet and cleanliness. In the author's view, the failures of care were embedded in the context of the conditions in which the hospitals were run, rather than the sole responsibility of individuals. Martin himself did not question whether so many or even any people should be in hospital; his recommendations were aimed at improving conditions within hospitals. But the series of hospital scandals which formed the background to his book publicised the negative features of hospital life the way no academic study could, and significantly contributed to the poor public image of hospitals.

The economic argument

Almost 30 years of research and polemic worked towards the creation of an enviornment in which institutions were seen as harmful to the interests and needs of their inhabitants. These arguments were early on taken up by politicians who could see other advantages: comnmunity care would save money because it was cheaper than institutional care (Scull, 1984, Walker, 1982). For a start, many of the hospitals, both in the UK and in the USA, were rapidly approaching a century in age; if continued in use, they would require major renovation or rebuilding. Closing them, or at least some of them, and selling the sites would raise capital. Next, those concerned with budgets could see that bringing people out to the community could save revenue in several ways. Demands for improved standards in hospital would require additional revenue; decreasing the number of hospital patients would limit the numbers for whom services would need to be improved, and thus limit the costs of improvements. There were people in hospitals who did not require the 24-hour care provided; these people could live more independently and more inexpensively in the community. It would also be possible to shift the costs of care in the community to other authorities or to families/relatives; this too would lower the cost to the hospital budget. In Britain, this shift would be from central taxation to local rates.

In the USA, similar financial considerations played a large role in developing programmes discharging patients particularly from mental illness hospitals. In the case of services in California, the interplay was among the state government which supported the hospitals, local communities which supported local health and welfare services, and the federal government which was willling to fund certain tyupes of programmes but not others. (Segal and Aviram, 1978, Cameron, 1978).

The case against de-institutionalisation

Ideology, professional practice, social research and economics thus combined to make deinstitutionalisation a favoured option, an ironic twist to mental health policy as these were the same kinds of arguments used to develop institutions a century ago. And now, as then, the new policy had its critics. Some argued, such as Brown et al (1966), that the disabilities attributed to long stays in institutions were in fact for some people, the symptoms of their illness; discharge to the community would not change their characteristics and might make their condition worse by placing them in too demanding an environment. Jones et al (1975) made a similar point with regard to people with a mental handicap; no theory about deinstitutionaisation, normalisation, labelling or any other theory could deny the existence of severe handicaps, and the need for special services. These critics challenged the assumption that institutions were always wrong for all people, and that the only types of disabilities were those acquired by living in an institution.

A second line of criticism was based on more pragmatic considerations; community care may be a viable alternative but the facilities in the community at present were inadequate and thus deinstitutionalisation as a policy was wrong because it encouraged discharge without adequate backup. Thus Sedgwick wrote that:

> "in Britain as in the USA, the reduction in the register of patients resident in mental hospitals (from a peak of 154,000 in 1954 to around 2/3 of this total in recent years) has been achieved through the creation of a rhetoric of 'community care facilities', whose influence over policy in hospital admission and discharge has been particularly remarkable when on considers that they do not, in the actual world, exist" (1982, p. 192).

This too was not a new argument. Titmuss (1963) had criticised the government for being too optimistic about the rundown of hospital beds. He argued that local authority expenditure on mental health services per head of population was less in 1959 than it was in 1951. He showed how various government policies conflicted with rehabilitation aims and warned that "to scatter the mentally ill in the community before we have made provision for them is not a solution" (ibid, p.223).

The more detailed documentation of the non-development of community services comes from the United States and deals largely with mental illness services. Much of this documentation underlines the dependency of state hospitals on the growth of the new custodial private sector to provide the alternative care to discharged patients - often unmonitored and by unqualified staff. Some states have programmes funded exclusively for ex-hospital patients, thereby excluding younger persons needing care but having no record of previous hospitalisation. Increases in homelessness are linked with the growing number of ex-patients in what Brown calls "the new marginality" - the way the public lumps together facilities for drug addicts, people with mental illness, convicts and other deviant groups (Brown, 1975a). Brown, along with Chu & Trotter (1974), also points to the way that mental health programmes in the community are not necessarily linked with the mental health care needs of discharged patients; community mental health services, for example, are based on a medical model of care and provide a range of medical/psychological services, but they at the same time ignore the most basic needs of accommodation, meals, clothing, income.

The American experience, especially of people with mental illness problems, largely publicised through television and newspapers, has been the basis for doubts in Britain about deinstitutionalisation for any group of people. The policy of successive British governments has been to argue for the development of facilities in the community which would result in hospitals no longer being needed; hospital closure has not figured overtly as a policy objective. Yet it has often been hospitals rather than community services which have received attention, because of their higher costs and the difficulties in managing them. Whilst it is in theory possible (and desirable) for new services to exist before old ones are dismantled, the reality of limited resources and ideological commitment to types of service provision usually have the two occuring simultaneously or even one contingent upon the other (Bradley, 1976). The growing number of homeless people, a proportion of whom have a mental illness, has underlined the difficulty of providing new services before running down the old ones.

Conclusion

The Darenth project was caught up in these types of arguments about deinstitutionalisation. The hospital itself shared many of the features identified by early sociological studies of large institutions and of large institutions for people with mental handicap (Morris, 1969; Martin, 1984): overcrowding of wards, inadequate staffing levels, poor clinical and environmental management. As will be shown in chapter 5, early attempts to bring about improvements resulted in little change within the hospital. When an opportunity arose to sell the hospital land, it became feasible to plan for its total closure.

The Darenth project attempted to avoid some of the pitfalls of the American experience of deinstitutionalisation by ensuring that every resident was discharged to a known address. Each person was to have day activities arranged. But doubts remained which could only be settled by the experience of living in the community. Would the community accept in its midst people with severe mental handicap, including unsocial behaviour? Would the residents benefit from being in the community? These were the kinds of issues against which the closure of institutions would be measured.

Chapter 3

Bringing Change into the System

This study of Darenth project is concerned with planning activities used to bring about the hospital closure and develop new services in the community. Chapter 1 identified some of the ways planning had changed over the time of the Darenth project. Before the 1974 NHS reorganisation, planning meant in effect capital planning, basically new district general hospitals to replace small and dated acute units (Brown, 1979). The 1974 reorganisation had as one of its key features the initiation of a planning system on a rational basis, looking at the best use of resources across all services and client groups (DHSS, 1972). Further, it was to be extended from capital planning to service planning, so that models of service provision, manpower plans, financial plans and coordination with other agencies became important componants of plans. Rational-comprehensive plans of this type lasted a little less than a decade, to be replaced by a planning system less detailed, more focussed on major change issues only and more closely aligned with a system of accountability reviews.

In this chapter, some of the ideas about the nature of planning and implementation will be explored and related to changes which have taken place in the NHS.

Rational Comprehensive Planning

The essence of rational decision-making is: a clearly stated objective; identification of alternatives; analysis of consequences of these alternatives; choice among them (Carley, 1980). Rational decision-making is therefore a technique for solving problems. Its origins lay in part in the work of F.W.Taylor (Tillet et al.,1970) and others of the "scientific management" movement who were concerned to achieve maximum efficiency. Taylor's objective was to promote efficiency in industrial firms through specialisation and rigourous control of tasks, resulting in optimum output and profit maximization. Finding the most efficient way of carrying out work was a matter of analysing a task into its component parts, including time studies. This was his approach to problem-solving: a detailed set of procedures based on an analysis of alternatives and viewed very clearly from the perspective of a manager.

Something of Taylor's approach was found in studies of efficiency in government activity during the 1950s and

1960s, initially by economists at RAND involved in US Defence Dept work and by others engaged in analysis of government functions for other departments (Glennerster, 1975). That approach became the basis of cost-benefit analysis and lay behind in part at least of other attempts in Britain to systematically and comprehensively quantify decision-making - programme analysis review in particular. Such concern was for the efficient allocation of resources, growing out of the increased social and economic interventions by government to provide goods and services for its citizens; "value for money" is the most recent expression of this concern.

A technique for allocating resources in relation to programme objectives, the starting point of sub-optimization, was the development of programme budgetting during the 1960s. Novick (1965) described programme budgetting as:

> S
> which the initial emphasis in on the identifiable outputs - major objectives of government processes. It then attempts to order the inputs - government activities produced by manpower, material, real estate - so that comparisons among wider ranges of alternatives are feasible and meaningful." (p.vi)

Such a system was introduced in Britain in the early 1970s under a more limited version of Programme Analysis and Review; it covered a selection of programmes for review rather than attempting to cover the entire range of activities of government departments each year (Banks, 1979). Within the Department of Health and Social Security, a programme budget approach was established in the early 1970s which focussed on principle policy areas, such as services for elderly people or physically handicapped. Within each of these areas, programmes were broken down further into in-patient services, day care, residential care, and so on, showing how the policies for a client group could be sub-optimized for for analytic purposes, in the hope that the programme budget would assist in the assessment of priorities across all the main service areas funded by the DHSS.

These various approaches to rational-comprehensive planning clearly placed considerable demands on analytic functions. Arguments against this mode of rational decision-making have been put forward on theoretical and pragmatic grounds.

A: Clear objectives: Some policies may have clearly stated aims but what is more typical of policy is that it will be ambiguously phrased to generate a high level of support from a wide range of groups. Issues are complex so that highly specified statements are neither possible nor desirable (Barratt and Hill, 1984).

A rigid distinction between ends and means fails to recognise the way in reality problems and solutions interact and goals are compromised throughout the policy making process (Hall et al, 1975, Lindblom, 1959, 1965). This is not to say that policy makers do not have goals; only that their goals get thrown into the ring with those of others involved in policy making who have their own perspectives on issues.

B: Information: Many commentators have argued that the information requirements of rational planning are so lengthy and costly that they become unattainable. The most common objections relate to assumptions about the time and cost of identifying and analysing all possible alternative courses of action and their consequences (e.g. Downs, 1965; Smith and May, 1980).

Information requirements include predictions about future events or conditions in relation to assumed costs and benefits (Abell, 1975) and to the certainty with which these predictions can be made (Banfield, 1959). There is little evidence that the ability to predict in complex situations is at all reliable and that the further into the future predictions relate, the less reliable they become. Consequences can be predicted only imperfectly, as they lie in the future. Given the multiple interests involved in deciding which option to pursue, it is evident that different participants will attach different estimates to costs and benefits, dispute the relevance of information and offer differing interpretations of what constitutes a "problem" or a "solution" (e.g.Allison, 1971).

A final limitation is the capacity of an individual or of a planning agency to actually be able to handle the amount of information a rational method of planning would generate: the limitations of memory; the limitations on dealing with more than a small number of items at one time apply to individuals and teams (Faludi, 1973).

C: Ranking of criteria: The multiplicity of interests involved will bring with them a multiplicity of values in identifying and ordering preferences among alternative courses of action. Similar issues are thus raised in ranking alternatives as were raised concerning information, namely whose values are to be ranked and by whom. The extent to which "public interest" might form the basis of a ranking of values is therefore open to question (Carley, 1980; Wildavsky, 1966). Rein argues that in democratic societies "there are only conflicting interests, each seeking to maximise its influence through the political process" (Rein, 1976, p.98).

Rational Planning Modified

Despite the inherent difficulties in the complete rational mode, writers have been reluctant to surrender the idea of decision-making as a rational activity: "It is fundamental to our culture that rational choice is better than irrational choice" (Novick, 1965, p.26). There have been different attempts to preserve the basic rational model by trying to limit its demand for comprehensive analysis.

A. Satisficing: Taylor's work concentrated on workshop production; critics argued that he had ignored issues concerned with the organisation as a whole. These ideas were taken forward by Simon (1945) who attempted to match a theoretical understanding of rational decision-making with the then current knowledge of behavioral sciences.

Simon based his thinking of decision-making on the rational model but developed the idea of bounded rationality: a recognition that our knowledge of a problem and its environment is limited, as is time and money to be spent on resolving that problem. Together with a colleague, Simon set out to produce a theory about organisations which "recognises that members of organisations have wants, motives and drives, and are limited in their knowledge and in their capacities to learn and to solve problems" (Simon & March, 1958, p.136).

B: *Normative-Optimal.* A second model of modified rational decision making was presented by Dror as the normative-optimal model (Dror, 1964). This model entailed a search for alternative courses of action or policies within a definite cut-off point; recognition that extra-rational processes, especially experience, played a role in understanding and evaluating complex issues; and that these processes could be consciously improved. Dror accepted that most policy-making followed precedent, and was slow to advance change even when problems or situations changed more rapidly. He stressed that the model he proposed not merely fit the experience of policy making but also had the potential to improve it, by showing how significant change could be brought about.

C: *Mixed Scanning.* A third attempt to combine what were seen as positive features of rational planning with the more realistic acceptance of human limitations was produced by Etzioni as a "mixed scanning" approach (Etzioni, 1967). This approach was related to the strategy of decision-making which he thought society needed: fundamental decisions which gave broad direction to policy areas; and incremental decisions which worked out the details of policy within the framework set by fundamental policy making. Fundamental decisions were related to fairly radical change seen to be needed; incremental decisions related more to "stable" situations.

Mixed scanning consisted of a broad brush sweep adopted at a more detailed examination of some selected areas, revealed as "requiring" detailed examination. Scanning was therefore both rational in a limited number of areas and "truncated" for the major portion of a field of study. The overview included exploring the main alternative courses of action, but without going into detail about any of them; that would come later when only a few had been identified for in-depth study.

Each of these models shares, to varying degrees, the weaknesses of the rational model. They all assume that given a set of data, the same choice of alternative will be reached by all - a one best solution approach. Secondly, these decision-making models are centralist; they imply a hierarchy of values and objectives which guide and inform work done at lower levels of an organisation. No recognition of the possibility of differences in perception of problems or in the merit of different solutions is given. Thirdly, information is treated as a cost-free commodity.

These three models of decision making represent attempts to preserve a rational approach whilst recognising the impracticality of the rational-comprehensive model. The recent history of government initiatives in planning follows a similar pattern. During the 1960s and early 1970s, government machinery in Britain was reorganised on what were said to be more rational lines, so that central government departments became larger, bringing together interdependent policy areas. New planning systems were established to achieve a higher degree of coordination between policy areas, to give a longer term perspective to plans and to introduce more rational considerations into the policy making process.

In this pattern, the Department of Health and Social Security was created in 1970 and the NHS reorganised in 1974. A national management structure was prescribed for the main management tiers of region, area and district, specifying the functions of the tiers, working relationships between them, and the roles of the senior staff of each tier (DHSS, 1972). In 1976 a comprehensive planning system was introduced into the NHS (DHSS, 1976b) and in the next year, joint planning arrangements with local authorities were announced (DHSS, 1977a) (see chapter 5). The DHSS issued guidance on the priorities for development across all the main service areas, with norms of provision which authorities should work towards, and differential rates of anticipated growth over the coming years (DHSS, 1976a, 1977b). The role of the DHSS was to make policy decisions and of the field authorities to implement these.

The NHS planning system soon ran into difficulty: managers found it too cumbersome to operate comprehensively on an annual basis; they lacked much of the information needed for more rational decision making; the declining economic circumstances made shifting resources much more difficult; the power of consultants was undiminished by the planning system, and power politics continued to influence plans. During the 1980s, the NHS planning system was reduced in operational complexity, but the centre became increasingly concerned with the failure to achieve better use of resources, so that new measures were created to try and hold the field authorities to particular targets: financial targets such as cost improvement programmes or policy targets such as reduction in waiting lists.

Disjointed incrementalism

The rational model displayed a centralist outlook which, in order to control the whole of a process needed to achieve an objective, emphasized the importance of centrally located strategic coordination. This was challenged politically and ethically by writers such as Hayek (1944) and Popper (1957), and from a public administrative viewpoint by those who saw decision making as a process of bargaining and negotiation.

The most radical challenge to rational decision making has come from Lindblom and colleagues (Lindblom, 1959, Braybrooke & Lindblom, 1963). In part, Lindblom's arguments were based on a recognition of the limitations on rational decision-making similar to those advocating a modified rational model. He, however, drew a totally different conclusion from those limitations and adding to this a distrust of centralised power, saw attempts at rational comprehensive decision-making as wrong and perhaps dangerous.

Lindblom's first attempt to sketch a model was successive limited comparisons. The key features of this model were an acceptance of the interaction of values and possible courses of action; limited means-ends analysis; acceptability of policy as the key test of its 'correctness'. The overall intention was to describe how people actually made decisions, showing a model stripped of complex demands on resources, capacity to handle a multiplicity of factors and carry out complicated calculations. The essence of this model was that decisions involve incremental change from existing policy and that therefore only those options which represented incremental change needed to be considered. Further, comprehensiveness was achieved insofar as every interest in society had a watchdog to look after its interests so that the consequences of policy proposals became the subject of concern to those affected by them, not merely the subject of a central analysis.

This model was further elaborated in *A Strategy of Decision* (Braybrooke & Lindblom, 1963). Successive limited comparisons now became disjointed incrementalism. The authors added to exposition already given, elaborating further their contentions regarding the interaction of facts and values, means and ends, emphasizing that the strategy, far from being conservative, was actually adapted to continuous change as positions, knowledge, experience and values shift. The model was also said to be characterised by its remedial nature - it formulated policies by moving away from identified inadequacies rather than towards known goals. Finally, it was fragmented; analysis of policy proposals took place in many different centres and by many different groups, all of whom could be affected by proposals in a variety of ways, and most of whom were in imperfect communication with each other. This latter point might be the authors' retort to those who argued for the construction of a social welfare function; in their view, each person (or group) decided for themselves whether and to what extent they benefitted from policy proposals.

Further modification to incrementalism was suggested by Lindblom in 1979. He introduced the idea of 'strategic analysis' which included "analysis limited to any calculated or thoughtful chosen set of strategems to simplify complex policy problems." He was now willing to consider longer term decision making based not on incrementalism but on "broad ranging often highly speculative and sometimes utopian thinking about possible futures...." (1979, p.522).

Various critiques have been made of Lindblom's writings - that it encouraged conservatism in policy-making, that it favored powerful and establishment groups or interests rather than recognising the needs of unrepresented interests; that disjointed incrementalism could not cope with technically complex issues or rapid change more frequently found in modern societies; that it represented a descriptive account of American pluralist politics but might have poor prescriptive relevance for other political systems. The significance of his work lies not in the detail but in his attack on an ideal of rationality as the form of problem solving:

> The strength of Lindblom's work lies in the way in which, both directly and indirectly, it illuminates the nature of a rationality of collective, i.e., political action, the crucial feature of which is its very collectivity. In the Lindblomian paradigm of public policy making, no one individual or group has a monopoly on truth, information or analysis. And the power to determine the ends and means of public policy is widely, though of course not equally, shared." (Gregory, 1989, p. 147).

At a time when expertise was highly valued in society, Lindblom reasserted the much older economic value of each person (or group) deciding what constituted maximum satisfaction by striking agreements for themselves with others. Lindblom's work is therefore particularly pertinent to an understanding of interagency collaboration needed to implement community care policies (see Glennerster et al, 1983). The understanding upon which disjointed incrementalism was based essentially underpinned the Audit Commission and Griffiths reports, and was enacted in the NHS and community care reforms brought in at the end of the 1980s.

The new approach to planning had the same objective, of achieving a better balance between use of resources and needs, and or more efficient servicve delivery. The rational-comprehensive planning system went out and in its place came more limited attempts to match needs and services through a health services market (Cm 555, 1989). Services would now be provided through contractual arrangements, and competition and financial incentives would ensure efficiency. Central government no longer needs to issue detailed policy advice on how services should be developed and at what rate; it is now the responsibility of the "purchaser" to assess local health needs and to contract for services to meet these. What remains to be tested are the consequences of a health services market, and whether some form of social planning will again be seen as necessary.

Other approaches to decision-making

The range of difficulties that organisations have had in attempting to act "rationally" in their decision-making structure has led to a recognition of other models of decision-making. March, for example, argued that theories of choice have ignored that decision-making may serv~~c~~e other functions than selecting the best alternative. (March, 1982). Conflict in decision making is often ignored or "managed" in a trade-off situation in rational decision-making; but there are models of decision-making which allow decisions to be made without resolving conflicts, such as in the political process, or in market situations or exchange or alliance formation; accommodation rather than efficiency is the key factor. Similarly, rather than seeking to identify alternatives for choice, the "correct" rule might be looked for, so that appropriateness becomes the criterion of decision-making.

March further considered the confusion and complexity surrounding decision-making. Any decision-situation was likely to be embedded in a web of changing circumstances, so that the idea of a hierarchy of control and a linear process of sequential activity was seen as singularly inappropriate. The decision-makers were themselves involved in many other activities than one decision-making situation; March argued that it was important to understand how one decision situation fitted into the requirements and demands of other facets of individuals' and groups' work. In these types of situations, problems and solutions may be related through temporal proximity, rather than hierarchical or consequential logic. March also notes that decisions are not always connected to outcomes but to other factors: to justify action; to distribute praise or blame.

Rosenhead takes up the idea of the complexity of decision-making situations in relation to the inadequacies of rational-comprehensive planning to cope with that range of complexity of what he calls "messy" situations (Rosenhead, 1989). These are often situations requiring strategic decisions, having general rather than specific objectives and high levels of uncertainty relating to unknown or unknowable factors, or situations in which conflict is prevalent, or in which problems are interdependent, so that a solution to one must interact with solutions to others.

These types of decision-making situations are the antithesis of the ideal context for rational-comprehensive decision-making; Rosenhead's book is concerned to show that logical and systematic techniques are available to help participants manage the process of decision-making rather than solve problems. What is important here are techniques that help shape perceptions of issues or the identification of threats and opportunities, remain sensitive to the organisational environment, and promote participation as a means of building a consensus. All these factors indicate that the objective of decision-making has changed from a best-solution situation to one in which change comes about through commitment to shared perceptions of issues and opportunities, taking into account the many differences in values and interests which may exist. As Rosenhead points out, this type of process is helpful within organisations, but even more significant for inter-organisational decision-making.

Implementation

Planning in only part of managing change, and is of little value if activity stops with the production of a plan or policy statement. The next issue for consideration is therefore implementation.

Compliance and control

The traditional assumption is that organisations exist to carry out the functions assigned to them, in whatever way such functions are legitimately assigned. The superior-subordinate relationship of hierarchical organisations is the cornerstone of implementation: the function of the subordiniate is to carry out the commands of his superior. This view would certainly accord with Weber's understanding of the nature of a bureaucracy. Weber would perhaps stress the legitimacy of issuing commands, and the acceptance of that legitimacy through a recognition of rules circumscribing the exercise of that authority. But in essence orders are given and officers act according to their roles. Obedience is owed because the command is legitimate. Implementation is acting in one's assigned role (Weber, 1947).

This view would also to some extent be shared by Dunsire. He maintained that implementation was a construct, not a process of work:

> "From their own viewpoint, the workers in the Ministry are just doing their job. It is the result of the way their jobs have been specified and of the procedures that have been laid down linking those jobs, that decisions of any particular kind can be implemented - whether as a 'one-off' or as a regular routine" (1978, p.151)

In writing about "perfect implementation" Dunsire thus assumed that a decision had been taken at an appropriate level, that it was transmitted unambigously to the level of operations where it was acted upon. But even in studying implementation as an abstracted process, Dunsire recognised that 'imperfections' were inevitable - lack of information, the need to monitor to ensure adherence to instructions, and unforeseen circumstances. Secondly, in public bodies in particular, there was a need to ensure that procedures were being correctly adhered to and this entailed organisations having multiple goals, bringing with it the potential for conflict of goals. Dunsire therefore introduced the idea of control as a corollary to that of implementation.

Yet the controls which Dunsire identified were surprisingly weak, depending largely on the willingness of subordinates to accept rules. Dunsire was left with the importance of subordinates becoming 'self-regulating' - that is, to monitor and modify their behaviour themselves to achieve the organisation's objectives, as the means of controlling people.

A slightly different approach by another organisational theorist was aimed at identifying the difficulties inherent in the structure of bureaucracies which lead to policy failures. Hood started with a definition of "perfect administration" as a condition in which "administration proper would have no limiting effects on policy outcomes" (1980, p.6) and suggested five structural and procedural features which would comprise a system of perfect administration:

1. unitary line of authority - no conflicts;
2. uniform and clearly ascertainable objectives for all components of the bureaucracy;
3. perfect obedience or perfect administrative control to ensure objectives were implemented;
4. perfect coordination between sub-units, perfect information about current operations and capacity to issue unambiguous orders;
5. the absence of time pressure.

Hood then went on to identify three types of limits: external conditions (such as inadequate resources or political unacceptability of implementation); quasi-administrative limits (the deliberate creation of difficulties ofimplementation); and administrative limits (problems in execution). His particular perspective on how administration of the imperfect variety, that is, that which was likely to occur in the real world, might contribute to policy failure was the degree of hostility to be found in the environment:

"...recalcitrance is the raison d'etre of administration, as we have already pointed out: one 'administers' because there is or may be resistence in the system. But recalcitrance is also a limiting factor, indeed <u>the</u> limiting factor in many cases." (p.192)

Control was a major theme of Hood's writing, as the means of dealing with recalcitrance. However, as this theme was explored, it became evident how difficult it actually was to exercise control. Like Dunsire, the available means of control which Hood identified were far from guaranteeing their effectiveness in achieving compliance. Most means of control became vulnerable in a hostile environment - to attempts to subvert or to be counter-productive or to produce inefficiency, undesirable outcomes, incompatibilities in levels of control, loss of flexibility. His general conclusion was that the various means of control often had high costs attached to them and were difficult to apply with- out increasing opposition.

Similar conclusions were reached by two other authors approaching organisations from an economic-model perspective. Both Downs and Tullock assumed that self-interest was the prime motivating factor of people in bureaucracies as elsewhere. Bureaucratic processes and objectives were thus subject to distortions of different kinds as officers sought to interpret commands and communications in ways which reflected best upon their own interests and positions, and furthered their own personal goals. If this was the basic assumption about people in bureaucracies, the problem was easy to define: how could those at the top ensure their commands were obeyed and work carried out that was in <u>their interests</u>, and not that of their subordinates.

Tullock had practically no answer to this problem; he saw distortion at all levels of hierarchy. Downs had a more structured approach. He too accepted that officers in bureaucracies acted out of self-interest and that it was self-interest which resulted in biased behaviour by officers to the extent that they responded favorably or officers to the extent that they responded favorably or disproportionately to actions which reflected positively on themselves and negatively to those which showed up shortcomings or deficiencies. Biased behavior distorted the transmission of information in any direction, in advice-giving or evaluative situations, compliance with commands from superiors and in the willingness of officers to perform their roles to the fullest possible extent. Such biases became manifested in bureaucratic activity through the exercise of discretion which each official used in fulfilling his functions within the hierarchy:

> At every level there is a certain discretionary gap between the orders an official receives from above and those he issues downwards, and every official is found to exercise discretion in interpreting his superior's orders" (p.134)

The potential for deviation was therefore built into the very nature of bureaucratic processes. To counteract the effect of the interjection of personal goals into official goals, Downs identified three principles of organisational control:

> "Law of Imperfect Control - no one can fully control the behavior of a large organisation."
>
> "Law of Diminishing Control - the larger any organisation becomes the weaker is control over its activities exercised by those at the top."
>
> "Law of Decreasing Coordination - the larger any organisation becomes, the poorer is the coordination among its actions."

The actual process of controlling the actions of subordinates was that of monitoring their performance, with several techniques being identified to generate information unbiased by the personal interest distortion. But Downs also pointed to the Law of Counter Control:

> "The greater the effort made by a sovereign or top-level official to control the behavior of subordinate officials, the greater the efforts made by those subordinates to evade or counteract such control." (p.147)

There are many examples of other writers who have treated implementation in this way and offered advice for improving implementation processes. Sabatier and Mazmanian (1979) produced five conditions for policy implementation to occur successfully, such as a sound theoretical relationship between objectives and outcomes, unambiguous directions, adequate managerial and political skills by main implementers, and so on. Solesbury (1981) wrote about strategic planning, based on an understanding of the methods of military strategy, including guidance on communication, target setting, intelligence gathering, resource allocation. Whilst recognising the poor performance of strategic planning, he was convinced that it could be improved so that it would connect better with day to day decision-making. Van Meter and Van Horn described a model of implementation based on features of six variables affecting its outcome (1975).

A similar approach to implementation but in relation to policy carried out in an inter-organisational setting was used by Pressman & Wildavsky studying the implementation of federal support to employment programmes in Oakland, California (Pressman & Wildavsky, 1973). For them, the basis of the "implementation gap" was twofold: the failure to create links in a causal chain of initial conditions, actions and outcomes; secondly, the failure to create adequate reciprocal relationships between organisations required to work together to achieve the desired outcome. Through their study they came to see failure inherent in a political situation which spread policy formulation and implementation among different agencies each with their own agenda.

So, having started with an ideal model of bureaucracy in which commands of superiors became the work of subordinates with no specialised intervening processes, further analysis has shown that 'implementation' for a variety of reasons, is far from automatic. Despite the formal roles, expertise and authority of superiors, the exercise of control over subordinates and their work has been shown to be far less effective than is commonly assumed. What Elmore called "the noble lie of conventional public administration", that the policy maker controls an organisation's political and technical processes, in fact masked a range of real world problems (1980).

The above writers discuss policy implementation as an abstract activity, giving no recognition to the complex set of relationships existing within or between large bureaucracies and the conflicting demands made upon them, through which policies will be "implemented". Rather than seeking to impose control over what is largely uncontrollable, other writers have proposed that the task of a policy-maker/manager wishing to see policies implemented should be concerned to create an environment in which subordinates (or equally other organisations) were encouraged to act in ways which would support implementation.

The task of management, according to Lynn, is largely centered around integrating the personal interests of individuals or groups with the objectives of the policy-maker; Lynn wrote about the "structure of purpose" created by individual executives (Lynn, 1989). To achieve this, the public service manager should use a variety of techniques: incentives and discentives and other reward systems created through using organisational processes, rules and structure; symbols and shared meanings; political skills in negotiating or promoting cooperative behaviour; skillful spotting of opportunities for change. Control should be exercised not directly over people but indirectly through manipulation of the environment and organisational processes to encourage certain types of actions and discourage others. This argument is supported by Peters & Waterman (1982) who see innovation and efficiency coming from a management structure that has a clear underlying and tightly adhered to value system, along with maximum autonomy allowed to individual product units:

> "Organizations that live by the loose-tight principle are on the one hand rigidly controlled, yet at the same time allow (indeed insist on) autonomy, entrepreneurship, and innovation from the rank and file" (ibid, p.318).

What has been discussed so far is often referred to as the "top-down" model of implementation (.e.g.Hunter, 1980, Ham and Hill, 1984, Gill and Thrasher, 1985). It is characterised by an assumption that policy is "fixed"; once agreed, it stays static during implementation. Secondly, it is characterised by an assumption that policy is implemented by managers issuing instructions to subordinates; implementation is a problem of achieving compliance through operating the right controls or incentives. If implementation fails to occur, it is due to poor management - ambiguously phrased instructions, poor communications (e.g. Nixon, 1980) etc. Thirdly, it is characterised by an assembly-line view of policy - implementation-change (action), each following in a logical sequence (Barrett and Fudge, 1981).

Dealing with conflicting objectives/interests

Arguments against a "top-down" model of implementation run parallel to arguments against rational comprehensive planning; both require a degree of centralist control unlikely to be achievable (or desirable). Other writers have challenged these views from different stances.

Lipsky, for example, wrote about policy-making at the service delivery level of public service organisations (Lipsky, 1980). His study of street-level bureaucrats, "public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (p.3) showed such workers as caught between the demands of managerial efficiency and effectiveness, and the impact of their clients' reactions to the allocation of benefits they made. The nature of the tasks they have to perform required that they be allowed considerable areas of discretion; it was largely this discretion which enabled them to evolve their own "policies": "the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out" (p.xii). In this tpe of situation, 'policy' is used descriptively rather than in a normative sense; the reality is that there may well be an 'implementation gap' with respect to the policies of the organisation.

A more explicit model of implementation needs determining the policy process is Elmore's idea of 'backward mapping' (Elmore, 1980). This model draws attention to the reciprocity between informal (deriving from skills, expertise and proximity to the performance of essential tasks) and formal authority within an organisation, and thus to the ways in which complex organisations go about solving problems. Backward mapping starts with the point at which behaviour must be modified to create a new policy intervention and then looks to the kinds of stances, operations and necessary resources at each higher level of organisation needed to bring about such changes. Instead of success relating to hierarchical control, it is related to the capacity of organisations to maximize discretion at the point at which a problem occurs and is identified as the ability of people at one level to influence the behaviour of people at other levels of the organisation.

Both Elmore and Lipsky remind us of the importance of considering the personal interests and objectives of workers furthest from the point of official policy making but closest to the point of policy delivery, providing an important perspective on implementation. In the same article, Elmore went on the discuss bargaining, the link between that and the problem-solving capacity of organisations being the amount of discretion allowed to workers. For bargaining to be effective, he argued, real stakes are required, with the terms of bargains being left fluid; there must be a real and valuable payoff. "To acknowledge that bargaining is essential to the process of implementation is to accept the consequence that policy outcomes will never be discrete, determinate end points that can be measured and objectified" (ibid. p.611).

Bargaining may take different forms. Bardach, for example, saw implementation as the "strategic interaction among numerous special interests all pursuing their own goals, which might or might not be compatible with the goals of the policy mandate" (Bardach, 1978, p.9). Most participants to this interaction would be independent of each other and could be lured into contributing to the process only through persuasion and bargaining (ibid, p.37). He proposed the concept of 'games' as a means of understanding the implementation process in terms of interactions:

> "It directs us to look at the players, what they regard as the stakes, their strategies and tactics, their resources for playing, the rules of play (which stipulate the conditions for winning), the rules of "fair" play (which stipulate the boundaries beyond which lie fraud or illegitimacy), the nature of the communications (or lack of them) among the players, and the degree of uncertainty surrounding the possible outcomes. The game metaphor also directs our attention to who is not willing to play and for what reasons, and to who insists on changes in some of the game's parameters as a condition for playing."

(ibid., p.56)

Bardach too saw 'control' at the centre of the implementation process, but for him, control is exercised through bargaining strategies. The games which Bardach identified, such as *easy money, pork barrel, the budget game, piling on, up for grabs*, all indicated that organisations use games not as give-and-take but a winner-take-all exercise, an attempt to maintain the autonomy of an organisation rather than to interact cooperatively with others.

This view of organisations is not far from Benson's analysis of interaction as a political economy (1975). Benson saw organisational interaction as a quest for both resources and authority, which would essentially be hostile and competitive until an equilibrium which realistically reflected the balance of strengths among organisations was reached. Benson saw the interaction of organisations occuring at two levels, the substructure concerned with the environmental forces affecting the pursuit of money and authority, and the superstructure concerned with interagency sentiments, such as agreement on the role of different organisations and agreement on appropriate approaches to common tasks.

Lindblom also described agency interactions in a similar way, under the name of partisan mutual adjustment (1965).

His concern was to show that coordination is possible without a central coordinator or a policy for coordination or even a common purpose. Lindblom deliberately ruled out a "cooperative and deliberate search" for common criteria to govern interactions; partisans act only when it is in their own interests to do so, and they act by adjusting their actions to their assessment of the actions or intentions of other organisations. Furthermore, the decision-making process is the interaction, as is the implementation process. There is no requirement of a separate control system to ensure implementation; each body will 'implement' its decision because that decision was made based on its own self-identified interests.

Conclusion

What the succeeding chapters will show is the extent to which the Darenth project reflected these different views about planning and implementation. We have already mentioned the attempts of central government to introduce rational-comprehensive planning to the NHS in the early 1970s. In the first phase of the Darenth project, up to the time of the 1982 NHS restructuring, regional officers faithfully followed the planning guidance given by the DHSS and acted as a strategic coordinator for the Darenth project. They proposed a model of service, consulted districts, and then produced a compromise model in light of comments received; on this basis they expected districts to plan local services. During the next three years, regional officers reminded districts of their obligations to plan services on this model, but were able to convince no more than half the number of districts to comply.

The second half of the project reflected the planning and management literature which emphasized the "tight-loose" principle (Peters & Waterman, 1982). Regional officers, and districts officers as well, used the Darenth project as a learning process to understand why so little was accomplished in the first half of the project, and how they could work together to achieve the common objective of closing the hospital whilst ensuring local diversity in service provision was respected. Regional officers in particular were flexible and realistic enough to adopt a different approach to implementation and planning which was based on a shared vision of service provision with districts and informed bargaining. This change to the planning and implementation approach adopted by the Darenth project will now be traced in the succeeding chapters.

Chapter 4

Research Methodology

The research on the Darenth Park hospital closure was originally commissioned by the DHSS at the request of the Darenth Park Steering Group. The DHSS at that time (1978/9) was in the process of developing research relationships with field authorities and welcomed an opportunity to be responsive to a request from an RHA, particularly as the topic would be of interest to other authorities. The research was requested because regional officers saw the uniqueness of the closure situation as one worthy of study - other authorities could learn something from Darenth when facing similar types of situations. Several topics were identified for research, but in the event, only two resulted in research projects.

The first Darenth research project, focussing on client assessments, had already begun, and DHSS research management wished to fund a second one on the planning activities involved in the hospital closure. In particular, the Darenth project was presented as a joint planning exercise between the area health authorities and social service departments, with the region as an interested but neutral coordinator.

A project implementation study

The Darenth project was an attempt to implement a new policy. The objective of the research was to learn from this experience: what worked and what didn't; what succeeded and how could other authorities benefit from that knowledge. As such, it followed a tradition of social policy research concerned with the detailed study of local policy implementation (e.g. Donnison, 1965, Dearlove, 1973, Barrett and Fudge, 1981, Glennerster et al, 1983).

The nature of the activity to be investigated to a large extent determined the type of research - a mainly qualitative in-depth study of a particular situation, to include an account of events and an analysis of successful and unsuccessful strategies. This approach to the research task seemed appropriate for several reasons.

First, the novelty of the situation made it difficult to predict what the research would reveal. No one had tried to close this type of hospital before, nor was the coordination of so many districts on a tight timetable a common occurrance in the NHS.

Secondly, the research extended over a 10 year period of time, and that emphasized what would have been equally true of a much shorter project, namely that in building up an understanding of a particular situation and how it developed over time, it is important for the research to stay fluid, able to respond to the range of unpredictable events and interventions likely to occur within the project and within the environment in which the project took place. The research project had no control over the Darenth project - that belonged to the field authorities who decided (in part at least) what would happen. The desired outcome - closure of the hospital - was by no means inevitable and the research had to be able to pick up on successes, failures, purposeful activity and diversions. Given all these features, it was important not to decide in advance what was worth studying, concentrating strictly on those features and missing reality.

Both these factors led to the importance of an opportunistic approach to research activity (Buchanan *et al.*, 1988), to respond to the diversity and unpredictability of activity over time, whilst coming out at the end with an account of events and the underlying logic of events which made sense to both the participants in the project and to the wider audience of health and social services practitioners and mangers. This approach is also supported by Silverman, who notes that sociological research is largely generated by chance circumstance, and that the published version of research "reflects a reconstructed logic with a problematic relation to how the research was carried out, and more certainly, to how it was conceived. . ." (1985, p.4). In an exploratory study, flexibility is all-important.

A third factor supporting a minimally-structured approach was the need to ensure that the multiple perspectives this project was expected to generate could be allowed to express their own points of view in their own terms. The participants in this project came from different professional groups, held different managerial or advisory positions and in many cases, worked for different types of organisations. It seemed important to capture how these differences were manifested in different viewpoints about the Darenth project - its values, how it was managed, how success would be judged, where conflicts or tensions lay (Bresnen, 1988).

If this approach enabled the uniqueness of the Darenth project (at least at that time) to be displayed, it also brought with it weaknesses, namely, doubts about the representativeness and reliability of the 'study'. It was clear that the research was not intended to produce a model or blueprint of how to close a hospital. But from the response of officers of other health and social services authorities, and of other researchers engaged in similar types of studies , the issues raised in this research have been similar to those found in other projects. Even if events differ in many or all respects, the consideration of issues - the factors needed to be understood, and the reaction of people to these issues - point to an underlying similarity of structures and processes. It is the understanding of these which has made this research project of use to other authorities.

As will be described below, accounts of interviews and reports on particular events or issues were fed back to participants for them to comment on accuracy. That the research reported represents an agreed version of events, and largely an agreed interpretation of events by the actors in that study should count as an indicator of its reliability as an analytic narrative of the Darenth project. Peer judgement has served as a measure or reliability and in these circumstances this may be as much as can be expected.

Boundaries of the project

Increasing familiarity with the Darenth project showed that although the project formally began in 1978 and extended over 10 years, in order to fully understand substantive issues and the positions taken by staff, it was often necessary to go beyond the immediate issues of Darenth Park and become knowledgeable about the external issues which impinged on the political and administrative world in which staff of mental handicap units lived. A sample of such issues would include:

> the development and growing acceptance nationally of normalization as the right way forward as a philosophy of care;
>
> growing financial pressures on districts and the region;
>
> central government regulations such as changes in social security regulations, or methods of financing community care;
>
> other service development needs of districts such as pressure on acute services, or on region such as maintaining RAWP redistribution, maintaining the capital programme or developing a mental health

strategy;

NHS management and organisational changes.

Such issues often formed the background to activity in mental handicap service developments, but without awareness of these, several of the key decisions of the Darenth project would make little sense. The context was necessary to the understanding of the activity.

Likewise the time identified as the beginning and the end of the project could also be justificably extended. The Darenth project, as indicated in chapter 5, grew out of an existing concern for mental handicap services within the region; as an example, the first decision to close Darenth Park was taken in 1973, and that decision coloured decisions taken about the hospital for the next five years. And the discharge of the last patients from the hospital was not the end of the story - the hospital had to be closed down, buildings made safe and the site itself eventually considered for another purpose. Some clients went into temporary accommodation - districts had to go on developing services after the hospital closed to accommodate these clients, and begin to find ways of making available facilities to meet the needs of people who could not not be admitted to Darenth.

Methods of research used

Written material: Initially, considerable reliance was placed on written records of what had already occurred in the history of the Darenth Park project, and how existing services and facilities had been developed. Regional officers made available their extensive records of RHB/RHA minutes, the minutes of the Regional Planning Group (RPG), the records of the Regional Strategies Sub-group on mental handicap services, all capital planning team minutes and working papers (including six volumes of a file on the development of Grove Park Hospital), all papers relating to the visits of the HAS to Darenth Park in 1970 and 1972, reports from ad hoc working groups such as the Darenth Park social services liaison group, the regional advisory team report of 1970 and a working group set up in 1976 to review the position of Darenth Park.

In local health authorities and social services departments, access was granted to a similar range of committee minutes and working files: AHA and DHA minutes and working papers, JCC, joint officer group and joint planning team minutes, district planning team papers, DMT papers and project team papers. Those social services departments which had special planning groups for people with mental handicap made available the minutes and working papers of those groups; all social services departments allowed access to files on special services and facilities for people with mental handicap - hostels, day centres, etc. After 1982, most districts also made available written records of unit management team meetings and other similar records when requested.

No request for access to written material was refused. In most cases, requests for access to files were dealt with by staff, but in one local authority, a written request was required to be submitted to the social services committee. Once this had been agreed, however, the researcher was stood in front of the filing cabinets and told to take whatever was wanted.

Documentary material such as minutes or notes of meetings represented the "official" view of what was happening. As such they were valuable as much for what they did not report as for what they said, and the amount of space allocated to different topics and discussions. They proved especially helpful in interviews, by asking interviewees whether minutes reflected the feelings of a meeting as well as its content

Observation: A significant part of the field work consisted of attending a wide variety of meetings, some regularly and others on a more ad hoc basis.

Meetings which were attended regularly included the Darenth Park Steering Group, the Regional Mental Handicap Steering Group, the Leybourne Grange Steering Group, all capital project teams for the districts, joint care planning groups for mental handicap services in four districts, district and social services planning teams, mental handicap liaison group in Greenwich, the Archery House commissioning team in Dartford, Bromley moving on committee, Bexley consortium, Dartford UMG, Dartford service review group. These groups met either bi-weekly, monthly or quarterly.

Those groups attended on an ad hoc basis included RHA or DHA meetings, social services committee meetings as relevant, other districts' UMG meetings and a large number of one-off office meetings focussed on specific issues.

Attendance at meetings served several purposes. It gave a picture of what was happening (and not happening) and thus provided pointers as to what issues needed to be taken up in interviews. It provided an opportunity to get to know staff involved in planning and managing services, what their attitudes were towards various issues, what their relationships were with each other and identified those whom it would be useful to interview. Observation at meetings gave the researcher a "feel" of what was going on in a way that a written record of a meeting could not do. At one Steering Group meeting, as an example, one district reported some local opposition to the planning guidance issued by the Steering Group; the look given to that district officer by the chair of the meeting expressed all the frustration and irritation felt by regional officers towards districts which were thought to be "dragging their feet" at accepting standard forms of provision and instantly demonstrated all the misunderstanding and, at that stage, lack of interest in the problems faced by districts.

Of equal importance to the success of the research, it gave those involved with the project a chance to get to know the researcher. Schatzman and Strauss write that people "want to be observed by a partly known person, not a stranger" (1976, p.60) and in the experience of the researcher, this is critically true. Staff remained guarded in their comments until they knew what kind of a reception more critical statements would receive, whether they would be treated confidentially. Attendance at meetings made the researcher a familiar face and provided topics for discussion after meetings when the "getting to know you" phase was being played out. Success in this area was being invited to meetings not previously known about.

The researcher also undertook two weeks of observation on four of the five wards which formed the Dartford and Gravesham sector of Darenth Park hospital. This included attending both the morning and afternoon shifts. The purpose of this was to get some idea of what actually happened on the wards - what staff did, what residents did - as a means of getting a better sense of how the hospital functioned and what staff on the wards thought about the changes ahead of them. Almost all staff were very forthcoming in expressing themselves on all aspects of wards and hospital management. The researcher seemed to be the only one concerned about confidentiality; almost all said " and I hope you tell the managers what I said", an indication of how much they thought their views were listened to.

"Loitering" (Hammersley and Atkinson, 1983): This concept embraces ways of making the acquaintance of people by frequenting their place of work, leisure or some other venue and getting to know them casually. Loitering in this project was using files in other people's offices, getting lifts to and from meetings, having lunch together or any other quasi-social quasi-work occasiion which allowed opportunities for sizing up and swapping stories. Loitering actually became a valued means of learning what was going on informally, of picking up the politicking that would never be mentioned at the more formal meetings, and seeing personalities in action. It enabled, on occasions, the researcher to be in the right place at the right time, to overhear phone conversations, for example and later ask for an explanation, and to hear someone come back from a meeting and complain with irritation about the lack of understanding being shown by other officers. Opportunism ruled and the research gained from it.

In order to maximise the benefits from being around, it was necessary to have something to trade for new information. As a rule, only one senior person from each district attended the Darenth Park Steering Group so that the researcher was able to build up a store of information on what had happened there to "exchange" with other staff in districts for stories about incidents or situations not witnessed (these meetings were not confidential in any sense and according to the chair of the Steering Group, there was no reason not to talk about them). The very casualness of these encounters encouraged such exchanges, and also demonstrated quite clearly the enormous distances between the different levels of organisation and the fantasies each level had about the others.

"Loitering" also made plain the importance of the researcher being willing to talk about herself. Staff asked, and it would be unhelpful and unsocial not to answer. Staff asked about work and personal life, just as they were asked - not always for research purposes but certainly for the purpose of establishing and maintaining social relations with participants in the project. Burgess (1984, p. 105) relates how his avoiding answering questions about his views on schooling, his teaching experience and so on would have ruined relationships with the teachers and pupils of the school in which his research was located; he called this approach interview-conversations. Spending time around people creates a sense of "social obligations" which if not recognised could ruin the research. The purpose of limited involvement and self-revelation is to make it possible for participants to develop trust and confidence in the researcher, enough for them to reveal their own feelings and views about unofficial understandings of events. What prevents the researcher from becoming captive to the biases of one participant is the cross- checking of accounts from the perspectives of all participants.

Interviewing: The understanding gained from the files, meetings and informal discussions were used as the basis of interviews. Interviewees were asked to give their understanding of events over a particular time or about a particular current situation. Histories of how services had been developed were given to them to comment upon, and these comments - clarifications, expansions or contradictions - formed the basis of further interviews. Some interviews were held on a regular basis and were written up and used as the starting point of the next round of interviews. Others related to specified events or functions and were intended to ensure that views were recorded as comprehensively as possible. None of the interviews used formal structured questionnaires.

Interviews were held with regional officers associated with the Darenth Park project and several others involved less centrally; senior managers within mental handicap units in districts; senior managers and consultants at Darenth Park hospital; staff within social services departments, including directors of social services; CHC secretaries and officers from local Mencap groups.

The interviews became a significant means of challenging, expanding or modifying the more "official" accounts of events. It was also through the interviews that the interrelationships between the Darenth project and other district or regional issues became apparent. The interviews also provided evidence for the multiplicity of views held within the same level of organisation. Interviews thus provided a wealth of material for making sense of events.

The issue of confidentiality was not a major concern. Interviewees were always informed that the interview notes would be seen only the researchers and the interviewee. Most interviewees were keen for their views to be known and were unconcerned that their identity might be revealed through written accounts of events. In a project of this kind, where almost all of the senior participants are quite well known to each other, any written account which adequately reflected the views of participants would inevitable identify them to each other. This would not of course be so to a wider audience.

Interviews lasted between 30 minutes and three hours or so, with the majority being about ninety minutes. No tape recording of interviews were done but notes were written up immediately after an interview to draw on a clear memory of the interview to supplement notes taken during the interview. No request for an interview was refused.

On-going relationships

Working on a research project for just over seven years, while not unique, is certainly unusual. It affords the researcher the experience of seeing a full development of a long term policy change and of becoming familiar with many of the unexpected opportunities and disappointments which together made the outcome something other than inevitable. Looking backwards towards the beginning may not give sufficient weight to those tendencies which at the beginning argued for a different approach; under such circumstances it becomes too easy for researcher and participants to discount those ideas and events of the past which distracted from rather than contributed to the object of the project. Being around for almost the entire period of the project enabled the final account to be something more than Whig history.

A further consequence of being part of the Darenth scene for so long was the sense of continuity the researcher gave to the project. By the end when the hospital finally closed, there were only three members of the Darenth Steering Group out of 15 or so who had been involved in the project longer than the researcher. The role of the researcher gradually became that of official historian of the project, and the researcher became part of the induction programme of new staff. The production of a report half-way through the project meant that there was an agreed narrative which was available for new staff.

The principal danger of this type of situation is becoming part of the establishment, of spending so much time with the managers of various services that it becomes diffficult to see the problems from other perspectives. A significant part of time was spent with regional staff managing the overall project; there was also much greater continuity of staff at this level than in districts, mental handicap units or in social services departments (over the years, all but one of the directors of social services changed). Many friendly relationships were built up over the years, and it was not always easy to remember not to get involved

Writing up

The method adopted consisted of writing up all formal interviews with individual participants or writing up an account of a particular event and then feeding back such notes to the participants, for their comments on accuracy and understanding. Such narratives often formed the basis of further interviews; they prompted memory or just stimulated more thought on a subject. In this way, an agreed version of events was built up over the years.

A written report on the first phase of the project was submitted to the Darenth Park Steering Group in 1984; the final report was sent in draft to directors of social services, mental handicap unit general managers and regional officers in 1989. In all but one instance, the comments made assisted the comprehensiveness of the report.

Chapter 5

The Darenth Park Project: an Overview

Darenth Park Hospital

Darenth Park was one of the older institutions in England built specifically for people with a mental handicap. The changes of name it underwent during its existence reflected the changes in public attitudes and policy to the care and treatment of mental handicap. It began as Darenth School for five hundred children in 1878. However, it soon found itself unable to place the children back in the community, and ten years after it was founded, it was accommodating over one thousand adults and children. In 1911, the Darenth School became the Darenth Industrial Training Colony, offering domestic, agricultural and industrial training for men and women. The colony was just about self-sufficient, providing much of its own food, furniture and clothing; it had its own water and gas supplies. In 1919 it was renamed the Darenth Training Colony, now with an emphasis on training "high-grade defectives". In 1936, the name was changed again to Darenth Park Hospital, at the time its management was transferred to the London County Council (LCC). In 1948 its management was transferred to the NHS.

In 1934, Darenth stopped admitting children, as other services for children in the area had begun to develop and the numbers at Darenth were declining. However, short-term care admissions for children were started again 1952, and long-term in 1954. The former was in response to a government circular, and the latter to local demands. In the early 1960s the region made special provision for children with mental handicap at Goldie Leigh Hospital in Greenwich, originally built as an orphanage in 1902 by the Woolwich Board of Guardians. It had then become, during the first World War, a hospital for children suffering from skin diseases. The use of Goldie Leigh for children from the catchment area meant that the only children at Darenth Park were from the Dartford area. When children at Goldie Leigh reached the age of sixteen or so, the policy was for them to then transfer to the adult facilities at Darenth Park.

Located on the outskirts of Dartford, Kent, the hospital had traditionally taken people primarily from the London area, but also on occasions accepted patients from the rest of England. In the early 1960s, the hospital was given a defined catchment area for the first time: the five London boroughs of Lambeth, Southwark, Lewisham, Greenwich and Bexley, and the north west part of Kent in which the hospital was located. Eight or so years later the region transferred to Darenth's catchment area the borough of Bromley, to relieve severe overcrowding at the second large mental handicap hospital in the region, Leybourne Grange.

The catchment area of the hospital contained quite diverse features. Politically the area ranged from strong left-wing Labour councils in the inner London districts to suburban Tories in Bexley and Bromley, and shire Tories in Kent. The political complexities of councils had a significant impact on the Darenth project - it coloured attitudes towards relations with health authorities, towards working with private and voluntary organisations including housing associations, and towards a general willingness to actively develop services. The various struggles with central government over constraints on local government finance diverted the attention of Labour authorities from service developments, but the constraints on finance would have limited that in any case.

Another important difference within the catchment area was the balance between private and public sector housing and the influence this had on districts' capacity to find properties suitable for use as group homes. (See Table 5.1)

The higher share of public sector housing in inner London should have made it more difficult finding properties, but this factor does not appear to have been a major problem and was balanced by the much higher cost of properties in the suburbs.

The inner London districts had a wider variety of active voluntary organisations to involve in both planning and service provision than existed in the suburbs. These included local branches of national voluntary organisations, parents' groups, a university settlement and other groups. This partially reflected the active encouragement given to such organisations by their local authorities - financial support, working party involvement and access to council committee meetings and officer time for advice and development.

The social and physical environment thus varied considerably: it showed in the style of clothing people work (Levis vs. suits for social services staff) and in the street culture - two very different worlds.

The 1970s

In the year that the report on conditions in Ely Hospital was published, Darenth Park Hospital had approximately 1500 residents. The hospital had more than 40 wards, of which 10 contained more than 50 residents. Ten wards were single storey pavillion wards; the rest were in two and three storey blocks, one male corridor, one female corridor. Long after wards became mixed sex, the corridor names remained in use.

In response to the Ely report, regional officers visited the hospital and began drawing up plans for improvements to living and working conditions there. Before much could be done, the Hospital Advisory Service (HAS) visited in February 1970 and again in October of that year. Poor communication between staff at different organisational levels and between different staff groups at all levels was a prime finding of their visits. A specific recommendation was that the wards, then organised in relation to the abilities of residents, be reorganised on the basis of local authorities, so that each consultant and his medical and nursing team would deal with residents with the entire range of abilities from one designated locality.

This "sectorisation" of the hospital into groups of wards matching the local authorities from which residents came took seven years to be achieved. The consultant staff were most resistant to change. The aim behind sectorisation was to make it easier for local authorities to work with their own residents in the hospital and it was hoped this would lead to easier discharge. That didn't happened. Social work support was the responsibility of the local authority in which the hospital was located, in this case Kent. What social workers there were assigned to the hospital came from Kent and they knew little about the facilities in the London authorities, and even less when a vacancy was available; they did not deal with the families of the residents. But with Kent social services having the formal responsibility, other local authorities did not get involved in the hospital.

Thus sectorisation did not bring local authorities into the hospital. Indeed it created two additional problems for the health service which later affected the Darenth project. First, local authority boundaries did not always coincide with district health authority boundaries. When districts became responsible for moving residents out of the hospital, some residents had to be allocated a second time to an authority. Secondly, sectorisation disturbed many friendships as residents were redistributed among the sectors on the basis of area of origin. When residents were allocated to districts at a later stage, district officers sought to negotiate with other districts to get friends back together again.

A second recommendation of the HAS report was that the Regional Hospital Board (RHB) give serious consideration to closing Darenth Park. Its buildings were simply not able to allow more modern methods of care to be given. Regional officers took this point seriously. Although they could not immediately agree to hospital closure (they did agree to work for its closure over ten years), they accepted that it would, at least, be an improvement to get some of the residents off site. They therefore began to look for places in the London area which could accommodate a significant number of residents. They very soon chose Grove Park Hospital.

Grove Park had been built in the 1890s as a tuberculosis hospital. It was located in about 15 acres of land, through which ran the boundary between Lewisham and Bromley. It was then being used as a chest, geriatric and thoracic surgery hospital but it had quite a number of unused beds. It seemed a simple proposition to transfer those patients to other hospitals and have the entire space available for Darenth Park residents from Lewisham. Grove Park presented certain advantages. It was available for NHS use; sites in London were always hard to find, certainly of that size. It would recruit nursing and domestic staff far enough away from Darenth so as not to compete with it. The distance also meant that it could make it significantly easier for relatives to keep in touch with family members in the hospital. The amount of land available would permit the construction of a series of purpose-built units so that the boroughs of Lewisham and Bromley could have services on the site.

Thus at the end of 1970 regional officers embarked upon what was intended to be a quick upgrading (largely redecorating) of existing wards of Grove Park. In reality it turned into a ten year project. Local health service officers and works professionals demanded high standards of conversion. Difficulties ensured, entirely predictable when an old building is tampered with. New fire regulations came into effect which necessitated additional work. The final wards of this temporary solution did not open until 1981; the new permanent units never got planning permission from Bromley Council.

Throughout the 1970s, regional officers also maintained their interest in improving conditions at Darenth. Various studies were undertaken to show how many residents would remain needing what types of facilities by the end of the decade. As a result of a review of conditions in Darenth in 1972 by a team of regional officers, new plans were made for improving conditions in the hospital, both physical environoment and staffing. Their report led directly to the RHB agreeing in January 1973 to work for the closure of Darenth Park, although over a very long period of time, as capital was not available for total replacement.

Another working party was set up in 1976 to review what had happened so far at Darenth, and to decide what the next steps were to be. A liaison group was established, also in 1976, with the social services departments using the hospital, as a means of improving communication and encouraging more discharges; neither of these groups achieved much.

Approach from Blue Circle

Towards the middle of the 1970s, regional officers were approached by the Blue Circle Cement Company with a view to the company buying Darenth Park Hospital because of the chalk which lay underneath the main hospital buildings. The chalk was worth only £2-3 million, but Blue Circle was willing to pay much more because of the proximity of the chalk to a newly built processing plant in the area. The chalk was needed to keep the plant fully operational. The Region was all for selling the hospital; here was the means of acquiring enough capital to actually provide for the complete replacement of Darenth.

Local protests, however, because of the number of excavation sites already in the area, led to a public inquiry in April 1978.

The Darenth Park Steering Group

If the public enquiry were to decide in favour of Blue Circle, the hospital site would have to be vacated by the 1st of January 1985, just six and a half years ahead. In order to be able to comply with this condition, the region decided to plan for that timetable and in June 1978 convened the first meeting of the "Darenth Park Steering Group".

Membership of the Steering Group, in addition to regional officers, consisted of representatives of the four area health authorities involved, the hospital, the health district in which the hospital was located, and two directors of social services, representing the seven directors of local authority social services in the catchment area. In its evidence to the public enquiry, the region had indicated its plans for accommodation as being one unit per district, with a day centre and staff accommodation also on site. The *Better Services* norms indicated that no district would require more than 180 places, and this was well within the *Better Services* guidance of no more than 200 residents on one site. Further, regional officers and the architects and works departments had been involved for several years in producing a standard design for mental handicap units which would incorporate some of the ideas found in *Better Services*, (especially more domestic environments) and be within cost limits. This design could now be advanced and made available to all districts, whose needs for new facilities would be similar. This way of proceeding would economise on both planning time, effort and staff, a major concern to the region. Standard units from the drawing board could be sited in each district; that was the hope.

Early meetings of the Steering Group and discussions with area officers outside meetings showed that this service model was unlikely to win approval. Informally it was made known that districts did not like what regional officers were proposing. It was seen as simply shifting the institution from Dartford to a new local site. It represented a centralised style of service. In short, areas and districts were unlikely to accept it. Pragmatically, it was also dubious whether sites of sufficient size could be found in each district.

The Capital Development Group, a sub-group of the Darenth

Park Steering Group, came up with a compromise model. Regional officers wanted to retain the economies of scale planning on a standard model would achieve, yet accepted the need to meet some of the local objections in order to get agreement to proceed. The Capital Planning Group recognised that a consensus did not yet exist as to the best way of providing services for people with a mental handicap. Any model proposed would have therefore to be flexible, to adapt to changing needs and changing perceptions of needs.

The new model consisted of a residential centre for each district. This would provide 72 residential places, in self-contained houses or flats, almost all single storey, of 6-8 places each. Staffing levels in the units could vary so that those residents capable of undertaking domestic activities could do so. Other facilities for staff and clients of mental handicap services would also be on site, requiring something like 15-18 acres. The remaining number of places needed by a district would be provided in 24 place hostels. Additional multi-district facilities would be required for those people with severe behaviour problems.

Consultation on this guidance with areas and districts resulted in group homes being added to the type of facilities to be provided. Regional officers were skeptical about this type of accomodation; if residents were capable enough to live in group homes then they should probably be the responsibility of a local authority. However, the new guidance was agreed and promulgated in the summer of 1979.

Some of the districts accepted the Steering Group's guidance - Bromley, Dartford & Gravesham (planning had already begun in 1977 for a replacement unit for the district's mental handicap services), Kings (now Camberwell), Greenwich and Bexley, although in the latter two cases, difficulties were experienced over adequate sites. Lewisham, already having Grove Park Hospital, did not need to plan further facilities.

At the end of 1979, the result of the public enquiry becaue known; permission was not given to Blue Circle. Although intensely disappointing, the Darenth Park Steering Group, local authorities included, agreed to carry on planning for the close of Darenth Park as so much momentum had built up towards this end. It was, of course, recognised that the closure would take place over a longer period of time because of the loss of external capital.

By 1982, when NHS restructuring removed the area tier, progress had been made in several districts but two districts rejected the planning guidance. Guys had set up its own development group for mental handicap services and was intending to provide services on a core and cluster model. St. Thomas's intended to develop community services first, so that there would be a network of services for residents to come back to. In effect, by 1982, only about half the residents in the hospital had an alternative place in the community planned for them; without further progress the hospital could not close.

Local Authority Involvement

Progress with local authorities fared little better. It was originally hoped that the Darenth Project would be a joint planning exercise, resulting in those Darenth residents not requiring health service care being transferred to the care of local authorities. This did not work out, largely but not solely because of finance. The local authorities suspected the region would profit from the Darenth site, and wanted to be certain that in taking over some responsibility they would receive adequate funding. When the sale of the site fell through, the local authorities still requested that region provide the full capital and revenue costs of service provision; without this they would not be willing to participate. Further, they wanted this to be "new" money, that is, something besides joint finance, for that they saw as being intended for people already living in the community.

A test case was put up by one local authority. When the region refused full funding, local authorities withdrew from the Steering Group and came back only after Care in the Community circular had been issued and the region had promulgated its own funding policy (see chapter 6). With one exception, no local authority made any significant contribution to the Darenth project in terms of local provision.

A Fresh Start

By the time of the NHS restructuring in 1982, regional officers were becoming increasingly concerned about the Darenth project. So far plans for only about 400 places had progressed enough to get into the capital programme; this represented about three-fifths of the number of places the region thought it would need for the hospital to close. The restructuring brought regional officers into direct contact at the Darenth Park Steering Group with district staff, and a clearer picture of what would be acceptable began to emerge. Restructuring also brought into districts staff who were more responsive to the emerging ideology of normalisation and had no commitment to previous planning guidance.

The problems the region faced included securing the commitment of each district to the closure of Darenth; getting agreement among districts as to how many residents each district would accept, and as part of that, how many non-catchment residents each would accept; and finding ways for the region to provide funds to districts to pay for the new services when the region's own development funds were being cut.

Commitment to proceed: Regional officers were able to use the substantial sums of money required by Darenth Park for upgrading schemes to get a higher degree of commitment from districts to actively work for the closure of the hospital. Because the hospital had no date for closure, district and hospital officers were concerned that standards be maintained at the hospital, and in particular, that conditions for those residents remaining in the hospital not be very much worse than the conditions of residents being discharged into new facilities in the community. Regional officers used this request for funds for Darenth as an opportunity to point out to districts that the same sum of money spent on facilities in the community would just about provide the remaining number of places needed to allow the hospital to close. No one could argue that it was wise to spend so much on the hospital and a tentative closure date of the first of April 1987 was therefore reached.

A new funding policy: In May 1983 the region produced its funding policy for mental handicap services. The resolution of the funding issue created financial certainty for districts and allowed them to get on with planning new services on a realistic basis (see chapter 6).

Allocating residents to districts: The funding policy helped to find a way forward to resolve the issue of how many and which residents would become the responsibility of districts. In part the problem was over those residents whose district of origin lay outside the catchment area. By agreeing a dowry for each person coming out of hospital, the distinction between catchment and non-catchment residents became less significant. Districts would now be funded for each person they received into district services (see chapter 6).

Specialist staff to prepare for closure: The capacity of the region to resolve the variety of problems it faced in working towards the closure of Darenth Park was considerably enhanced by changes which took place at the regional level. At the end of 1983, a regional staff training co-ordinator was appointed, a joint appointment between the RHA and Kent University.

Next, the region gained a mental handicap coordinator in April 1984. Previously, no extra administrative support was available to the Darenth project, one of the reasons planning had got stuck. One of the first tasks undertaken by the mental handicap coordinator was to review the capital programme and see what could be done to speed things up.

These two appointments eventually came together with other regional officers concerned with progressing different aspects of the Darenth closure through regional procedures to form a Task Force to support the Darenth project, and the staff involved in it. It was the Task Force that saw through the housing programme and negotiated between districts and the hospital.

A new form of provision: Districts used their membership of the post-1982 Darenth Park Steering Group to make plain their intentions to make greater use of general housing stock in the community rather than relying on purpose built units. The regional mental handicap coordinator was able to show other regional officers that relying on purpose-built units would not allow the hospital to close by the date set, because of the length of time needed to plan and construct these. Reliance on general housing stock would speed up the closure process and be more ideologically acceptable to districts. On this basis, a new housing programme emerged by the end of 1985.

Special needs policy: The initial plans for the Darenth closure included two 24-place multi-district units, one for severely handicapped people with challenging behaviour, and the other for mildly handicapped people with challenging behaviour. Post-1982 districts expressed the view that they wished to care for all their clients within the district whilst needing help to do so. From a working group set up to resolve a similar issue concerning services for severely handicapped people at Leybourne Grange hospital came the idea for a special development team, a multi-disciplinary group of staff to both devise a service model for individual clients and to work with local staff to develop strategies for helping clients.

For people with a mild mental handicap and challenging behaviour, a short-term unit was established at the Bethlem-Maudsley hsopital. The third strand to the special needs policy was the appointment of a development worker to identify service requirements for residents with sensory handicaps.

This new special needs policy was approved by the RHA in April 1985 although new services were not actually ready to receive clients until 1987.

Consultation on Closure

In February 1985 the Darenth Park Steering Group considered the results of consultation on the closure document for the hospital produced by Dartford & Gravesham Health Authority. The closure document had been sent to all local authorities and health authorities using the hospital, asking for their views. A National Development Team report on Darenth Park, issued in January 1984 had urged that all mental handicap hospitals in Kent be closed as they were too old and too unsuitable for modern care. This report made it more difficult for any to argue that these hospitals should be kept open. Objections to the closure document largely concerned the need for assurances about the maintenance of adequate care standards in the hospital before closure and in the new facilities in the districts after closure.

The consultation process on a hospital closure in this kind of service is paradoxical. Consultation cannot be undertaken until there is sufficient detail about the new services to replace the hospital so that those being consulted will know what is being offered in place of the hospital. Yet by the stage that is known, the process of closing the hospital is so advanced that the only possible response is agreement to close.

Goldie Leigh Hospital

Goldie Leigh was a mental handicap hospital for children, serving much the same catchment area as Darenth Park. In 1980 the hospital had 95 residents. No plans existed for the closure of this hospital until 1983, when the DHSS initiated a programme to discharge all children under the age of 16 from mental handicap hospitals into more appropriate health, social services or voluntary agency facilities in the community. Lewisham & North Southwark, Greenwich and Bexley health authorities were all successful in getting national funding to develop local services for their children in Goldie Leigh. With the removal of the under-16s, it became accepted that the remaining residents in Goldie Leigh should be incorporated into the Darenth project and accommodated in the community; in the past, they would have transferred to Darenth Park as adults. The closure of Goldie Leigh was therefore scheduled to take place around the same time as the closure of Darenth Park.

The final stages

One major issue remained to be resolved - a group of residents not yet allocated to districts. In most cases, districts took residents who originated from their districts, and the agreed number of non-catchment residents from those who resided on the district's wards. There were nevertheless about 50 residents left by 1985 who had not been allocated to districts.

These 50 residents were categorised into two groups. The first group were residents who could fit in fairly easily to a district's service. Districts were assigned one of these residents to replace one of their own who had died in hospital. The second category of residents presented varying degrees of challenging behaviour and so would require special arrangements or higher staffing levels. No district volunteered to take these residents. The Chairman of the Steering Group arranged for these clients to be assessed and at a meeting of the Steering Group in January 1987, she simply insisted that each district take at least two residents from this second list and thus the problem was resolved.

Slippage

As time progressed, the Task Force reports began to show that slippage was occuring. The target date for closure was March 1988. At the end of 1985, 50 places had slipped beyond the deadline. By May 1987 this had increased to 75 and by July 1987 to 100. In fact, on the 31st of March

1988 there were 114 residents still in the hospital. Sufficient places had been found but they were not ready on time.

Various factors accounted for this slippage. There was a general problem with building contractors in the south east because of the high level of private house building/conversion that was the result of the house buying boom of 1987/88. Building firms and housing associations were overstretched. In almost all districts some schemes fell through because house prices were rising rapidly and District Valuer's valuations did not keep pace. This meant that the process of acquiring accommodation had to be started again. Some districts were beginning to experience difficulties in recruiting the number of staff needed, and in particular, enough experienced or qualified staff, causing delays to opening projects.

None of this was the region's fault. Nevertheless, some part of the delay probably was. It relaxed too early. In 1987 and 1988 it seemed that the part the region could play had come to an end. The Mental Handicap Coordiniator became more intensively involved in the production of a strategy for the wider development of mental health services. His work with the Darenth project was in part delegated to others who, whilst familiar with the issues, lacked the status of the the Mental Handicap Coordinator and perhaps the overall view of the project. Other participants, not connected the the project, began to intervene at regional and district levels on particular planning issues, and these activities tended to divert attention from the prime goal of reaching the target date. There was no one with sufficient authority to stop this from happening.

The delays in seeing through the replacement projects had a serious impact on the hospital. Fewer people going out in one year meant more staff had to be retained at the hospital and more had to be redeployed in a shorter time at the end. It meant more residents would be going out in the following year, creating more work for staff to prepare them in a shorter period of time. It meant more wards and services had to be kept open and less revenue saved from the hospital. At a time when the project could have speeded up, the pace actually slowed

Last minute arrangements

The need for contingency plans in case of slippage was first raised at the May 1987 Steering Group meeting. It was then thought that 76 residents would remain in Darenth on 31 March 1988 when the hospital was due to close. Most of these residents were the responsibility of two districts, Greenwich and West Lambeth, and these two districts were requested to come up with contingency plans for them. By the July meeting, the number of residents projected to be in Darenth at the time of closure had increased to 100 and a third district, Camberwell, was now asked to produce contingency plans.

West Lambeth fairly easily found solutions to its two groups of residents whose homes would not be ready on time, and as a result, all its residents had been discharged from the hospital by the beginning of July 1988. The situation for Greenwich was more complicated. Its contingency plan was dependent on other districts taking their remaining residents out of Goldie Leigh, and as it happened, one district was not able to meet the deadline. This meant there was no space available for Greenwich residents stil remaining in Darenth Park when it closed. Camberwell too had problems, especially with several residents with challenging behaviour for whom the district had not made adequate plans. It was able to rent accommodation for some residents, but several were eventually discharged to a private psychiatric hospital until the district could made adequate provision.

By the May 1988 meeting of the Steering Group there were still 104 residents in Darenth Park, of whom 24 had confirmed discharge dates. A review of plans in districts showed that 43 residents would remain in the hospital after 30 June, living in three wards, with the majority of these coming from Greenwich and Camberwell. The hospital had about 14 nursing staff left, who would not adequately cope with the rapid exodus of residents in a very short space of time. Dartford & Gravesham health authority were eager to close the hospital and not to allow things to drag on. But the hospital manager, and most officers involved in the project, accepted that after all the hard work, they did not want the project to end badly. It would be unfair to the residents to force unnecessary moves on them just to keep to a deadline. It would also be unfair to them to have so many leaving at the same time that they could not say goodbye to the hospital which had been their home for so many years. The Steering Group therefore agreed that the hospital could stay open until mid August.

As the new deadline approached it became clear that, even then, not everyone would have left the hospital. The districts still having residents in Darenth, Greenwich and Camberwell, could do very little more themselves. It was left to Dartford to cope. An unused ward at Stone House Hospital, a mental illness hospital in the district, was opened for twelve residents. Temporary use was also made of two houses bought but not yet needed by the mental illness unit of the district. This allowed the last 20 residents of the hospital to be discharged on 12th August 1988.

On the 8th of September, the 67th meeting of the Darenth Park Steering Group was held and the group disbanded.

Conclusion

This chapter briefly reviewed what was a very complicated narrative of a project which lasted ten years. In doing so, it has highlighted the themes which will be taken up in succeeding chapters and illustrated the theoretical issues developed in chapter 3.

The region's approach to planning changed from a rational-comprehensive and strategic coordination model to a more interactive and bargaining model in which regional officers facilitated service developments in districts within a framework of agreed principles: a deadline for closure, an agreed distribution of funding and residents, cooperation over special needs policy and staff training. The stretegic coordination role of the region failed to generate any commitment to closure and any sense of involvement on the part of the districts; with a change in approach to planning, one which recognised and worked with the particular interests of districts regional officers were able to secure collaboration for the project to achieve the overall objective of closing the hospital. Without the region and the leadership it exercised, Darenth would not have closed.

Secondly, joint planning was a non-event, despite the good intentions expressed at the start of the project. The inability to transfer significant sums of money across to local authorities was a principal reason for its failure, but underneath this lay differences in philosophy of care, different political pressures, concern with different populations, different timescales. The process of joint planning, as outlined in the DHSS guidance, was assumed a one-best solution approach favoured in rational planning systems and that implementation would naturally follow identification of that solution. It could not cope with having to resolve this number of major differences and had no means of achieving compliance of those participants who did not agree with the formal planning guidance.

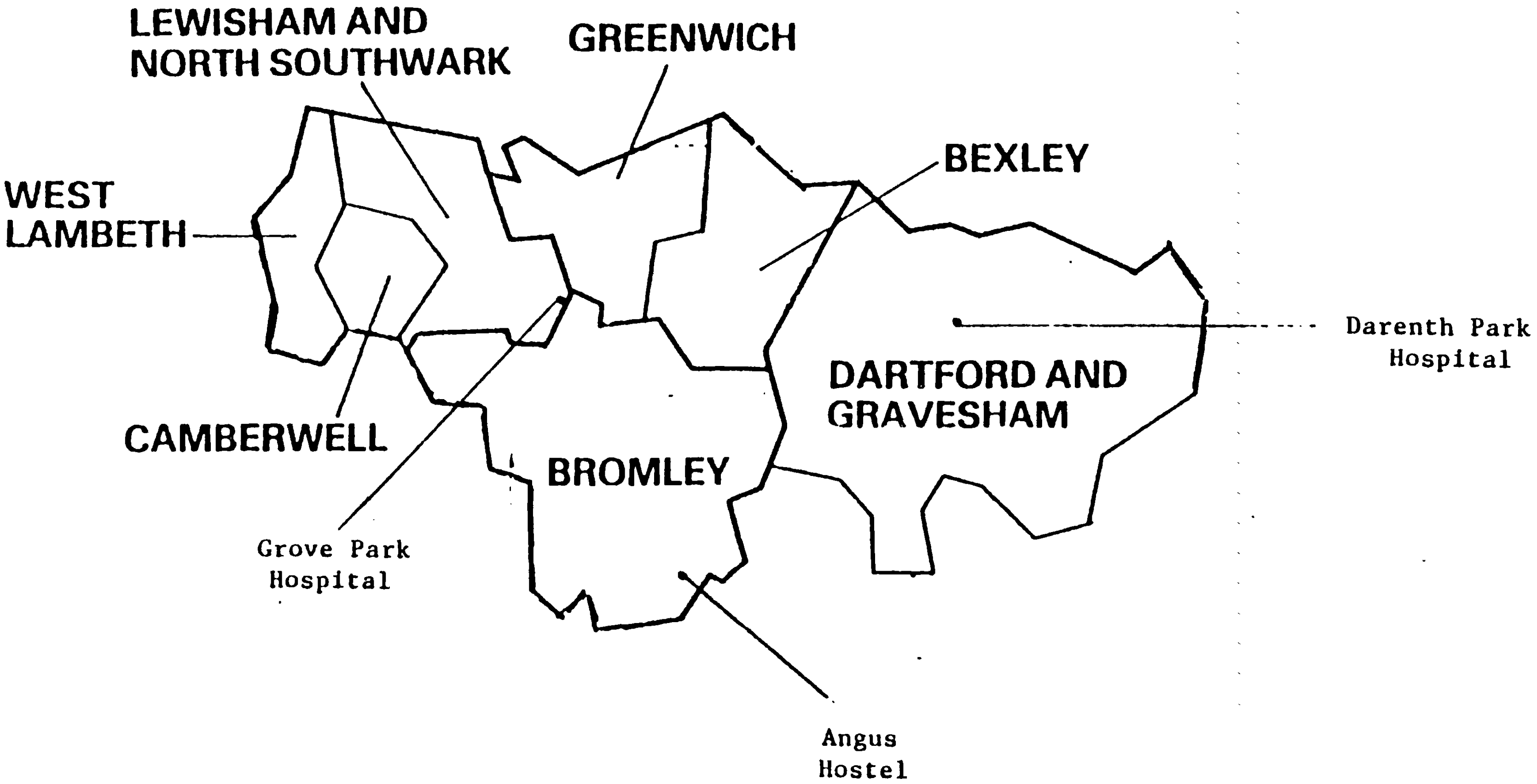
Thirdly, the complexity of activity needed to bring about the closure is at least a partial explanation of why hospital closure took so long and had not happened before despite the intentions of the 1959 Mental Health Act to promote community care. The number of actors, the number of interests, the coordination of staff, finance, property - all combined to show that implementation of plans was far from being an automatic follow-on from planning. A range of qualities not associated with bureaucracies - imagination, a willingness to try new management techniques and to recognize the validity of local interests, a determination to override opposition - were required to see through the completion of the closure programme.

Table 5.1 The housing stock in the catchment boroughs*

	% in public sector (inc. housing associations)	% in private sector
Bromley	17%	83%
Bexley	20%	80%
Greenwich	47%	53%
Lewisham	49%	51%
Lambeth	54%	46%
Southwark	74%	26%

*Taken from Table 1.2.1 Total dwelling stock by Sector 1986, London Housing Statistics, 1986, London Research Centre Housing and Surveys Group, August 1987

Figure 5.1 The Catchment area for Darenth Park Hosppital and residential facilities for mentally handicapped adults, 1978



Chapter 6

The Role of the Region: New Style Planning

In the review of the history of the Darenth Park project, it became clear that the role taken by regional officers was vital to the project. The brief history showed that nine years before the Darenth Park Steering Group was established, regional officers were visiting the hospital, and making plans both to improve services within the hospital and to encourage and assist the provision of services for people with mental handicaps over a wider geographic area.

Thus it was a regional decision to make use of Grove Park hospital in Lewisham and to pursue the use of the hospital despite the mounting costs; it was also a regional decision to progress the development of a standard residential unit which could be replicated in as many geographic locations as could be found. There was also considerable personal committment from regional officers. Many regional staff interviewed remembered the former regional medical officer searching for sites in south east London, "walking the streets" as one person said. The regional chairman had formerly been chairman of a mental illness hospital management committee; he thus had some personal knowledge of the problems faced by long stay institutions, and some idea of the poor quality of life within for the patients.

Yet for a long time, all this commitment resulted in little change within the hospital and few developments in the community. Other factors intervened to reduce the impact such commitment had on bringing about change. This chapter explores the significance of different approaches to planning adopted by regional officers had for the development of the Darenth project.

The impetus to close

Even before the approach from Blue Circle Cement, consideration had been given to the closure of Darenth Park. Plans to modernise at least part of the hospital were included in the Hospital Plan (Cmnd.1604, 1962). Later, at the end of the decade, when regional officers began their visits to Darenth in the aftermath of the Ely hospital inquiry, further recommendations were made, particularly for upgrading of wards.

Similar recommendations were made by the Hospital Advisory Service in its two visits in 1970 and again in 1972. Their recommendations for improvements were more extensive than ward upgradings, including funding for domestics, catering and nursing services, and improvements in relations between different professional staff groups. Lastly, it was their recommendation for sectorisation to improve links between the hospital and the communities it served. It was also the HAS which first recommended the closure of Darenth Park hospital: "it has such singularly ugly, ill-equipped and badly designed buildings that consideration should be given to its eventual total replacement" (20 April, 1970).

The previous chapter reviewing the history of the Darenth project described the various steps taken by the region to reduce the population at the hospital: approaching Kent County Council to take over the management of the mildly mentally handicapped residents; liaising with the seven social services departments to try to speed up discharges; developing facilities on the Grove Park site to take residents from Lewisham and Bromley.

None of these efforts during the 1970s had very much effect on the hospital which continued to display all the characteristics of long-stay hospitals criticised in literature on institutions. It was isolated from the major portion of communities it served: public transport required one and a half hours travel from inner London. Other deficiencies have already been mentioned: overcrowding on wards, inadequate staffing, poor client management regimes because of poor communication and hostility among the different staff groups working in the hospital. The underspending on the nursing budget because of recruitment problems was traditionally used to balance the overspending of acute services of the district, and this was not remedied until the Darenth budget was frozen in 1983 when the region's funding policy came in. The patient training department was particularly poorly staffed, and there was no speech therapy or occupational therapy staff at the hospital at all during the last five years that the hospital was open, and probably for many years prior as well. When able to recruit, the hospital had one psychologist for its residents.

There were, therefore, good reasons for wanting to close the hospital. National policy was also moving in the direction of a greater emphasis on the development of community services, with hospitals providing a true specialist function. The questions are: why did it take so long and what had the region learned during the closure process which enabled it to achieve a goal previously unobtainable.

A rational comprehensive approach to planning

The start of planning for the replacement of Darenth Park coincided with the initiation of a planning system in the NHS. This new planning system combined methods of local needs assessment and consultation within the NHS and with a wide range of bodies external to health authorities. The system was kick-started by guidance from the DHSS being sent to regions, then from regions to areas and then to districts. Each of these tiers was to evaluate the guidance in light of their own circumstances and then produce plans to fit. The intention was that the guidance would be influenced by assessments of needs (in the form of plans for service developments) coming upwards. The role of each tier was to assess the plans of the tier below, and coordinate the plans of all of the tier's sub-units into a coherent plan for itself.

This was the system which regional officers needed to follow in planning for Darenth Park closure. The similarities between this model of planning and models of rational planning as discussed in chapter 3 are evident. First, the NHS planning system assumed that objectives, values and priorities identified at a national level would be shared at the regional, area and district levels. Sharing of these would be brought about by the hierarchical nature of the planning system; the plans of each tier were intended to implement the plans of the tier above. All plans were to dovetail together so that the overall objectives chosen at the top were carried through all levels of organisation. The planning system also assumed that shared information led to shared objectives and the possibility of compromises for the "best" solutions.

Next, there were similarities to the "efficiency" model of decision-making: stragetic objectives would be broken down into operational objectives, and these would be further divided into factors relating to service planning, such as revenue, manpower and process factors of service designs. It further assumed that implementation would be programmed to follow plans in a linear process, and would be fairly straightforward. The model of planning upon which the NHS system was based therefore had many strong links with rational comprehensive planning. The experience of the Darenth project, of regional officers attempting to working within such a planning framework, illustrated the weaknesses of such an approach.

The limitations of a central rationalist approach

Divergent interests: Within the regional health authority, there were officers who thought that far too much attention, and far too many resources, were being given to the Darenth project. In their view, community services should be developed first, so that no further admissions would take place to hospitals, and gradually residents could be discharged from hospital into a community prepared to receive them with a full infrastructure of health and social services in place. When given a chance, usually through plans having to pass the Regional Planning Group, these officers could delay approval.

Divergent interests were even more apparent at the local level. Local concern, expressed by community health councils, local voluntary organisations and often but not always by social services departments, was about the paucity of local community services for people with mental handicap. Families had been urged to keep a son or daughter at home and that eventually something would be provided for them; they now saw others getting accommodation but not their family member. For others, hospital admission had been made difficult; they too felt their needs were being ignored.

There were divergent views about the planning timescale. Local interests wanted time to study new models of care, to investigate the best way of providing services; if they were to plan for the next several generations of people with mental handicap, they wanted to think about those plans. But from the regional officers' perspective, speed was of the essence. The hospital needed to be off-site in less than seven years; there was no time to waste thinking. The offer of a seminar on new models of care, made in 1978 to be held at the King's Fund was rejected by the Steering Group on the grounds that there was no time for such an event; plans had to be made immediately.

Divergent models of care: Regional officers took the lead in putting forward ideas about the type of accommodation to be built. As mentioned in chapter 5, regional officers from the architect's department had been working on a standard unit of 24 places which could be used in every district, linking units together to form the correct number of places according to *Better Services* norms. When planning began for Darenth's replacement, this approach was still thought suitable, as no district would require more than 180 places, and *Better Services* had recommended no more than 200 on one site. This became the basis of the region's submission to the public inquiry. Yet this proposal was immediately rejected by districts when it was put to them. None thought it would be acceptable to have such large concentrations of people with handicaps on one site. Practical reasons - the difficulty of finding a site large enough for that level of accommodation and the other facilities needed to provide a full range of services - were added to the ideological one of all the disadvantages of an institution albeit a smaller one.

Regional officers, in the spirit of national planning guidance, proposed a compromise. They created the concept of a residential centre of 72 places, arranged in self-contained houses or flats of eight places each. In addition, there would be a day centre, staff accommodation and offices for mental handicap services on site also. The remaining places required by each district would be provided in 24 place hostels on different sites, thus dispersing services throughout a district. Further consultation led to the inclusion of group homes as a form of accommodation, although at this stage (1979) regional officers tended to regard residents able to live in group homes which traditionally had low staffing levels as the responsibility of local authorities. However, with the compromise reached, regional officers expected all districts to follow the steering group guidance.

This of course did not happen. Several districts did accept the guidance -Bromley, Kings, Greenwich, Bexley - whilst others, such as Dartford and Lewisham, already had plans or facilities. But the remaining two districts each went their own way. One had already agreed that community services had priority so that there was something for hospital residents to come home to; the other rejected the model of care, preferring to develop services initially on a core and cluster model.

Opinions about services for people with mental handicap were changing rapidly, and the more regional officers stuck to their compromise model, the more they antagonised some districts and made those who had accepted it feel uneasy about their acceptance. Ultimately the compromise was rejected by those districts whose capital programme allowed change. The compromise itself failed to generate the progressing of plans which regional officers had hoped and expected it would.

No incentives for cooperation: When the public inquiry about the excavation of chalk under Darenth Park Hospital was announced, local authorities were approached by regional officers and the regional chairman to consider what role they might take in the hospital closure. A survey two years previously of the patients in the hospital had showed that about half the residents could easily live in local authority hostels, especially if they were given some additional training in community and personal care skills. The response of the local authorities was to request funds for their own assessment of the residents at the hospital. The cost was estimated to be about £80,000 p.a. for two years. Local authority officers claimed, at the start and throughout the project, was that the change from hospital to community care had to be funded by the NHS; responsibility could not be passed to local authorities without funding also being passed over. At first, regional officers refused full funding, but when the directors threatened to pull out of the project completely, the region agreed to meet all costs of the survey.

The results of the pilot for the survey were similar to those of previous studies of Darenth residents. The line then taken by the directors was that they were willing to make accommodation available for Darenth residents but expected the NHS to make all capital and revenue costs available to local authorities. A "test case" occurred in 1981.

Southwark identified a property suitable for conversion, and requested funding from the region. Capital was no problems, but the sticking point was revenue. The region could see no way to channel revenue directly to the local authority; there were no means for effecting such a transfer and it would be unfair to all other districts in the region if, for example, joint finance were top-sliced. The area health authority was unwilliing to use its own joint finance as that would leave nothing over for other projects. A final meeting was held with directors of social services, chief executives and leaders of councils on the one hand, and regional officers and members on the other. When it became clear that the region's position would not be altered, local authority representatives walked out of the meeting and withdrew from the Steering Group. They came back only after the care in the community circular had been issued and the region promulgated its funding policy.

A number of assumptions were made by both sides, each of which indicated the suspicion each side held for the other. Local authorities assumed that the sale of the land would provide more than enough funds for the health service to replace the hospital with local facilities; they were unwilling to see the region making a"profit" on the project, by transferring residents without transferring funds. Regional officers felt that there were many people in Darenth who were there only because of the absense of community facilities; they had already been "paying" for community responsibilities for years. For their part, local authorities felt they were now having to care for more severely handicapped people who would previously have been admitted to hospital, but for whom they received no extra funds for the higher staffing costs this entailed. The inability of the NHS to transfer funds to local authorities at the start of the project removed the only real incentive to cooperation that the local authorities could accept and made a number of other issues more difficult to deal with.

Neither sanctions nor good will: We have seen that a main difficulty that regional officers faced in progressing the

Darenth project was the absence of sanctions in dealing with the districts. They could issue guidance, they could extol or demand, but unless districts actually agreed and wanted to do what regional officers wanted them to do, nothing happened. The region had no means of forcing compliance, as the studies of implementation theory discussed in chapter 3 showed.

Likewise, the planning activities generated little good will at the local level. Regional officers and local organisations had their own objectives which, to some extent, were mutually exclusive. They also had different senses of urgency about reaching agreed plans. At the same time as the Darenth project was going on, other actions of the region repercussed on districts and increased the distance between the two levels: a prime example was the constraint on finance due to the operation of RAWP. In London, this meant that all districts were losers and hospital closures of acute units or of wards was a consequence.

Local sanctions: Regional officers had no means of enforcing models of care on districts, but locally, organisations could block the region's intentions. Local authorities could withhold planning permission for sites, as occurred in Bromley. In another district, permission was delayed for two years, because of hostility of several local pressure groups to plans for a residential centre. Another district required three years to reach agreement with its local authority because key actors from both sides had different philosophies of care. Another district simply refused to plan until its conditions had been met. In the end, it became apparent that regional officers had to listen to the points of view of districts, otherwise the project would fail. The local level could not achieve its plans without regional support, largely finance, but region could not achieve its objectives without local support.

These various reason for delays in agreeing plans illustrate why so little was achieved between 1978 and 1982. They illustrate the weaknesses of the original strategic coordinator theory of planning, of central determination of action which depends of local participants to bring about the desired change. If, however, the Darenth project began by showing the weaknesses of the rational comprehensive model of planning with its emphasis on a strategic coordinator, it ended by illustrating several features of Lindblom's model of partisan mutual adjustment as the more successful approach to inter-organisational cooperation and coordination. It was only by recognising the quasi-independence of the local district level, and therefore of the legitimacy of its separate interests, that regional officers learned to deal with divergent views in a way that still allowed the overall objective of closing Darenth to be achieved.

Learning to work together

Starting in 1983, when regional officers were confronted with district representatives of the Darenth Park Steering Group, the reality of the strength of opposing views was brought home to them, and they began to find ways of meeting local and regional objectives.

The policy issues which required attention by the Steering Group immediately after restructuring were the number of residents each district would be responsible for, the nature of the provision of accommodation in the community and the means of funding it, and the resolution of special needs policy issues. In each of these issues, regional officers, especially the newly appointed mental handicap coordinator, took a lead from district staff themselves. Thus the allocation of residents to districts was resolved by accepting districts' own estimates of what they could achieve - those who wished to take a larger number of residents than required and those who wished to take fewer. The new housing programme, based on the use of community housing stock, reflected the initial steps taken by new district mental handicap units to contact local housing associations and establish ways of working with them. The mental handicap coordinator built on this by organising a seminar on the use of community housing to stimulate districts not yet in contact with housing associations; he also liaised with the Housing Corporation, getting central recognition for the Darenth project so that housing associations were more successful in their bids for capital. Similarly, the training course on staffed group homes run by the regional training coordinator gave support to districts who were interested in but lacked experience of this form of provision.

The special needs policy recommendation for a special development team for people with severe handicaps and challenging behaviour and limited stay unit for people with mild handicaps and challenging behaviour also represented forms of provision which were more acceptable to districts than the two proposed multidistrict units they replaced. Districts wanted to have all provision for people with mental handicaps locally based but needed the means of acquiring the skills and expertise to manage clients whose needs made greater demands on the service. The new special needs policy allowed those with expertise to share that with district staff.

In each of these issues, then, regional officers recognised the interests of district staff and supported them in developing their capacity to provide local services in line with local interests. But these developments were undertaken within a framework which recognised regional objectives of closing the hospital by a given date to avoid excessive capital expenditure, of reproviding services within the revenue released by the hospital closure without retarding other regional uses of revenue, and of being certain that districts accepted responsibility for all residents, even those with challenging behaviours. The second phase of planning by regional and district officers was characterised by a much higher degree of interaction and recognition of legitimate if differing interests. A broad agreement on objectives emerged, as a result of active negotiation on a range of issues, leading to a much better understanding of the needs of various participants in the project. Planning became a matter of political activity, not applying formulae.

New mechanisms to manage change

The changes in the approach to planning were matched by the development of new mechanisms by which regional officers monitored and managed the process of change they were creating. The distinctive feature of these new mechanisms was their flexibility, so that they were able to recognise and work with diversity across the districts. Districts now had the freedom to be different and still participate in the project, a significant change from the initial stance taken by the project in the form of planning guidelines.

Consent and communication: Once the legitimacy of local diverse interests was accepted by regional officers, the Darenth Park Steering Group became more open to discussion of issues of mutual concern. The Steering Group was the mechanism which took the Darenth project out of the region's annual planning system, giving priority to its schemes in the region's capital programme. This also helped to by-pass those officers at the region who did not agree with the priority given to the Darenth project. It helped to focus the attention of senior officers at region and in the districts on the range of issues needed to be considered to complete the project. Lastly, the Steering Group provided a forum from which the actors in the districts could derive some moral support, by being in contact with staff from other districts facing the same problems. A sense of common purpose evolved which helped to sustain the drive to close the hospital.

A new approach to capital planning: As was discussed in chapter 5, the move away from purpose-built units towards the use of traditional housing stock in the community was accompanied by a move towards a more decentralised and flexible approval system for housing schemes. Approval could now be given on the basis of whether projects fell within cost allowances defined in terms of the number of bed spaces provided. The regional bureaucracy, or at least some parts of it, did not like giving up its power to approve schemes. The works department, in particular, had an obvious interest in maintaining a programme of purpose-built units. The treasurer's department was not keen on handing over NHS funds to housing associations. Working with housing associations threatened the existing methods of approval and control over projects and was not accepted easily by those who had little committment to the Darenth project.

Financial incentives: The region began the Darenth project under the old system of providing revenue for new capital projects. In 1982, these rules were changed by the Department of Health; those wanting new capital schemes had to show how they would meet the revenue consequences of these schemes from within their own resources. More importantly, under the RAWP system which was being applied more rigorously, South East Thames region no longer had the expected level of growth funds available. The districts participating in the Darenth project were in the London end of the region, and many were already well over their RAWP targets. For the region to make funds available to these districts would not only worsen their RAWP position, but make it impossible for the region to undertake any geographic distribution of resources, something it was strongly committed to achieving; two districts in the southern part of the region were only receiving 70% of their RAWP targets.

The funding policy selected overcame these problems and in addition provided a strong financial incentive to all districts in the region to get on with developing services for people with mental handicap. At the end of 1982, the regional treasurer produced proposals which were based on some of the suggestions made in the government's green paper, *Moving Resources for Care* (DHSS, 1981b). The funding policy identified in-patient expenditure in all mental handicap hospitals in the region which served more than one district. It calculated the number of residents these hospitals would have by 1992, based on previous trends for deaths and discharges; this was done to create a smaller hospital population. This population and in-patient expenditure were then used to calculate a per resident cost which became the dowry each resident brought to a district upon discharge. The dowry represented a revenue transfer to districts, in perpetuity, regardless of degree of handicap of the resident. Districts could use the dowry to provide a service themselves or to buy a service for that resident from a more appropriate agency such as a local authority or a voluntary organisation.

Working the funding policy in this way produced several advantages. First, it eliminated detailed negotiations between districts and region. If the per capita revenue was the same for each resident, there was no need to negotiate about the degree of handicap. The funding policy created certainty for districts. They could calculate for themselves exactly how much they would receive, once they agreed how many residents they would take out of hospital. Next, by channelling funds to districts, the funding policy made available to districts "new" money without taking away from region's growth funds or reallocation from other services. It met the districts' demands for funding without 'costing' the region anything. Fourthly, by removing mental handicap RAWP targets from districts' overall RAWP target, it allowed the region to give funds to those districts already over their RAWP target without worsening their position. Lastly, regional officers were able to show that the amount received by almost every district under the dowries would still leave them below the RAWP level of expenditure. This allowed regional officers to pressure districts into reallocating from their general revenue allocation because it could be shown that the dowries were not sufficient in themselves.

The funding policy also gave districts a considerable degree of freedom for developing services. It was not tied to any particular style of service development, nor was it related to the cost of the new service. Districts were free to make whatever arrangements they saw fit without being driven by a regionally-determined policy.

There were weakness to the funding policy as well as strengths. It was not adequate to pay for all the services needed by people moving out of Darenth, let alone what was needed to meet community needs. The dowry represented, in theory, a share of all services provided at the hospital, but in reality that was a poor selection of services, with some paramedical groups not even represented on the Darenth staff, and was based as well on the economies of scale possible to achieve in a hospital but not in a dispersed community setting.

As time went on, it became increasingly difficult for districts to reallocate funds to mental handicap services, although most managed to give something. As cash limits became tighter, rationalisation of acute services was used to keep within cash limits; it did not generate revenue for reallocation. Several districts delayed opening facilities while they tried to get additional funds from region, with varying degrees of success. In one district, a pre-election bonus helped to bail out the mental handicap programme which had been brought to a standstill because the district could not afford the costs. In all districts, services tended to be more expensive than anticipated.

Region was able to provide dowries up to three months in advance of residents being discharged, to allow staff to be employed in advance. But it did not provide double running costs; giving the dowries in advance simply meant advancing the payment - it was not extra money. That in turn reflected another problem the region faced - getting money out of hospitals.

The funding policy applied to all multi-district mental handicap hospitals in the region. Obviously different hospitals had different running costs, so that the amount withdrawn had to relate to that hospital's average in-patient expenditure. (Otherwise, some hospitals would lose all funding before all residents were discharged, and others would have lost all residents whilst still having funds.) In 1981/2 average in-patient costs varied from £4,834 to £13.500.

In addition, the fixed costs of hospitals continued after residents were discharged: plant, heating, many key staff. These would only be lost when whole wards, or ward blocks could be closed. Therefore, region and hospitals had to negotiate each year as to what proportion of the budget could be returned as a savings to the region. Naturally, each hospital had good reasons for keeping as much of its budget as possible. The funding policy therefore went into "debt" from about its fourth year onwards, borrowing from other funds at region to cover the payments in advance to districts.

Nor did the funding policy make any allowances for putting extrafunds into the hospitals during the rundown period. In the case of Darenth this led to a decline in some aspects of the physical environonment and its inability to recruit staff.

Leadership: It is still somewhat unusual in the NHS to find an officer willing to step out of "standard operating procedures" and openly take on a leadership role on a controversial issue. Without the regional nursing officer (now director of personnel and manpower planning) who did this, the Darenth project would not have succeeded.

It was the regional nursing officer who gave evidence to the public enquiry on the sale of Darenth to Blue Circle and who two months later chaired the Darenth Park Steering Group. It was also the regional nursing officer who secured the backing of the RHA Chairman and of RHA members, making the closure of Darenth a regional priority. Over the ten years of the project, she gave the project a sense of continuity belying the many changes which took place in the NHS during this time. It was the RNO who took it upon herself to see that all obstacles were overcome - negotiating with colleagues at region to bend rules to get what was needed to see Darenth closed. Before general management came in, the RNO acted like a manager.

This in itself was not enough. The RNO gathered around herself a task force of other regional officers immediately connected with the Darenth project. Begun to speed up the new housing programme, the task force gradually expanded its remit to include all issues related to Darenth and to mental handicap services in general. It was primarily problem-oriented and tried to ensure that all members likely to be in contact with districts spoke with the same message.

The task force helped to overcome the sense of isolation felt by the small number of regional officers associated with the Darenth project at the start. Through the task force and the support members gave each other, regional officers were able to be much more active in keeping districts moving towards closure.

Conclusion

The material presented in this chapter illustrates many of the concepts developed in chapter 3 in relation to rational-comprehensive planning and alteratives to such a model. A rational-comprehensive model of planning required agreement on objectives which could then allow planning to treat succeeding issues on a technical basis (what is the best way of achieving something) and required a high degree of coordination of all factors which could affect the achievement of the stated objective. This chapter has shown the extent to which planning in the Darenth project had an intensely political nature, which required some recognition of local interests in order to achieve agreement on objectives. When this was understood, districts, region and local authorities could enter into more fruitful bargaining relationships, as Lindblom argued, each seeking to satisfy their own conditions on a piecemeal basis, allowing progress to be made incrementally.

We began by reviewing the various ways in which Darenth Park hospital shared the characteristics of traditional long-stay hospitals. Regional officers were aware of the difficulties experienced in managing the hospital and had a long record of trying to bring about improvements. The factors which made the hospital difficult to manage in terms of providing good quality care for its residents were the same factors which made it so difficult to improve to hospital: poor staff recruitment and retention; weak support for change from its management team and from the district; intellectual isolation from changing ideas about service provision.

Along came the opportunity to sell the hospital's land and acquire capital to provide replacement facilities in each of the districts using Darenth. A Steering Group was set up and regional officers began planning the closure with area health authorities.

We then showed how the rational-comprehensive model of planning failed to achieve its purpose. It failed because it did not engage the commitment of all districts, did not recognise the diversity of local interests needed to be taken into account, and provided no incentives for districts to participate. It failed to generate a common philosophy of care and a common set of objectives for the project. It failed to take into account the capacity of local actors to actually block developments they did not like.

After four years of working with the planning system, regional officers accepted they were failing to achieve their objectives. A series of discrete actions were taken which together represented a different approach to planning, one which had strong affinities to a disjointed incrementalist approach and to ideas about how organisations work together.

First, the new approach was characterised by its concern with solving problems. As issues arose, solutions were found, but the stimulus was the identification of a problem, something blocking progress. No attempt was made to link these solutions together into an overall system of service provision - they remained discrete issues to be handled in whatever way was possible given the current constraints on the project.

A second characteristic was the interaction of values and solutions to problems. The new philosophy of normalisation, with its emphasis on personalised and individualsed services, community presence, integration of handicapped and non-handicapped, influenced the range of solutions offered for problem-solving. Normalisation pushed towards work with housing associations. Financial benefits pushed towards a wider consideration of provision within the community. Housing associations led to greater emphasis on the rights of residents as tenants. The range of possibilities was expanded because of the interaction of ideology and provision.

A third feature was the way in which local interests were recognised and brought into the bargaining process of what to do and how to do it. This is in strong contrast with the previous approach when any questioning of the planning model was looked at as treason. For each issue raised - the number of residents for each district, special needs policy, type of housing provision, financial allocations -

there was a local perspective; by learning to work with these and share responsibility for decision-making with districts, regional officers were able to identify solutions.

In other ways as well, actions taken by the region began to approximate techniques or processes by which different organisations learn to collaborate:

-the appointment of a mental handicap coordinator installed a "reticulist" (Friend et al, 1974) into the Darenth project, to cross boundaries between districts and region (and within region) to get action when there were no established paths;

-the development of a shared vision of a service model (Brazil *et al*, 1988) by events such as the housing seminar, the training course on staffed group homes, and the attachment of new staff to the region who had experience and committment to principles of normalisation, which gradually gained the confidence of other regional officers;

-financial incentives, which encouraged districts to work with other organisations and to consider a wider range of accommodation than NHS provision.

In these ways, and through others detailed in the chapter, the rational comprehensive model of planning which entailed a formal structure to planning gave way to a more flexible model of planning, which emphasised the political nature of the process. In the end, it was through political activity of negotiation that regional officers were able to see the hospital closed.

Chapter 7

Getting services ready for people

In the previous chapter, the various approaches to planning adopted by the region were discussed. It was shown how regional officers modified their initial stance when they found that it was not capable of achieving the goal of providing sufficient facilities in the community to allow the hospital to close. They gradually learned to establish different types of relationships with district officers which gained the commitment of districts to help close the hospital. In this chapter, we shall now see that districts too had something to learn about planning whilst reproviding Darenth's services locally.

Service planning up to 1982

We have already shown that the original intentions for the Darenth project were for new services to be developed through joint planning and working with local authorities and that districts would plan on the model recommended by the Steering Group guidance of a 72-place residential centre and 24-place hostels. Ultimately, neither of these intentions were realised. The first failed when local authorities' demand for full capital and revenue funding was not met by regional officers, the second when the 1982 restructuring brought into the districts staff who were influenced by ideas about normalisation and who therefore rejected segregated sites for large numbers of residents.

In chapter 6, the various issues which hindered local compliance with regional planning approaches were discussed: divergent local interests; divergent models of care; local sanctions against plans; lack of personal commitment at the local level to the project. The result of these factors meant that by the time the 1982 restructuring removed the main planning tier at area level and brought in new district members to the Steering Group, the regional capital programme contained less than 400 places for reprovision schemes; at least a further three hundred places were required to enable the hospital to close. It was hard to feel optimistic that these could be found, given that NHS-owned sites had already been used and there was considerable difficulty in finding other sites large enough for purpose-built units, especially in the inner city districts.

New plans

Within two years of restructuring, all this had changed. Chapter 6 related how regional officers tackled the various problems which were preventing further progress: a flexible funding policy tied to discharge; a local commitment to help close the hospital to avoid undesirable capital expenditure; an agreement on the number of residents each district would be responsible for. The resolution of these issues made it possible for districts to develop plans for new services which were acceptable locally.

Dartford & Gravesham: A project team had been set up in

1977 to begin planning a replacement unit for the district's residents in Darenth; the design of this pre-dated even the Steering Group's guidelines. The planned unit was to accommodate 96 residents in four buildings. Each building was divided internally into two separate wings, each having bedrooms, bathrooms, sitting and dining rooms; a small kitchen was shared by the two wings. The site chosen could scarcely be said to be in the community; it was between two other hospital sites, a housing estate in back and a rubbish dump in front. There was no local bus service nearby and only one shop within walking distance. Its main advantages were that it was large and was owned by the NHS. On site as well would be a 120-place day centre, staff accommodation and a school of nursing. All this is a good example of how service provision was driven by site availability.

In addition to Archery House, a 24-place hostel was also planned; however, no site could be found, and so the plans were modified in 1984 to provide those places in community housing.

The new residential centre, Archery House, was handed over in 1985, and new problems were immediately identified. The most significant one was that it proved impossible to fit in the necessary amount of furniture into the four-place bedrooms and be able to manoeuvre a resident in a wheelchair in the room as well; there simply wasn't enough space. The obvious solution was to reduce numbers, but that meant places would have to be found elsewhere at no capital cost. At the same time, a second problem over numbers arose; the closure of a supposedly short-stay mental handicap unit in the district, which had accumulated several long-stay residents.

The way out of this dilemma was found by the local authority, who negotiated the appointment of a social worker to work with the health authority to identify a minimum of 16 places in private and voluntary accommodation. In fact, she was able to find places for more than 30 residents, and in the process, helped to change ideas about residents and services within the district. Of these places, 12 were in private registered homes, 8 in family placements, 7 in maisonettes rented by the social worker from the council, 2 in privately rented accommodation and 2 in an unregistered private home. Most of the residents in this scheme came from Archery House, and moving on represented a further step towards independence and contact with the community for them. The social worker had quite a struggle at first to convince the nursing staff that clients would be well looked after outside the health service and that they had the potential for growth. One consequence of this programme was that the staff at Archery House became interested in developing a programme of active preparation for more independent living. For this district, then, necessity pushed it into more imaginative forms of service provision.

Bromley: Initial plans for Bromley included a 72 place residential centre with a day centre and staff accommodation, and three 24-place hostels. In 1983, plans for the third hostel were dropped in favour of using the first hostel more intensively and making better use of an existing women's hostel. In the following year, plans for the second hostel were also dropped in favour of group homes, after staff attended the regional training coordinator's course on staffed group homes.

The senior mental handicap staff clearly did not feel confident about basing all residential services on the use of small homes. Yet they were well aware of the changes taking place in professional and service values. They wanted to ensure that the services they provided did not prevent or limit the development of individuals but were not convinced that all people with a mental handicap could live successfully in the community and be accepted. They therefore decided to modify their plans for both the kind of care and the kind of staff employed at the residential centre. Centralised services, such as laundry, catering and cleaning were dropped and would be provided through the care staff of each house, who would now be responsible for all home-making as well as care functions within the residential units. Residents would be encouraged to participate in running the home as much as possible. Similar changes were made the plans for the day centre to allow the users to have a more active role in running the centre.

Bexley: By 1982, Bexley had a 24-place hostel in the capital programme, located opposite the district's headquarters. It was willing to have a residential centre, but could not find a site large enough for one. When it was decided to close Goldie Leigh hospital in 1983, the district agreed to use that hospital on a temporary basis to accommodate its Darenth residents.

By 1985, the district's plans were based solely on the use of community housing stock. This change was brought about by several factors. First, the 1982 restructuring brought into the district staff who had worked in other districts which were planning services around the principles of normalisation. These officers began to suggest a greater use of traditional housing, supported by Bexley Mencap and the CHC. Next, a team of officers from health and social services attended the regional training course on staffed group homes; this provided them with support for change and with practical advice on achieving it.

A third factor was the support given to the district for acquiring properties by the local authority. Bexley was one of the districts participating in the programme sponsored by the DHSS to get under-16s out of hospital, in this case Goldie Leigh. A suitable home in the community was found for 6 children, but there was sustained opposition from neighbours, supported by ward councillors.

Eventually planning permission was refused on spurious ground of lack of parking facilities. The DHA was ready to appeal to the Secretary of State, and the local council, wishing to avoid the embarrassment of having to defend its refusal of planning permission for a home for children, agreed to make available another site and to help the district get planning permission for all the properties it needed.

The overall position of the district was eased when it was agreed that the district need take only its catchment residents from Darenth. This reduction in numbers by about 40 made it feasible to provide all accommodation in ordinary housing and to give up any intention of using the Goldie Leigh site. By late 1985, the district was negotiating with housing associations to take over the management of the homes and was actively considering establishing a housing consortium (discussed later in this chapter).

Greenwich: In 1981, Greenwich opened a 30-place hostel for Darenth residents from Greenwich and Bexley, previously used as a convalescence home for elderly people. The district had in the regional plans a 32-place hostel, arranged in four self-contained flats, and had agreed to a 48-place residential centre on the site of the Royal Herbert, formerly a military hospital. This development had started as a 72-place centre, but pressure from the local authority succeeded in reducing the number of places. This compromise on the number of places was not reached easily and the negotiations around the reduction emphasized the different philosphies of care held by the local authority favouring principles of normalisation and the health authority holding a nursing model of care.

Planning for the Royal Herbert was stopped by the district in 1985, when it became dissatisfied with the amount of space within the homes. The situation was one familiar to all districts in the south-east of England: to keep within cost limits meant building to only 70-80% of space allowances. This made the units unusable by people in wheelchairs. The district wanted to make a special case to the DHSS but regional officers prevaricated.

While all this was going on, the district had opened discussions with housing associations about using housing stock in the community to make up a shortfall in places which existed, even if the Royal Herbert development went ahead. The local authority heard about this indirectly and asked to be involved.

By the end of 1986 the district's plans had changed almost as dramatically as had Bexley's. Regional officers informed the district that the Royal Herbert site was no longer available; it now had hopes of selling it to a supermarket chain. A new UGM for priority groups' services had come into post, and was clearly committed to working closely with the local authority. The loss of the Royal

Herbert site required the district to rethink the major part of its programme, and under pressure from social services, the CHC, Mencap and many of its own staff, the decision was made to work collaboratively with social services, use housing in the community which would then be managed by housing associations or the local authority, with the district retaining management of only about 20 places (see chapter 9 for a full discussion of this collaboration).

Lewisham & North Southwark: At the time of restructuring, this district was required to accept only 24 residents from Darenth Park, because of the number of residents then in Grove Park hospital, 160. However, the district agreed in take responsibility for all its catchment residents remaining in Darenth (81) because the new funding policy would allow it to receive dowries for each resident for whom a place was made available. It suited the district to take these residents because this larger number would allow it to develop a more substantial element of local services based on the model of care found in *An Ordinary Life*, countering the effect of hospital-based services.

Camberwell: The district's main development was to be a 72-place residential centre at Crystal Palace. The land was a disused part of a British Rail station; a planning team had begun work in 1979 but the land was not purchased until 1984, due to opposition from local residents and the CHC.

Once again, plans changed considerably from original intentions. The restructuring brought into the district staff more drawn towards principles of normalisation than to traditional services. The new staff attended a PASS workshop and the region's training course on group homes, both of which reinforced the ordinary life model of service provision. The districts on either side were each basing their services on community housing. A small group home was opened in 1983; it provided a home for 8 very able residents, giving a misleading impression of how easily residents could adjust to living in small homes. A financial comparison of the costs of services based on a large residential centre or a smaller centre with many more clients in group homes showed the latter as a more economic service, thus gaining support from the administrative and financial staff. Moreover, with no existing service predating the planning of Darenth closure, there was no one locally to argue for the model of a residential centre.

The district put forward arguments to regional officers to allow them to reshape the Camberwell service to make greater use of community housing. Regional officers gave the district one year to show they could find enough housing in the community; this they did and the centre was reduced to 42 places in 1985.

West Lambeth: At the start of the Darenth project, regional officers expected that this district would accept responsibility for 88 residents of Darenth, based on the district's population and *Better Services* norms. This was not acceptable to the district, because it ignored the 88 residents in a long-stay hospital in another region; it had only a dozen catchment residents in Darenth. This situation was resolved in 1984 when regional officers agreed to allow the district to be responsible for accepting 30 residents from Darenth. With this agreement, the district began to plan for all provision in small group homes.

Factors for change

This brief description of the ways in which service planning in districts changed, in some instances quite radically, over a short period of time hinted at some of the factors which contributed to these changes. These will now be explored more fully.

(i) New people

The 1982 restructuring of the NHS brought into almost every district in the Darenth project new faces with new ideas. Many of the officers successful in getting senior posts within the new mental handicap units were noticeably younger than the area level officers who up to then had been undertaking the planning work. For the new officers, this was the first chance they had of heading up a service, and they were keen to make the most of that opportunity. Their age, and in many instances, their lack of experience of traditional mental handicap services, led them to enthusiastically accept principles of normalisation.

The shift to general management two years later under the recommendations of the Griffiths Inquiry (DHSS, 1983a) further strengthened the hands of those wanting to bring in new ideas to services. Griffiths did away with consensus management and gave a clear responsibility to general managers for decision making on all issues relating to the work of a unit; the administrators now became more powerful general managers, answerable to their line manager for fulfilling stated objectives and once appointed, they had a mandate for bringing about certain agreed changes. This more powerful position of general managers gave a stronger lead to the acceptance of "ordinary life" as the service philosophy, despite reservations by nurses and some consultants, and without perhaps a full awareness of implications. In only one of the Darenth districts was a professional appointed to the general manager post; the administrative rather than professional background of the general managers may have allowed them to place more importance on philosophic "human rights" approach and on financial considerations than on traditional service values.

This stronger role of the UGMs was illustrated most clearly in Greenwich when a new UGM rapidly reversed a stand-offish attitude towards collaboration with social services. At other levels of organisations as well, new groups of staff within the NHS and in other organisations, were putting forward their own views on mental handicap services: greater involvement of clinical psychologists and the remedial therapies in mental handicap services which challenged on professional grounds the former prevailing medical/nursing model of service provision; the willingness of housing associations to become involved in the new area of houses for more severely handicapped people; local voluntary organisations supporting the social belief that handicaps should not disqualify people from participating in community life; a shift from nurses to support workers as the main providers of residential service.

This last point may be illustrated by a comparison of staff employed by Dartford health authority and those employed by an inner London district in which a short survey was conducted by questionnaire (response rate about 50%) (see Table 7.1).

Quite a number of staff employed in the inner London district had some relevant work experience: 37 had worked with people with a mental handicap; 22 had previous experience in residential or day care with other client groups; 8 had youth and community work and 12 had other types of voluntary work experience.

The staff in Dartford were all from Darenth Park. In the inner London district, 32 staff were recruited through the national press, 50 through the local press and 14 through friends already employed in the service.

A further contrast lay in the length of time staff had been employed by their district. In the inner London district, only one staff member had been employed since 1983; five others began employment in 1986, 16 in 1987 and 73 in 1988 (one did not reply). The experience of Dartford staff differed sharply:

Employment started before 1970	15
1970-1974	31
1975-1979	47
1980-1984	21
1985-1988	6

The new services were attracting a younger staff, quite a number of whom went on to training after work experience in a group home, who brought to mental handicap services experiences of working in other types of services. They often expressed a strong commitment to the principles of normalisation and had negative feelings about hospitals and the quality of service they have offered in the past. In short, there was a considerable difference in outlook and work expectations from staff in more traditional settings.

(ii) New providers

New government regulations which allowed health authorities to make capital and revenue grants to voluntary bodies to provide housing for people coming out of hospital opened up the possibility of new forms of accommodation and of residents claiming a variety of housing and care benefits from social security, thus getting additional funds into local services. Health authorities turned to housing associations with which to work in the Darenth project; they had far more expertise in building or converting ordinary housing than did the NHS, and it made sense to use that expertise. It was also hoped that housing associations would produce results faster than the NHS.

Housing associations welcomed this opportunity of working with health authorities. They already had some experience of providing care in the community through their special needs projects with local voluntary organisations. The Darenth project allowed them to expand their experience to provide housing in many instances for more severely handicapped people. Nevertheless, there were difficulties in the NHS adjusting to some of the implications of this new relationship.

The relationship of regional officers with housing associations was limited to issues relating to capital. First, in recognition that its own capital planning procedures were more suited for much larger projects, regional officers agreed a streamlined process for approving grants based on a fixed cost per place. It was more difficult to find ways of bridging the difference in cost limits between those allowed by DHSS regulations to regions and those allowed by the Housing Corporation to housing associations and the frequency with which these limited were upgraded. These two cost limits were always different and regional officers needed considerable skill in trying to ensure that housing associations were given adequate funds to provide the kinds of houses required by the Darenth residents. Works professionals - at district and region - remained suspicious that housing associations were aiming at too high a standard of provision, but that of course was exactly what staff involved with residents wanted.

At the local level, the main issue was the role of housing associations. Officers in the mental handicap units tended to see housing associations, naturally enough, as organisations to provide housing - the bricks and mortar of the service. They were concerned with the total physical environment of the home, at the time of opening and afterwards. Housing associations saw a more extended role for themselves. They saw themselves having a role in protecting the housing rights of residents who could no longer be moved from their home at the will of a health service officer. They were also concerned in general with the quality of life the residents had.

Health service staff saw themselves as the ones who "knew" the residents and would determine what would happen to them. They were intitally reluctant to share information with housing associations about residents even though some of it had a bearing on the design of the house - behaviour, for example, which might require secure fittings, locks on doors, etc. Sharing this information earlier would have saved costs of modifying houses already prepared for occupation and would have led to more accurate assessments of housing need for clients, possibly to other solutions being adopted. Over time, much closer and freer working relationships emerged, but it required effort and flexibility on both sides to make that happen.

What difference did this make to the Darenth project? Besides their housing skills, the asociations brought a firm commitment to the rights and privileges of their tenants or licencees, and thus they gave strong support to the implementation of "ordinary life" as far as housing went. They insisted, for example, that the resident's right to privacy, a lock for the door to his or her bedroom, be written into the operational policy for houses. They had views on how a resident's money was to be handled and the resident's involvement in decisions about the running of the house. They were instrumental in giving practical expression to the principles of normalisation in housing, checking some of the health authorities' more autocratic tendencies.

(iii) A new style of joint "ownership"

Two consortia were established by three health authorities; a third consortium was established after the hospital closed. In one district, an agency already in existence and manageing homes for people with a mental handicap, was used to manage houses on behalf of the health authority in part of the district. The creation of consortia to manage houses funded by health authority and social security funds represented a new development which matched the ideology of ordinary life and presaged the separation of assessment of need and provision of services recommended in the NHS and community care White Papers (CM 555 and CM 849). This section describes how consortia came about and the work they did.

The Southwark Mental Handicap Consortium was established at the beginning of 1984, the first of its kind in England. It grew out of an approach by Lewisham & North Southwark health authority to Cambridge House, a Southwark-based university settlement, to manage a housing scheme the health authority was planning in Southwark. From that meeting came the idea of a conference, based on the theme of an "ordinary life", to consider the creation of a consortium to coordinate a borough-wide housing service for people with a mental handicap and to develop and manage the new housing projects. Camberwell health authority was then brought into the discussions as was Southwark social services. From this conference in January 1985 the consortium was established (Rochester, 1987). It initially was funded by grants from Joseph Rowntree Memorial Trust, the Kings Fund and the Mental

Health Foundation.

Legally the consortium is both a registered charity and a company limited by guarantee. Constitutionally it is a federative structure composed of two health authorities, Southwark Council, housing associations providing housing in the borough, Southwark Adult Education Institute, Cambridge House, other local organisations and individual members. Its management committee has representatives from each of these categories so that the consortium is much more than a housing agent for statutory organisations. As a membership organisation, members participate in the development of policies and management of activities through a committee system. Below the management committee are four sub-committees: finance, supported housing, service development and project development. Further, each house has its own project committee as a subordinate group of the supported housing committee.

The consortium has three sources of funds: the charges it makes to residents (the majority of whom claim some form of social security benefit), hostel deficit grant from the Housing Corporation, and grants from the statutory agencies.

The Southwark Consortium had a major stake in coordination and joint planning because the borough contained two health authorities which, along with the Council's social services department, tended each to go their own way. The consortium acted as a neutral meeting point where issues could be discussed with many agencies participating. Expertise was shared, especially by the social services department which had considerably more experience in running group homes than either of the health authorities. Once the immediate need for housing development was over, the objectives of the consortium were expanded to consider day care issues and ways in which local people, including those resident in the houses, could have a more active role in management.

A second consortium was established in Bexley in 1987. It came about largely at the instigation of the health authority. The local authority, whilst not objecting, gave very little support. The Bexley Consortium, unlike the Southwark one, was intended to coordinate housing schemes only, and was strongly supported in this role by Bexley Mencap and the CHC. The consortium, however, got caught up in wider issues of joint planning and local politickinig between the health authority and the Council (see chapter 9) and stated its intention to disband itself in June 1988.

The third organisation, Providence Project in Lewisham, was quite different from the two consortia. The project started in 1981, when a group of parents and professional staff got together to provide accommodation on a different model of care than was then available from statutory agencies, at that time a council-run hostel. The capital cost of a new home was met largely by the Mayor's appeal which was enough to purchase a 12 room house. Several years on, when some of the residents of this home wanted to move to smaller accommodation, Providence Project was able to get help from a Rotary Club to buy a house. It became apparent they would be better off establishing links with housing associations and getting financial support from the Housing Corporation than by dealing with each house as a separate project.

At the same time, Lewisham & North Southwark health authority was looking for an organisation to work with them on the housing programme in Lewisham. Officers felt it made good sense to link up with an existing organisation with its own stake in manageing housing and links with local people.

Consortia presented a new form of shared or joint ownership between the NHS and the local community, through joint working with social services, local voluntary organisations, and in some cases, interested individuals. They brought residents into a contact with a separate organisation which claimed some responsibility for the quality of care they received and which, because of its independence from statutory agencies, felt free to criticize services on behalf of residents.

Further, consortia made residents into private citizens, no longer the wards of the NHS. No longer could hospital managers (lay people appointed by health authorities to visit and inspect hospitals) have the right of entry to these homes; people with a mental handicap were no longer public property. Through the involvement of people on management committees, and through these people getting to know the residents of homes, the adequacy of services provided became the subject of more widespread discussion among members of the community, which, over the long terms, may become a source of support for the further development of these services and of a greater acceptance of people with mental handicap living in the community.

Conclusion

The main theme of this chapter has been the ways in which planning activity in the districts changed over the last five years of the Darenth project, becoming more responsive to local wishes and to financial incentives provided by regional and national policies. If the first five years of the project were dominated by capital planning considerations, the last five demonstrated the increasing emphasis on managing the interaction between a wide range of providers, incentives and a new philosophy.

Three factors contributed to this change in planning activity and content. First was the philosophy of service provision - "ordinary life" - which joined moral principles and a pattern of service provision. "Ordinary life" gave a sense of direction and justification to mental handicap services which matched the professional aspirations of staff then beginining to work with people with mental handicaps and emerging social values about the integration of people with disabilities into mainstream community life. Staff involved in service development created a clear image of what kinds of services they wanted through adherence to principles of normalization, and it was that philosophy which legitimated the changes being brought about and allowed mental handicap services to develop so rapidly during the 1980s.

A second factor was the development of strong mental handicap units, based on the devolution of responsibility as part of the 1982 restructuring of the NHS and of general management following the 1983 Griffiths report. The staff working within these units were not essentially planners but service managers and service providers; they had the authority to identify problems, find solutions and get them implemented. The introduction of general managers who had an administrative rather than professional background made it more likely that service development would differ more radically from traditional mental handicap services. Buildings were only part of the service they were planning.

The third factor was the creation of new forms of service provision by health authorities in collaboration with housing associations and consortia. This was made possible by the Care in the Community circular allowing health authorities to use mainline revenue to buy services from other agencies, private, voluntary or statutory. The capacity to entice other agencies into providing residential accommodation resulted in a radically decentralised residential service: from a 1000-bed hospital in 1978 to 74 homes, hostels or residential centres in 1988, only 7 of which involved more than 8 people on the same site (see Figure 7.1). Not only was this more decentralised than traditional NHS services; it was equally true of local authority social services at that time as well. One of the ironies of community care is that the NHS, at least as far in mental handicap services, developed a model of residential provision seen as more progressive than local authority provision.

The actions of senior service managers in districts reflected the general approach to policy implementation outlined by Lynn (1989) and discussed in chapter 3. These managers offered incentives of personal and organisational development to secure collaboration from their own staff and housing associations/consortia. They were opportunistic in exploiting changes in legislation which allowed them to change the type of service provision being planned. They used the moral force of the principles of normalization to gain support for the use of ordinary housing. In brief, they created an environment in which a new style of service was seen as desirable and feasible.

Thus, health authorities, using the dowry system, began to work under a purchaser/provider model before this was revealed as the new model of statutory agency functioning. The concept of organisational altruism gave way to cash transactions: one agency buying the services of another, an example of partisan mutual adjustment (Lindblom, 1965). The evidence of the Darenth project shows how much more successful was this method of joint planning than the process described in the various planning circulars issued by the DHSS which assumed responsibilities could be transferred on the basis of *Better Services* recommendations. Negotiations were successful between health authorities and housing associations because each had something to offer the other. Moreover, the decentralised model of residential provision spread without strategic coordination; it spread because local agencies recognised it was in their interest to work in that way.

There were, however, serious negative features to this process as well, many of which were highlighted in the Audit Commission report (Audit Commission, 1986). Services being developed by health authorities and the use of funds from hospital places provided care in the community only for residents discharged from hospital; people with a mental handicap who had been cared for at home by their parents were left out of these new developments, and this generated both resentment and hardship. It became a concern to both health and local authorities as well as to parents that a "two-tier" service might be developing, based on previous residency in hospital.

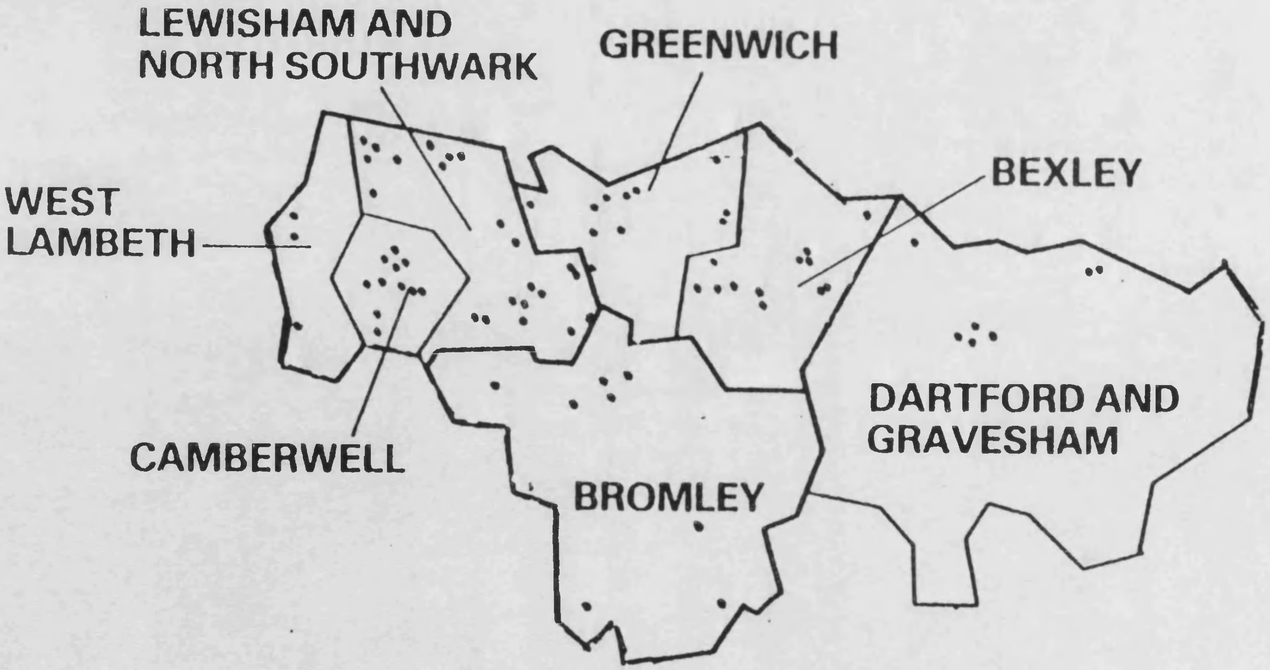
The dowry system was usually based on an average in-patient expenditure, covering all the services provided in the hospital, and intended to cover similar services in the community as well. But the reality was that with the loss of economies of scale and the provision of residential services to higher standards, dowries were used to purchase residential services only, and even then, required topping up by the health authority. Residential services were therefore reasonably well funded, but day activities, staff training, provision of remedial therapies and other associated services were left unsupported. This too was a source of concern to local authorities, worried that they had no funds to provide these additional services, and concerned that without these services, residents were left trapped in their new homes. Additional demands for community health services would also be generated by people coming out of hospital; these too were left unfunded.

The DHSS, then, in trying to speed up and smooth the process of closing long-stay hospitals, chose a method of financial incentives which in reality generated service developments unbalanced in their impact on the population of people with mental handicap and unbalanced between residential and other services needed by clients.

Table 7.1 Staff in Dartford and Inner London

Age	Dartford	Inner London DHA
Under 20	-	1
20-24	3	34
25-29	8	20
30-34	10	20
35-39	14	12
40-44	24	5
45-49	21	1
50-54	22	-
54-59	16	3
No. of male staff	20	50
Qualified Nurses	51	12

Figure 7.1 Residential Facilities for mentally handicapped people, 1988



required residents to attain comparatively high levels of functioning in terms of personal care and social skills if they were to be discharged into community facilities - local authority hostels or private or voluntary homes. These types of facilities were usually designed for people with moderate care requirements and were certainly not prepared to accept people with challenging behaviour or profound handicaps. The closure of Darenth presented a new situation - everyone in the hospital was to be discharged into the community; there would be no large scale transfers to other hospitals. All clients therefore needed to be prepared for discharge.

Researchers and clinicians have been interested in identifying what factors seem to account for successful placements in the community, and what can be done to enable residents to succeed in their community placements. One study by Eyman *et al* (1971) pointed to ambulation, continence and arm-hand use as crucial for successful discharge. Similarly, work by Sutter *et al* (1980) highlighted the absence of (frequent) behaviour problems - physical violence, absconding or devious behaviour - as significant to successful placement. Other studies have made the same points. None of this seems startlingly new or helpful in situations where all residents are to be discharged.

Other research does begin, however, to challenge some of the sorts of assumptions made about people with mental handicap and the ease with which they will fit into the community. Willer and Integliate (1981) argue that the best indicator of how a person is likely to behave in the community is how they behave prior to discharge in the hospital, and further claim that IQ is not as important an indicator of successful placements as are measures of adaptive behaviour. They stress the relevance of social and environmental factors in overcoming skills deficits or behaviour problems of clients, in particular the orientation of the home, its guiding principles. This latter point is reinforced in an article by Hull and Thompson (1980) who see normalisation as an effective technology for the promotion of individual functioning as well as an ideology. They claim in their study that IQ accounted for only 21% of variation in adaptive functions of people in residential settings; 35% of variations were accounted for by environmental factors, especially those related to principles of normalisation. Other studies make similar points about the relative lack of significance of IQ (Sutter *et al*, 1980, Shalock *et al*, 1981).

Another factor which has been seen to contribute towards successful placement is the existence of a 'benefactor' (Edgerton, 1971, Edgerton and Bercovia, 1976), someone to intercede on behalf of the person with a mental handicap to help solve problems, give advice and support. Other studies have pointed to the importance of family support for successful placements (e.g. Brolin and Wright, 1971, Malin, 1982), which represents a similar type of support to clients.

Several of the above mentioned studies and others as well (e.g. Stacy *et al*, 1979) also point to the importance of intensive training programmes to increase the capacity of individuals to be successful in community placements.This is supported by a study by Birenbaum and Seiffer (1976), who claimed that institutional care tended to induce a 'trained incapacity' in residents which could be overcome by resocialization programmes. Eyman *et al* (1981) noted that there was little evidence that institutions produced maladaptive behaviour but also no evidence that they had effective means of reducing it. This was certainly the case at Darenth; at a time when training was more, not less, important, the client training department was weakened by the absence of professional structured leadership.

Further studies have identified other factors making it difficult for hospitals to actually provide such preparatory activities. O'Connor *et al* (1970) point to the reluctance of hospitals to discharge elderly residents who on assessment could easily live in the community because of their usefulness as ward helpers and to the belief of the nursing staff that community-based nursing homes or foster care would not provide adequate care for such elderly people. Several studies describe the unwillingness of ward staff to engage in resident-oriented activities (Schmidmeyr and Weld, 1971) or to adopt positive expectations about the accomplishments of people with a mental handicap (Moores and Grant, 1976). This latter point may actually be a reflection of social attitudes of the general population; Gibbons *et al* (1979) report a small study showing that people were more likely to reduce blame after failure and give less credit after success to the same actions once they realised they were undertaken by someone with a mental handicap.

This chapter is about the residents in Darenth Park and the work undertaken to prepare them for departure to their new homes. We will see how much the Darenth situation reflects the studies mentioned above in this and in chapter nine. The first issue is to look at the residents as they were in Darenth Park, estimating how much difficulty, based on other studies, districts would face in making suitable places in the community for their residents.

Residents in Darenth Park

Information about the residents in Darenth Park has been made available from the assessments carried out by Dr. Wing and her research team. Full details about the residents may now be found in their recent publication on the first phase of their research (Wing, 1989). The 888 residents living in Darenth in August 1980 formed the baseline of their study; what follows is a summary of the detailed assessments they carried out.

The hospital had somewhat more men than women. Less than 4% of the residents were under the age of 20; just over 42% were under the age of 50. Over 18% were 70 years or more. 122 residents were dependent on wheelchairs. 44 were blind or almost totally blind; 6 were both blind and deaf. One-fifth of the hospital population was both socially impaired and had severe behaviour problems; at the other end of the spectrum, 44% of the residents were sociable and had no behaviour problems. More than 60% of the residents were assessed as being sociable (recognising other people and engaging in some sort of interaction). 96 residents had been in the hospital for more than 50 years; almost half the population had been in Darenth for 25 or more years. 40% of the residents came from outside the official catchment area, although threequarters of these originated from within South East Thames region. About half the residents had no contact with family or friends beyond the hospital; this was particularly true of the elderly people in the hospital whose family members might have died or lived furthest from the hospital. On the other hand, as these residents were often among the least handicapped, they were more likely to have definate friendships with other residents or staff known for many years than were the younger and more handicapped residents. (See tables 8.1-8.4).

Almost 40% of the residents needed assistance to undertake such self-care activities as washing, dressing and feeding. 25% of the residents suffered from severe incontinence. Around 33% had severe behaviour problems, although some of these residents were sociable in other respects. These recognised disabilities in terms of capacity for successful community placements were not evenly shared across the districts. Thus, Bromley sector had the highest percentage of people with behaviour problems (40) whilst Dartford/Gravesham sector the lowest (33); Greenwich/Bexley sector the highest for people who were sociable and had no behaviour problems (47) whilst Dartford/Gravesham sector the lowest (38). Dartford/Gravesham had the highest percentage of clients in wheelchairs (24) with Bromley the lowest (9).

In general terms, the Darenth population did not pose unmanageable problems for resettlement. The deficit in social and personal care skills were aspects which could be compensated for by good environmental support and training. Good detailed planning, based on a knowledge of the residents' needs, could enable all the residents to live in the community.

Organising for departure

When the Darenth project began, residents of the hospital were organised into five sectors, relating to local authorities. Residents were further categorised as catchment or non-catchment. Hospital staff and regional and district officers were faced with the need to resolve several issues:

getting agreement on the number of residents to be taken by each district;
assigning residents to districts;
assessing residents and forming groups to live together;
finding placements for those residents for whom district placements were not suitable.

We consider each of these issues in turn.

Getting agreement on numbers: Regional officers intended to use the closure of Darenth Park to reduce the traditional dependence on the hospital by local authorities for admissions based on social factors. Although in some local authorities, local provision had improved, the hospital still had a large proportion of residents who could fairly easily live in alternative provision in their local communities - they had no medical or nursing reason to be in hospital. According to *Better Services* norms, the seven districts using Darenth Park required 825 beds instead of the 988 places available in the hospital in 1978. The decision was taken to fund no more than 825 places in the districts.

This decision seemed reasonable because of the age structure of the hospital's residents. Statistical analysis showed that about 30 deaths would occur annually over the next five to eight years, and that would result in the number of residents needing to be accommodated reducing to better match the number of places the region would fund. At a global level, then, the region's problem of convincing districts they would not have to take more residents than *Better Services* indicated norms, was resolved.

The non-catchment residents posed a separate problem. Agreement was reached early on by the Steering Group that the non-catchment residents would be distributed to districts in proportion to the resident population of the districts. However, it had been shown (Korman and

Glennerster, 1985) that, when taken in conjunction with the number of catchment residents each district had and the planned level of provision, the formula would result in some districts having places but no residents and others too many residents for the number of places they would be providing (see Table.8.5).

Negotiations between regional and district officers resulted in this problem being resolved by two districts (Bromley and Lewisham & North Southwark) agreeing to take more non-catchment residents than the formula indicated, and Bexley being allowed to take no non-catchment residents because of the difficulty the district was experiencing in finding sites. The resolution of this problem was eased considerably by the new funding policy which allowed districts to receive dowries for each resident discharged from hospital, regardless of norms. By mid-1984, there was agreement on the number of residents going to each district.

Attaching residents to districts: Once the numbers had been agreed, it was then left to those districts taking non-catchment residents to choose which ones they would take. For the majority of non-catchment residents this process worked smoothly; they were selected by the districts whose wards they were on, ensuring continuity of medical cover and of familiarity with other residents.

In October 1985, the Steering Group was notified by the hospital that approximately 50 residents remained unallocated and that some clients were on the discharge list of more than one district. The main proposal made by the hospital manager affected Bromley HA; Bromley was asked to take a further 24 non-catchment residents. This was rejected for local political reasons, namely, the impact it would have on its relations with the local council. What was accepted by the meeting was a new procedure by which the hospital would notify a district of the death of a resident so another resident could be selected from the non-allocated list. By the end of 1986, the number of non-catchment residents remaining unallocated had declined to about 30.

Of these 30, however, 16 were thought to have special needs. Five were subject to detention orders under the Mental Health Act. This problem was brought to the attention of the Steering Group in October 1986. Regional officers thought it unlikely that these residents would be willingly selected by districts; they would require higher staffing levels which would be expensive; with no ties to the districts, districts might find it hard to justify using local funds for their services.

In light of these factors a special meeting of the

Steering Group was called. To prepare for it, a consultant psychiatrist and the leader of the Special Development Team assessed the 16 residents so that information about them could be given to districts. Assessments were based on medical records, not personal interviews.

The meeting at which these allocations to districts took place could scarcely be described as congenial. District representatives recognised that the hospital could not close until these residents had alternative places. But assigning these residents to districts could hardly have come at a more difficult time for the districts. Only one district, Dartford & Gravesham, planned to cater for special needs residents within its main development, Archery House, which allowed some flexibility of numbers and of care. All other districts had built services more or less around the residents they had known they would be taking; absorbing new residents meant planning new services. This factor was in addition to questions about costs. Further, there was a time factor; Darenth was due to close in 15 months time and districts had doubts as to whether they could organise new services in that period of time as well as maintaining the existing programme of discharges.

Regional officers, however, were adamant that the meeting would resolve the issue of district responsibility for these residents. Districts were reminded that they had been required to make provision for the whole range of mental handicap services. The possibility of negotiating extra funds for these residents was held out to them; they were also reminded of past examples of region showing sympathy to districts' problems. In the end, the inevitable prevailed, and districts agreed a distribution of these residents.

Assessing residents: Residents of Darenth Park had already been assessed twice. The first was by a nurse team within the hospital. The second was by the social work assessment team, appointed through joint finance in 1980, and completed by a social worker from Bromley who remained at the hospital until it closed. This assessment was concerned principally with the appropriate kinds of residential accommodation needed, but was not used by many districts because the range of residential options considered (hospital, LA hostel, NHS hostel, Part III home) did not match the types of facilities being planning by districts. Some districts also rejected these assessments because they failed to show any potential for development by the residents; this may or may not be true, but it was how they were seen.

The third assessment was carried out by Dr. Wing and her team as part of their DHSS funded research. These assessments were used by two districts (mentioned below) but were rejected by others for reasons similar to those rejecting the social work assessments.

In general, districts wanted to assess their residents themselves. Assessment was a way of getting to know the residents as people; respecting the individuality of residents was an ideological principle and also a practical way of determining who would live with whom in the new houses. Further, as so many of the district staff were new, coming into post after 1982, it is questionable whether they were aware of these prior assessments.

Dartford & Gravesham had perhaps the easiest task, as the senior staff were already in post and knew their residents quite well. Despite this, they held multi-disciplinary reviews of each resident involving medical, nursing and training department staff. There was no input to the assessments from anyone outside the hospital, and thus no challenge to the health perspective.

Bromley developed a moving on committee which had responsibility for assessing and grouping the residents prior to discharge. Shortly after the 1982 restructuring of the NHS, the district appointed several senior staff to mental handicap services: a director of nursing services, a clinical psychologist, and a head of client training (a social worker by profession). A new consultant psychiatrist was appointed when the district's consultant at Darenth retired. These officers, along with the senior nursing officer for the Bromley sector at Darenth, the Bromley social worker at the hospital and a representative from the Darenth training department, formed the moving on committee. The committee reviewed each resident, inviting the ward sister/charge nurse who knew the resident best to participate in the review. Residents were also invited to attend. From 1983 onwards, staff appointed to the client training and the psychology services worked part-time at Darenth, getting to know the residents of the sector. They too contributed to the reviews.

Reviews were re-examined closer to the time residents moved out to ensure any changes which had taken place were noted. In this way, the moving on committee was able to get an overall view of their residents and reach decisions about the most appropriate placements for them. This overview of the residents contributed to the development of the district's philosophy of service provision which was significantly modified during 1984 to create more variety of living situations and to 'de-institutionalise' the district's 72-place residential centre.

The Bromley model of a moving on committee was also used in Greenwich, largely at the instigation of the clinical psychologist appointed in 1985. In addition to the social work assessments and Dr. Wing's assessments, the district also had available assessments completed by its consultant psychiatrist who retired in 1984. These latter assessments were on the whole rejected as being too judgmental and anecdotal as well as lacking information on self-care skills. An interview schedule was designed which incorporated the results of Dr. Wing's DAS asseswsment, asking questions about mobility, continence, self help skills, communication skills, eductional ability, behaviour, medical information. A further set of questions dealt with the resident's social network: friends in and out of Darenth, family contacts, sociability, day care and leisure activities, work experience, use of community facilities and potential for developing homemaking skills. These questionnaires were used in interviews with both Darenth Park ward staff and the resident where possible. Each member of the committee interviewed six to eight residents.

Other districts used their community mental handicap teams (CMHT) to assess the Darenth residents - Bexley, Lewisham & North Southwark, Camberwell. **Lewisham & North Southwark** had earlier (1981/2) experimented with detailed service needs assessment carried by central core staff, but these proved to be very time-consuming and tended to date fairly rapidly. The work was then handed over to the district's three CMHTs who would also be managing the new services. In **Camberwell**, the CMHT was drawn into assessing Darenth residents because of the absence of any other staff in the district able to carry out that work; their main function was to provide clinical support services in the community. The appointment of house managers and support workers several months in advance of the opening of homes brought in another group of staff concerned with assessing and grouping residents. Eventaully a resettlement officer was appointed at the end of 1986 to bring in a degree of coordination to a situation in which no progress was being made.

In **West Lambeth** the role of the CMHT had already been established as providing services to the community, and team members' time was fully occupied with these tasks. A separate high support team was established of four people, funded for three years by the Special Trustees of St. Thomas', to assess residents and help them make the transition to the community. This team was in post by late 1986 and had 30 residents to assess.

With so many staff involved in assessment, most districts saw the need to systematise the assessment process. Some of the CMHTs in Lewisham & North Southwark used *Getting to Know You* (New Concepts for the Handicapped, Inc., 1982) as a basis of collecting information. The high support team in West Lambeth used *Pathways to Independence* (Jeffrae and Cheseldine, 1982) as an initial procedure. In all cases, they added considerable personal knowledge of their residents as they got to know them. It was important for the assessors to spend alot of time with clients to see how they responded in different types of situations. No one form was seen as being capable of encompassing the idiosyncratic features that make up a personality.

Forming groups among the residents: The overwhelming majority of Darenth residents would be living in groups rather than in individual placements, and the purpose of assessments was also to identify compatible groups.

All districts were against grouping people according to levels of ability as this would scarcely be seen as a move towards creating a 'normal' environment, both for the residents and their neighbours. It would result in a houseful of people with the same weaknesses and lack of skills and would not foster good living together relationships within the house. Neighbours would see people with a mental handicap as "the same", particularly for those with greater disabilities.

Instead, the principal criterion for grouping of residents was friendship. Residents were asked with whom they would like to live and districts tried, as much as possible, to ensure that these preferences were met. In some instances, this meant 'swapping' of residents from different districts to allow friends to live together.

What districts soon found, however, was that the majority of residents did not have strong friendships and so staff were required to create compatible groups. This was done on the basis of common interests, compatibility in terms of behaviour, lifestyle and personalities (e.g. not putting more boisterous or noisy people with elderly residents who liked quiet), avoiding known incompatibilities, or recognising preferences for particular geographic locations.

Many of the staff interviewed found this the hardest part of their work as they were attempting to make decisions about the preferences of people whom they were just getting to know themselves. The 'getting to know' stage had by its very nature to occur over time because many residents would only begin to express their preferences or wishes after they began to trust the new staff. Through visiting the hospital district staff were able to spend time with groups of residents either in the hospital's training facilities, or in empty wards which were given to districts to use as a meeting place, or by taking the residents out of the hospital to see how various combinations of people got on together.

In some districts, the views of nursing staff were sought as to how compatible particular groups of residents were. In other districts, nursing staff were thought to be too judgemental or protective of residents and their views were not sought. In one district, considerable incompatibility and even hostility grew up between district staff and nursing staff, based at least as much on personal life styles as any particular grievance over work. The staff employed by the district were typical of the kinds of persons found in inner city social work type situations: young, probably more left than right, usually in jeans and occasionally outright punk. Nursing staff felt they were ill-chosen to act as models for their residents ("we don't allow our patients to wear torn clothing!") (not actually true:NK).

Some districts had more difficulty in forming groups than others. In West Lambeth, only 30 residents were transferring to the district, and this small number gave little flexibility to forming groups; happily, the majority of these residents were elderly, sociable and had known each other for years; there were several friendships which formed the base of groups. In Bromley there was the opposite problem of too many factors to be taken into account. The district was taking out 152 residents. It had a purpose-built hostel of three 8-place units, a 72-place residential centre of nine houses, and places available in an existing hostel which up to then had been used for women only. The first group of 24 residents transferred to the hostel moved on to group homes within 2 years, so there was a second intake to the hostel. The district was therefore working with about 12 groups of residents, most of whom would be moving out of the hospital within a six month period of time. Changes were frequently made to groups to meet the following conditions:

ground floor accommodation for those in wheelchairs or unable to walk stairs;
keeping friends together;
keeping a balance of sexes in groups;
allowing those wanting a single bedroom to have one;
introducing men into the all-women's hostel;
ensuring groups were at least compatible, if notbased on friendship, in terms of conversational ability and behaviour.

Each change in the placing of one resident often resulted in changes to other groups to keep these factors in balance.

Another factor to be considered by districts was the type of accommodation available for people with restricted mobility. The inner London districts often had difficulty in finding suitable property for conversion for wheelchair users; houses were terraced, tall and narrow. Gardens were not always large enough to allow a back extension bedroom and bathroom. The cost of such conversions was often quite high. The alternative was a purpose-built unit which by necessity tended to congregate the wheelchair users separately from other residents. Such problems caused real difficulties in deciding between ideology and reality.

Likewise, however much thought was given to groupings of residents, it did seem inevitable that some residents were grouped together solely because they had been rejected by others - no known friendships and disruptive or unsociable behaviour which was thought harmful or unpleasant to others. Some districts met this problem by designating one facility for those with 'challenging' behaviour, whether or not this was officially recognised as the purpose of that unit.

All districts were involved in 'swapping' residents as a way of maintaining identified friendships. In most cases, this happened during assessment and before the residents moved out, but occasionally it occurred after one of the residents had been discharged and had expressed his or her unhappiness because of a missed friend. Other exchanges were made because parents or relatives had moved to another district and wanted their family member near them. Usually such exchanges were easily made although in one or two cases financial considerations may have thwarted an exchange. It was not always seen as necessary for friends to live in the same house; close by would be good enough so that they could visit.

Individual placements: All districts were involved in finding some places in private or voluntary homes or in local authority accommodation in other parts of the country. The region's funding policy for mental handicap services was posited on the assumption that some residents would be placed in the community at little or no cost to a districts and these 'savings' would be used to balance out the cost of services directly funded and provided by the district.

However, individual placements were not a major consideration for most districts. Only one district, Dartford & Gravesham, made a special arrangement to find places in the private and voluntary sector, due not to finance but to a shortage of places in relation to the number of residents it had to accommodate.

In other districts, private or voluntary placements have been made for the following types of reasons:

a wish to be near a relative;

a requirement for a specialist facility;

a wish to remain in the Dartford area;

a wish to return to an area of origin.

Considerable care was taken to see that such places were appropriate and in at least two cases, districts paid the cost of additional staff to ensure their residents got the services they required in someone else's facility.

Preparing residents for the move

Care staff were appointed in advance of houses or other facilities opening in order to get to know the residents and help prepare them for the move to a very different type of home from the hospital.

Clients met with staff as individuals and as a group, to see how they got on together. They began by staying in the hospital as a group, having a cup of tea together or perhaps preparing a snack or light meal. They visited the Dartford area individually or in a group - local shops, pubs, the outdoor market, the pedestrian shopping precinct, libraries, cafes, cinema or bingo. They visited friends in other wards or other training centres. Sometimes special outings were arranged to central London.

In helping to prepare clients for a move, staff would assist clients to identify the kinds of activities they enjoyed doing or would like to try, the kinds of food they especially enjoyed, what personal possessions they would take from Darenth, what sorts of things they would like in their new homes. Clients would be taken to see their new homes even if builders were still working on it. Later on, before the final move from Darenth, clients would be invited to visit their home, have a meal, stay overnight and then for a weekend, so that they were moving into a place already a bit familiar. In some instances, clients were able to choose personal items such as sheets and towels or furniture for their bedrooms. Staff often encouraged residents to make up an address book and/or photo album of frends - staff and residents - from Darenth Park, thus showing clients that their life in the hospital was valued as part of their personal history.

Districts were in general keen to help clients maintain contact with their families - Greenwich appointed a liaison officer to see that families knew what was happening, had time to express their views and get reassurances when needed. Families were invited to visit homes before residents moved in, to see where they would be living. Many families had expressed, at the beginning of the project, a great deal of concern about the ability of their hospitalised family member to live in the community or of the community to tolerate them. Hospital staff, often the only ones known to families, had little idea of what would happen to the resident, and so could offer families little comfort or knowledge. Once district staff, however, and especially those who would be working within the homes, were put in touch with relatives, many of their concerns were allayed. In one instance, parents wrote to the Prime Minister because they were so unhappy with their son's placement; they had moved to a neighbouring borough and the DHA there did not have a service suitable for their son, so he could not live as close to them as they would have liked. Yet they too came to accept the placement made for him as acceptable and their objections lessened.

Conclusion

The work reported in this chapter illustrates the complex range of tasks needed to be undertaken in order to move residents from hospital wards to small homes in the community.

No district attempted to be guided by the literature on characteristics of successful placements in the community. If they had, they would have realised an early necessity of devising training programmes for those clients with challenging behaviours to prepare them for life in the community. Had this been done, there would have been time to learn constructive ways of training to minimise the strain of the move for the residents and their staff.

Instead, what did happen was fairly predictable: the most difficult residents were discharged last, making the hospital more difficult to manage during the rundown period and putting districts at a disadvantage in resettling these residents because of the pressure towards the end to close the hospital. The hospital itself provided no additional facilities for these clients; the traditional weaknesses of the hospital - a custodial approach to care, an emphasis on tidiness and routine rather than involvement with residents - prevailed during the rundown as much as before.

A second lesson from the literature was that almost half the residents could live in the community without major training programmes. This would have helped districts, and in particular staff working in the homes, to be less anxious over the move. There were instances of delays in discharge which seemed to be due to staff reluctance to actually opening a home and taking responsibility for the residents. There is also strong anecdotal evidence that most residents made the move very successfully with preparation which lasted only a couple of months.

That so many issues relating to residents were resolved comparatively late in the project emphasizes both the initial capital-led impetus of the Darenth project and importance of the role of the region, especially the contribution of the mental handicap coordinator and the regional staff training officer. The hospital by itself did not have authority to compel districts to accept solutions to problems which went against their interests. The authority of region was needed for such issues; without a willingness to exercise such authority, the hospital would not have closed. Likewise, the development of a staff training programme aimed specifically at running staffed group homes provided an incentive for most districts to reengage with the Darenth project and develop services at a much faster pace.

This chapter also illustrates the extent to which districts had to learn what to do as they went along. Only one district, Bromley, set up a structure and process for systematically assessing residents and exploring possible residential accommodation and pursued these tasks over four years. The other districts struggled until they acquired staff who were not fully engaged in developing the housing programme and so could assess residents, and provide some form of central coordination so that work was tackled systematically and comprehensively. The importance of having assessment and service development responsibilities as a continuum of management underlines the futility of the assumption that districts could have picked up assessments of residents carried out by others and used them for their own planning. The new arrangements of purchaser and provider functions in both health and social services authorities are strongly supported by the evidence of the Darenth project.

……

The difficulties most mental handicap services had in securing adequate staff to help in these tasks was also a reflection of the lack of recognition given by district officers to the complexity and volume of work needed to get the new facilities open, and therefore to the need to make resources available to undertake the development of services up to the point at which they became operational. For several districts, their failure to meet deadlines was an outcome of inadequate staffing to carry out the necessary work, thereby adding to the difficulty of managing the hospital and to stress on existing staff. How well or otherwise districts were organised to carry out this work was important to service managers in order to be in control of their work; it was of equal importance for residents and their families in helping them through the transition process.

Table 8.1

The age and sex of residents in 1980
(of whom full details available)

Age (%)

	Lambeth/ Southwark	Lewisham	Greenwich/ Bexley	Bromley	Dartford/ Gravesham	All Districts
Age Group						
0-19	2.2	3.8	1.1	-	16.7	3.8
20-29	14.7	24.1	17.2	13.8	15.1	16.8
30-39	12.5	14.3	14.2	11.6	20.6	14.3
40-49	10.7	6.0	11.6	13.8	13.5	11.2
50-59	18.8	21.8	15.0	21.0	15.1	17.9
60-69	18.8	21.0	22.1	20.3	11.9	19.3
70-79	16.1	6.8	13.5	16.6	6.3	12.6
80+	6.2	2.2	5.3	2.9	0.8	4.1
All Residents %	100	100	100	100	100	100
Sex						
M	61.6	45.9	50.7	57.9	57.1	57.1
F	38.4	32.2	49.3	42.1	42.9	42.9
Numbers	224	133	267	138	126	888

Table 8.2

Residents and their type of disability in 1980: by borough

Lambeth/ Southwark	Lewisham	Bexley	Dartford & Gravesham	Bromley	All
In Wheelchairs					
25	15	40	30	12	122
Totally or almost totally blind					
9	16	7	10	2	44
1	1	1	-	-	3
Blind and Deaf					
2	1	2	1	-	6

Table 8.3

The behaviour patterns of residents in 1980

Type of Behaviour	Lambeth/ Southwark	Lewisham	Greenwich/ Bexley	Dartford/ Gravesham	Bromley	Total
Socially impaired with behaviour problems	40 (17.4%)	37 (27.8%)	56 (21.0%)	28 (22.2%)	25 (18.1%)	186 (20.9%)
Socially impaired with no behaviour problems	40 (17.9%)	23 (17.3%)	41 (15.3%)	37 (29.4%)	23 (16.7%)	164 (18.4%)
Sociable, behaviour problems	43 (19.2%)	15 (11.3%)	44 (16.5%)	14 (11.1%)	31 (22.5%)	147 (16.6%)
Sociable, no behaviour problems	101 (45.0%)	58 (43.5%)	126 (47.2%)	47 (37.3%)	59 (42.7%)	391 (44.0%)

Table 8.4 **Residents' length of stay in hospital in 1980**

Years	Lambeth/ Southwark	Lewisham	Greenwich/ Bexley	Dartford/ Gravesham	Bromley	Total Nos.
Less than 1 year	2	0	0	6	0	8
1-5	15	6	14	16	15	66
6-10	12	12	16	18	5	63
11-15	11	12	33	13	4	73
16-20	39	21	43	28	17	148
21-25	23	15	27	20	13	98
26-30	8	8	9	7	7	39
31-35	9	6	16	3	5	39
36-40	14	4	11	3	11	43
41-45	15	11	18	4	13	61
46-50	47	24	48	2	33	154
51-55	8	6	13	2	7	36
56-60	11	6	8	2	4	31
61-65	8	2	6	1	3	20
66-70	1	0	1	1	0	3
71-75	0	0	1	0	1	2
76-80	1	0	3	0	0	4
Total	224	133	267	126	138	888

Table 8.5 Numbers of places and of residents

Sector	Catchment Residents	Agreed no. of non-catchment	Total number	Number of places being being provided
Dartford and Gravesham	80	40	120	120
Bromley	36	50	86	144
Greenwich/Bexley	137	72	209	214
Lewisham	39	31	70	24
Lambeth/Southwark	150	91	214	120*

* These places were for Camberwell/West Lambeth residents, including those sector residents who belonged to the N. Southwark part of Lewisham and North Southwark.

Chapter 9

Local Authorities and Joint Planning

Introduction

For at least three decades, an objective of central government has been to promote collaboration between hospital and community-based health and social services. That collaboration was seen as necessary was a recognition that, for clients who were elderly, or suffered from chronic physical or mental disabilities, services would be required from separate and autonomous agencies to meet their full range of needs, and how these agencies worked individually would affect other complementary agencies. Collaboration was therefore important at different levels: at an operational level delivering services to clients in a coherent and comprehensive way; at a strategic level to ensure a balanced approach to service provision, including working towards mutually compatible goals, and to support the shift from hospital to community care. There was also an efficiency aspect to collaboration; effective collaboration would avoid wasteful overlap and duplication of service provision.

An early example of parallel planning was the Hospital Plan (Cmnd 1604, 1962), followed one year later by local authority community health and welfare plans (Cmnd 1973, 1963), intended to be a response to the consequences of the Hospital Plan by setting out the development of community services to lessen dependency on hospital care for several groups within the population. In reality, the two plans had little to do with each other; there was no evidence that the local authorities responded to specific hospital plans for their localities, only to general trends.

A more significant attempt at joint planning was made as part of the 1974 NHS reorganisation, which was intended to create a structure able to overcome the recognised deficiencies of the existing health and welfare systems: imbalances between geographic areas, between acute and chronic care groups, between hospital and community services, and between treatment and prevention (Cmnd 5055, 1972). Once it was agreed local government would not be made responsible for managing the NHS, other means needed to be found to secure better integration of related services. Joint planning was to be the means by which two separate authorities produced a single plan mutually acceptable, the product of "close and continuing cooperation" (DHSS, 1973).

The first step was to provide co-terminous boundaries between area health authorities and local authorities, so that each service was concerned with the same population.

Secondly, the 1973 NHS (Reorganisation) Act required health and local authorities to establish a member-level Joint Consultative Committee (JCC) whose function would be to advise their respective authorities on appropriate joint approaches to service development and delivery. In addition, local authorities were given one-third membership of AHAs.

A planning system was initiated in the NHS in 1976, at the same time that arrangements for joint planning were strengthened. Joint care planning teams (JCPT) were established for strategic service development; these were to report directly to the JCC and their respective authorities (DHSS, 1977a). In addition, joint finance was introduced to help joint planning by requiring both authorities to agree on the expenditure of this money. Joint finance money, in reality a relatively small sum, was top-sliced from the NHS budget to be used for projects in the community which would represent better use of that sum of money than if it had been spent on health care. It was used largely for priority groups; the government hoped it would influence local authority priorities by stimulating community-based services. A further boost was given in 1983 through the care in the community initiative which extended joint finance for up to ten years at 100% funding but tied this closely to people coming out of hospital (DHSS, 1983c).

The experience of joint planning, up to the mid-1980s, showed that it had largely failed to live up to early aspirations. Many case studies of joint planning cited the differences between health and local authorities which worked against joint plans: differences in political accountability, budgetting processes, operational and planning procedures, professional perspectives and traditions, and differences in priority attached to issues (e.g.Brown 1976, Booth 1981, Glennerster *et al* 1983, Wright and Sheldon, 1985, McGrath 1989). Coterminosity was not universally achieved. In the shires it related to only one level of local government (Wistow, 1982); in other situations it ignored the problems of an AHA providing services to local authorities beyond its boundaries, the traditional long-stay hospital situation (Sargent, 1979). Beyond these structural issues, however, were others which related to the types of knowledge individuals and organisations needed to have of each other (Nocon, 1989) and to bargaining and negotiating skills needed to made joint planning work (Challis, 1988).

Joint finance was not thought to have been very much more successful. The incentives provided by joint finance and care in the community were seen as inadequate to bring about a significant shift towards community care (Wistow and Hardy, 1985). Both these schemes highlighted a further set of differences between health and local authorities, in terms of definitions of community care (more local residential or more domiciliary/day care) and how community care was to be brought about (by closing hospitals or by developing local services to prevent admissions) (Wistow, 1983).

Reflecting on 16 years of joint planning, two broad features stand out. First, the same assumptions made about planning in the NHS planning system were made about joint planning: both planning activities were based on a rational comprehensive model which posited certain conditions for successful planning: concordance on objectives; an adequate and shared information base; a rigorous analytic capacity; organisational good will (Webb and Wistow, 1986). Critiques of the accomplishments of joint planning showed how far from reality these assumptions were and their authors were drawn towards recognising that those instances in which joint planning had been successful displayed quite different features: frequent and consistent interaction to evolve a shared view of service development and personal trust in the personnel of "the other side"; focus on limited and current problems rather than an abstract strategy; a greater emphasis on user involvement or representation as a means of focussing on outcomes rather than inputs. Even the successes of joint planning, however, had not resulted in significant changes to the social care system and have been patchy over the country.

The second feature impacting on joint planning aspirations was the disharmony between policies for joint planning and other types of policies for health and social services. During the 1980s increasingly tight financial controls were being exercised by central government over both statutory services which made the NHS eager to shed responsibilities and local authorities unwilling to acquire new ones without guaranteed funding. A new system of accountability reviews was initiated in the NHS which provided an incentive for the health service to plan community services separately if agreements with local authorities could not be reached. Allowing grants to be made directly to housing associations by the NHS had a similar effect. Central government gave out contradictory messages, thus failing to support its intentions for joint planning.

The Darenth Park project was intended to be an exercise in joint planning. The seven local authority directors of social services were represented on the Steering Group by two directors, one of whom was vice-chairman of the Steering Group; it was seen then as a novel arrangement to have a non-NHS person as vice-chair and health service officers were proud they had encouraged this. We now examine how joint planning fared in the Darenth project.

Collaboration prior to 1983

The initial stance taken by local authorities in the catchment area was that they were interested in becoming partners in the Darenth project; they believed that there were many people in Darenth who could be more appropriately cared for by social services than by health services. The assessment study funded by the region but carried out by a team of social workers showed that this was true. But local authorities expected the health service to meet all costs associated with relocating these residents into the community. The NHS was currently receiving funding for these residents; transfer of responsibility should be matched by transfer of funds.

This argument was tested by Southwark Council in 1981 and the region refused to meet the full costs of that scheme, on the grounds it could not legally transfer mainstream revenue outside the NHS (see chapter 6). Its funds had to be used to provide health care; if residents did not need health care, the NHS could not pay for them. Secondly there was an issue of how much money. New services were likely to be more expensive, because they were intended to be a significant improvement over the quality of care provided in the hospital. Local authorities wanted full costs to be met; the region was beginning to get worried it would not have enough funding to meet those costs.

Local authorities withdrew from the Darenth Park Steering Group at the beginning of 1982, and did not return until after care in the community circular had been issued and the region had devised its own funding policy. Their absence, however, allowed district health authorities to get on with their own arrangements so that by the time local authorities reappeared, most districts had more or less completed plans for the number of residents they would be taking out of Darenth. The absence of social services representation at the Steering Group made no difference to the progress of the project; some thought it helped.

Finance was not the only problem for local authorities; there were other factors which added to the difficulties of joint planning. First was a difference in populations. Local parents were of course aware of the Darenth project and of places being made available in the community for people from the hospital. They began asking about residential facilities for their children whom they had kept out of hospital; this put pressure on local authorities to pay attention to a different audience than Darenth Park residents.

A second factor was planning capacities of local authorities. During the first five years of the project, no local authority devoted any of its own staff time to planning replacement facilities for Darenth Park. Most social services departments were fairly weak in planning and development capacity; staff in these sections were often seen as more expendible than were service providers when cuts came (Glennerster *et al*, 1983). Development time was used for a department's own priorities, not for helping Darenth. At a practical level, it was doubtful whether local authorities had the capacity to plan and implement a programme at the pace required by the region without additional resources.

The relationships established between health and local authorities varied considerably across the seven districts as would be expected given the different service traditions, political makeup and personalities involved. The following examples show how varied the nature of the interactions were amongst those who most actively pursued "jointness".

Examples of a joint approach

Collaboration through conflict: One district emerged with an agreed comprehensive joint strategy - Greenwich. This came after two years of quarterly meetings, with the Joint Care Working Group (JCWG) chaired by an assistant director of social services. The JCWG succeeded a health care planning team for mental handicap which had been chaired by a health authority member who was also a local councillor. Both the health authority and the local authority had recently drawn up plans which were fairly different in content and tone. The JCWG was to reconcile these two documents to ensure that service developments would be complementary.

The two statutory authorities had quite different views about the size and type of provision, based on divergent philosophies of care. The DHA used *Better Services* norms, adding to that the known shortfall in the local authority provision and new provision for short-term care. The local authority thought that would result in excessive health service beds. Likewise, district officers thought the local authority's wish to make part of its provision suitable for severely handicapped people misguided; it should be concerned solely with the more able.

Because existing plans would not be adequate for the number of residents in Darenth Park for whom it was responsible, district officers began contacting local estate agents to find suitable property. This interested the social services department considerably, as it represented a very different model of care from existing or planned NHS provision, and one which the social services department saw as coming within its range of responsibility; there could be a "boundary problem". By the end of 1985, some degree of compromise had been reached which recognised that the health authority should retain responsibility for the more severely handicapped coming out of hospital, and possibly for people with severe handicaps still in the community. The local authority would now become involved in planning for residents of lower dependencies coming out of Darenth. This was the basis of the *quid pro quo*.

This truce was brought into question when at the end of April 1986, plans for the development of the 48-place residential centre and a 90-place day centre at the Royal Herbert site had to be scrapped, because the region had received what was termed a "generous" officer by a supermarket chain for the site. The district's health care planning team was reconvened to inform the local authority and voluntary organisations of this and to present to them alternative proposals.

The local authority did not react well to this. To some extent officers felt that they had been made fools by the health authority; negotiations about the site had been going on for several months, but they had not been informed. They had loyally supported the Royal Herbert development in public consultation and through the local authority planning process, not because they liked it, they did not - it violated almost all of their philosophy of care; they supported it because the DHA seemed determined to go ahead. All this now seemed in vain.

The health care planning team meeting took no decision, but allowed some time for comments. One month later the JCWG met. This meeting was attended by the director of social services. He and his colleagues protested that they were being presented with a *fait accompli* by the DHA yet again. They saw the change in plans making possible a radical rethink of the overall service position in the borough.

The social services officers objected to the proposed concentration of 32 people on one site, especially as they would be the most handicapped residents. At the same time, they put in a bid to manage the remaining 16 places lost from the Royal Herbert, now to be provided in ordinary housing, claiming they had the experience and established management procedures to support group homes. To further these schemes, it suggested a joint resettlement team of one officer from each authority to produce plans and to turn these into services. More dramatically, the director of social services put forward the social services' case himself. Rather than reject the borough's views out of hand, the health service officers agreed to consult the region to see if time would permit rethinking their services.

By July, the proposed plans had been modified. They now consisted of 20 places at the British Hospital for Mothers and Babies site, and two purpose-built bungalows of six places each at the Goldie Leigh site, lessening the concentration of residents on one site. The district hoped that the remainder of Goldie Leigh site would be sold for ordinary housing, thereby integrating the bungalows into a local community. Two resettlement officers, one from each statutory agency, were being appointed to progress these plans; these officers gradually took on the role of "reticulists" (Friend *et al*, 1974), forging new chanels of communication between the authorities. By the middle of 1987, the joint planning group had an agreed joint statement of strategy for the next four years of service development.

The withdrawal from the Royal Herbert site had provided an opportunity to rethink service philosophy. Other factors were also at work.

-the consultant psychiatrist retired in the middle of 1985. This meant one less voice to speak up for a more traditional, medically oriented service.

-A new UGM for Priority Care Services came into post in

May 1986. He had worked in an area where health and social services had collaborated together to develop new mental handicap services based on ordinary housing. He was sympathetic to the social services model of care and to their claim for expertise in managing that type of service.

-A new full time psychologist was appointed to the mental handicap service. She created a moving on committee to assess the Greenwich residents in Darenth Park, showing that they were younger and had a much wider range of abilities than had been previously thought.

-The district had received funds from the DHSS to develop a new facility for children (under DA(3)83 Getting mentally handicapped children out of hospital). This unit was run with operational policies close to the principles of normalisation, and this gave confidence to the district about providing services on a different model of care.

This coincidence of events, which occured roughly within six to twelve months, led to the only instance where a significant number of Darenth Park residents were transferred across to the care of a social service department within the timescale of the Darenth project. Some measure of collaboration came after considerable conflict; the two authorities agreed to shift the boundary of service provision between them so that the local authority confined the health authority to care for the most disabled residents only. New personalities and a loss of a site for a new facility created the space in which change could be negotiated.

Collaboration through privatisation: Bexley provided another model of collaboration - privatisation. In the middle of 1988, consultations took place on a proposal to provide a joint residential service by a newly-formed private organisation. This was the culmination of attempts over six years to find ways for the authorities to cooperate. The health authority had relied totally on Darenth Park; there were no local mental handicap health services and no local tradition for such services. The local authority had some services, principally for people with moderate handicaps. Day care services were provided for the more handicapped, but these were limited and still excluded some adults on the grounds that they were too difficult to manage.

When Bexley became a district health authority in 1982, a joint care planning group (JCPG) for mental handicap services was established. The district wanted to ensure that progress on services for the Darenth residents took place in the wider context of comprehensive community mnental handicap services. Within a year, the DHA had produced a draft comprehensive strategy; the local authority was not able to either respond to it or to produce a draft plan for its own services. The JCPG drifted and was eventually dissolved by the new district general manager at the end of 1985. In its place, he established a task force, much smaller in membership and focussed solely on progressing plans for the Darenth Park project; out of this group came the proposal for and implementation of a Bexley Housing Consortium. Joint working discussions now took place in the Joint Consultative Committee which soon issued a statement of intent to create a joint service and a joint strategy. This engendered no action but was a marker at member level that some arrangement needed to be worked out.

Both statutory authorities were experiencing changes in personnel at senior level. Bexley Health Authority had created a common structure for mental handicap and community health services in 1982. No senior appointments were made at that time; instead posts were gradually filled below. A projects officer was appointed in 1984 to develop plans for the Darenth residents. A unit administrator was also appointed. A UGM for both mental handicap and mental illness came into post in the middle of 1986. A divisional manager for mental handicap services was not appointed until January 1988. The consequence of this slow build-up of the management structure was that decisions about the nature of services were made fairly low down in the organisation and not all of the wider implications were seen. In March/April 1987, the DGM was dismissed and a new one appointed, as well as a new Director of Finance and in 1988, a new Director of Planning.

Within the local authority, personnel changes were also occuring. The Director of Housing and Personal Social Services took early retirement after a mild heart attack in 1985; the Chief Social Services Officer left not long after that and at short notice. An Assistant Chief Social Services Officer, responsible for research and development, was appointed in mid-1986. The vacancies of the two most senior social services officers brought into play senior staff from the Chief Executive and finance directorate. The central concerns of these staff were to get issues resolved and to do so at minimum cost; they were not particularly concerned with debates about the nature of care.

Within months of his arrival, the assistant chief social services officer produced a paper outlining how local authority services could be developed at no additional cost to the Council, through the involvement of an independent organisation to provide residential services on a contractual basis. This would allow clients to claim a higher level of social security benefit. With these savings, the Council could both expand and improve its existing services, including day and respite care.

These proposals recognised several problems currently facing officers and members of the council. First was the inadequacy of existing council services to meet current and future anticipated demand. Secondly, by showing how such developments could be undertaken without requiring additional council funds, the social services officers were offering an inducement to members to agree to an expansion of services, something it was known councillors would not agree if it had to be funded by the rates. The involvement of an outside organisation was another inducement; the Council could be seen to be "leading the way" in the central government's philosophy that local authorities should oversee rather than directly provide services.

Lastly, these proposals showed a way of overcoming the concerns felt by councillors about the expense of mental handicap services being developed by the health authority. The DHA's service was based on a significant contribution towards costs by the clients claiming social security benefits. Local authority officers thought that the Bexley Housing Consortium was simply too close to the health authority to be seen as independent. If at some stage, the DHSS decided to stop paying the high level of benefit, the DHA would not be able to meet the full costs of the service and the local authority would somehow have to pick up the pieces. Alternatively, the financial crisis could jeopardize the independence of Bexley Health Authority.

The proposals for a joint private residential service eventually appeared as a brief proposal in February 1987. The DHA Director of Finance agreed with the local authority that the costs of the health authority's current residential services were too high. He in turn was able to convince the district's other senior managers that changes had to be made and an agreement on a joint service with the local authority would present the best way forward. The two authorities agreed at member meetings during the summer of 1987 to open negotiations on a joint service. The CHC was informed by the DHA that it would not be formally consulted but regional officers intervened and suggested consultation was necessary.

Separate from these negotiations, the local authority pursued its intention to engage a voluntary organisation to take over management responsibility for its own residential services for people with a mental handicap. Three national organisations were approached and expressed interest. No final agreement was reached because of difficulties relating to staffing issues: each organisation wished to have a larger say in staff structure and managers than the local authority wanted.

At the same time, the DHA was pressing the virtues of the existing consortium. The consortium had already been established, was employing housing staff and had taken on the housing management responsibilities in a satisfactory way. Moreover, the local DHSS had agreed residents were eligible for higher levels of board and lodgings allowances. On this basis, the local authority agreed, towards the end of 1987, that the consortium could act as the third party. Negotiations were then opened with the consortium.

Both the DHA and the Council made two mistakes. They assumed that the consortium was a creation of the health authority, and would do exactly what the health authority officers asked of it. Secondly, negotiations with the consortium were expected to be fairly simple, with an interim agreement in about two months.

In reality there were major differences between the consortium and the statutory authorities, who did not appreciate the extent to which they were asking the consortium to change: to take on 20-place hostels in addition to small houses; to develop new working relationships with the local authority; to take on the management of all DHA and local authority care staff in residential services.

The consortium itself had weaknesses. Its management committee was weak in management expertise, certainly in management of independent organisations. The most active members were health service officers (or ex-officers) and housing association representatives. Many members of the committee had been closely involved with development of the district's new services and were understandably reluctant to see them change in a way which they considered would lower their quality. Because of the earlier discussions with other voluntary organisations, they felt the consortium had been treated shabbily.

By Christmas 1987, the local authority and the health authority had agreed on a model of care which in prinicple was close to that of the consortium. The key issue then turned on the management structure. The consortium submitted a management structure which was seen as too extensive and therefore too expensive. In point of fact, the real issue was the lack of faith the two statutory agencies had in the consortium to manage a much larger service. Negotiations which had been going on during the first four months of 1988 were broken off in May, when two senior officers announced to the consortium that health and local authorities had reached agreement with a private non-profit organisation to take on the management responsibilities. The consortium, later in June, began proceedings to dissolve itself.

The organisation with which the statutory authorities had reached agreement was a private company limited by guarantee, owned by the former Director of Housing and Personal Services of the council, called Social Policy Management Services Ltd. It was established specifically for the purpose of taking on residential services within the framework desired by the statutory agencies.

Meanwhile, the DHA had agreed in March to go out to consultation on the basis of the consortium being the voluntary organisation mentioned in the proposed change of service, although officers argued that consultation was about the prinicple, not the organisation. As part of this consultation process, the CHC in early July 1988 held a public meeting on the proposal for a single residential service. It was an odd meeting, concerned with consultation on a health authority document, with most of the issues related to local authority responsibilities and intentions. It was less than harmonious, indicating some of the hostility generated by recent events in the borough and to the concept of privatising residential services.

The results of consultation were presented in a report to the July DHA meeting. In that report the health authority attempted to offer reassurance to the CHC and others that the main points of disagreement were being discussed and resolved. Because of the CHCs objections to the initial proposals, the RHA became involved as a participant in further negotiations. The two authorities then produced a joint service specification and draft code of practice which spelt out how the service would operate. A further CHC meeting was held in October 1988 and at that time, although the CHC still opposed the proposals, CHC members were pleased with the major advances made in developing the framework for a new service. A number of points were still outstanding and because the proposals of contracting services out to a privately owned company was so new, the CHC was reluctant to give formal approval until all points had been clarified and all documents finalised. These views were conveyed to the November DHA meeting.

The local authority signed a contract with SPMS in September 1988; the health authority did not do so until mid 1989. In this case, a joint management arrangement was avoided through the creation of a new agency to work on behalf of both health and local authorities. Both authorities saw advantages for themselves in not directly managing the services.

Collaboration through a single statutory service: In a third borough, negotiations were being conducted towards the end of 1988 to create a single statutory service. Bromley was chosen by the Audit Commission for a trial audit based on the ideas found in its report on community care. Discussions about a joint service had been going on for some time, but several changes now made the negotiations more likely to succeed.

Over the past 10 years, the local authority which could no longer gain admission for its residents to the hospital learned how to cope with more handicapped people. Differences in philosophy of care lessened, with both statutory agencies seeing that at least a part of their services could be provided in ordinary housing. With the health authority having taken out all its residents form Darenth Park, both agencies had a much clearer picture of what their existing commitments were. The social services department and DHA had recently developed a joint children's service with three houses having joint staff appointments and three having mainly NHS staff because of the degree ofdisability of the children. The closure of a children's hospital and an underused children's home provided the opportunity for the joint children's servcice.

In this case, a "joint trade" was the basis of an agreement. The DHA was also responsible for the closure of a nearby multi-district mental illness hospital, and would be creating new community services for people being discharged from there. This gave scope for negotiations with the local authority. The essence of the arrangement was that the local authority took lead responsibility for mental handicap services, and the health authority for mental health services. Both community services became single agency services, on the basis of which authority employed (or could employ) the dominant professions involved in the service. By dividing up these two services, each authority got something it wanted.

Conclusion

Local authorities and health authorities began joint planning more as protagonists than collaborators. We rehearsed in chapter 5 the reasons why the initial approach to joint planning, structured largely by regional officers' understanding of the new NHS planning system, achieved little in the way of cooperation or collaboration. The rational comprehensive planning model could not work if there was no agreement on objectives, different views on what kinds of services to provide, who should provide them and therefore how they should be planned, and no organisational good will to drive through plans in the face of a range of difficulties. Both sets of authorities looked at the problems of closing Darenth and developing new local services differently; joint planning had no way of coping with such differences. The role of strategic coordinator failed to achieve collaboration because it could not engage local interests.

The Steering Group meetings showed that joint planning was at a stalmate position. Local authority officers insisted they had to be paid for the full costs of services they provided; regional officers refused to hand over any money. Regional officers insisted that they were rehousing the Darenth residents; local authority officers wanted services to embrace people still in the community as well. The proof was that when local authorities withdrew from the Steering Group, it made no difference to the Darenth project; districts simply kept on making and implementing their own plans. Both sides attempted to manipulate the other into complying with their own wishes; neither succeeded.

How did the three examples of successful joint planning come about? The first factor was the removal of constraints by regional guidance which imposed a model of care selected and owned by the NHS. The incentive this created was the possibility of developing a local service according to local interests. Both authorities now had a stake in negotiations. Lindblom, and others who do not adopt a central top-down view of organisation, argue that organisations will cooperate only when it is clearly in their interests to do so. The opportunity of gaining resources is a powerful incentive for interaction, as is getting rid of something you don't want to do, or giving up something to get something you want more. With the removal of the requirement to adhere to the regional model of care, local collaborators could now select their own objectives and bargaining chips; their interest was firmly engaged in the process.

Secondly, personalities did make a difference. In Greenwich, the arrival of a new UGM with a social services background, and the appearance of the director of social services at a key meeting contributed to the impetus for change by each one using events to further their goals. In Bexley the introduction of the borough's chief executive and the district's finance officer swayed the views of other senior staff to see the problem not as one of service but of organisational viability.

Political status played a role too. The single private partnership scheme in Bexley went ahead despite opposition from almost all operational staff and a number of parents because the senior managers and chairmen of the two authorities wanted it. In Greenwich, the attendance of the director of social services at the JCWG made it impossible for district officers to ignore the proposal to start again. Major change requires the attention of the top of hierarchies.

The experience of the Darenth project shows that there is no one way to approach joint planning. The three instances of collaborative planning illustrate that arrangements and issues will grow out of situations and interests specific to a locality. Yet these three examples also show that there was in reality very little jointness in these new arrangements. In each case, the local authority involved felt the development of residential services by the health authority represented an "invasion" of what had been considered to be local authority responsibilities.

In these instances, Benson's model of interorganisational relationships as a political economy offers insight into these interactions (Benson, 1975). Although on the surface, each of these three cases represents an efficient management solution to a problem (who is best able to provide care for this group of people?), underneath lie other issues to do with domain consensus (the role and scope of each authority) and ideological consensus (the approach to the provision of services). And there were issues about resource allocation and the mismatch between sense of responsibility and funding. The closure of Darenth Park on the basis that health authorities would continue to provide care for these residents within districts rather than in the hospital challenged local authorities' responsibility for community care. For these three local authorities, this created an imbalance between health and local authorities, enough to make them spend considerable organisational time and effort in resolving it on a more favourable basis to their own image of what they should be doing and in convincing their health authority of the correctness of that view. The shift in boundary represented the new equilibrium between authorities.

Appendix to Chapter 8

Service Developments in the community

Involvement with the Darenth project was only part of local authorities' concerns about the development of services for people with mental handicap. Several local authorities were already active in increasing services for this client group when the Darenth project started in 1978. Over the 10 years of the project, local authorities continued to develop their own services for people who had never been in hospital. Closure acted as a catalyst, although the pace of change slowed down for some authorities as constraints on local government finance began to bite.

Table 9.1 lists the changes which took place in local authority services during this ten-year period.

Core and cluster is a development of several units geographically close (not necessarily next to each other) with the core unit having more specialised staff, and the other nearby units functioning independently but drawing on the core unit for additional help if needed. Originally these schemes used older, community housing.

Small group homes for 2-4 people living together, usually in community housing stock. The homes may have peripatetic staff, day staff, 24 hour staff, or no staff. The residents are encouraged to run the house themselves, performing as many of the tasks as they are able to do.

Home care is a scheme providing relief to families caring for a member who is doubly incontinent, or has disturbed behaviour. The development officer recruits and trains workers who link in with a family, getting to know all members and learning how to handle the member with handicaps. The family may book relief care up to two and in some cases three weeks per annum. The family contribution to the cost of this service was £1 per half day up to £21 per week (1988 prices).

Semi-independent living is the provision of small group homes or individual living arrangements near a hostel or staffed group home, so that residents may easily call for help if needed.

Hostels are for much larger groups of people living together (up to 30 people) usually with 24-hour staff.

Family care/boarding out/adult care are all schemes provising individual placements in a family setting or in a small lodging housde. When part of a family setting, the home owners are expected to provide care and support as well as board and lodgings. DHSS makes some payments for this type of service and local authorities may often top-up depending on the level of care being provided.

Table.9.1 **Local authority developments in detail**

1978	1984	1988	Better Services Norms, 1988 LA pop. estimate
Dartford & Gravesham			
	25 Hostel	24 Hostel	
	9 Group Home	9 Group Home	
	10 Vol.in-borough	18 Vol.in-borough	
	35 P/V	36 P/V	
		1 Assisted landlady	
	140 Day care	162 Day care	
	20 Special Care	34 Special Care	
	79 Res	88 Res	168 Res
	160 Day	196 Day Care	160 Day
Bromley			
25 Hostel	46 Hostel	24 Hostel	
35 Agency	4 Group Homes	29 Group Homes	
225 Day	28 Vol. in Bromley	55 out-of-borough P/V	
	3 Shared Care		
	41 Vol. outside	8 Family Placements	
	3 in other LA facilities	48 Vol. in-borough	
	19 Private	10 Private in-borough	
		11 Live-in carers	
240/250 Day	276 Day		
	40 Special Care	40 Special Care	

~~Table 9.1 cont'd.~~

Total Bromley	60 Res. 225 Day	144 Res. 280/290 Day	181 Res. 316 Day	224 Res. 387 Day
	Lewisham			
	30 Hostel	68 Hostel	68 Hostel	
	4 Group Homes	8 Group Homes	14 Group Homes	
			14 Flatlets	
		30 Boarding Out	28 Boarding out	
	80 P/V		33 P/V in-borough	
		17 Vol. in-borough		
		78 P/V Out-of-borough	64 P/V Out-of-borough	
	160 Day Care	260 Day Care	280 Day Care	
	20 Special	20 Special Care		
Total Lewisham	114 Res. 180 Day	201 Res. 280 Day	221 Res. 280 Day	173 Res. 299 Day
	Lambeth			
	20 Hostel	12 Hostel	17 Hostel	
		8 Group Home	18 Group Home	
	10 P/V in-borough	17 Vol. in-borough	77 P/V in borough	
	60 P/V Out-of-borough	90 P/V Out-of-borough	104 P/V Out-of-borough (inc. some children)	
		12 Sheltered Hsg	12 Sheltered Hsg	
		6 Boarding Out		
	150 Day	150 Day	150 Day	
	15 Spec.Needs	33 Special Needs	53 Special Needs	

~~Table 9.1 cont'd.~~

Total Lambeth	90 Res. 165 Day	168 Res. 183 Day	228 Res. 203 Day	182 Res. 316 Day
	Southwark			
	36 Hostel 4 Group Home 50/60 P/V 180 Day Care	38 Hostel 4 Group Home 53 P/V 180 Day Care	80 Hostel 12 Group Home 18 P/V in-borough 1 other LA 232 Day Care attendance 9 Day Care out-of-borough	
Total Southwark	90/100 Res. 194 Day	105 Res. 194 Day	181 Res. 241 Day	158 Res. 273 Day
	Bexley			
	38 Hostel 25 P/V 163 day care	38 Hostel 4 semi-independent 25 P/V 202 day care 18 special care	42 Hostel 4 semi-independent 9 group homes 5 indepen. tenancies 60 Out-of-borough P/V 232 day care 18 special care	
Total Bexley	63 residential 163 day care	67 residential 220 day care	120 residential 250 day care	164 res. 285 day

Table 9.1 cont'd.

	Greenwich			
	42 hostel	42 hostel	42 hostel	
	16 shelt. housing	21 shelt. housing	22 shelt. housing	
	49 P/V	64 P/V	56 P/V	
		7 group homes	3 group homes	
		3 boarding out	40-45 boarding out/ family placements	
		2 CSV-supported indep. living	5 CSV-supported indep. living	
			6 shared tenancies	
	235 day care	220 day care	273 day care	
	30 special care	45 special care	45 special care	
Total Greenwich	107 residential	139 residential	174-79 residential	161 res.
	265 day care	265 day care	318 day care	280 day

Chapter 10

Rundown of Darenth Park Hospital

Perhaps the most quoted sentence in the 1985 House of Commons Select Committee Report was :'Any fool can close a long stay hospital: it takes more time to do it properly and compassionately'. This chapter will show that this statement is basically untrue. Managing the rundown of a hospital is at least as complex as developing new services, with the additional complication that staff may often be hostile and uncooperative because they feel the closure to be a rejection of their work. Moreover, the pace of closure is determined by the pace at which new facilities in the community open; hospital managers are more often responding to situations over which they have no control than initiating activities which are in the hospital's interests.

If the complexity of hospital rundowns is poorly appreciated by politicians and senior managers, it is in part because there has so far been little effort expended by researchers in understanding that activity. The attention and the interest have all gone towards new developing philosophies of community care, new forms of service provision, new means of supporting people with severe handicaps/challenging behaviours and specifying the qualities of new services (e.g., Renshaw et al, 1988, Sharkey & Barna, 1990, TAPS, 1990). One study has been made of hospital staff during a rundown (Allen *et al*, 1990) and a few of the views of hospital residents (e.g. Cattermole *et al*, 1988). The hospital itself is neglected; it is seen as an inappropriate form of care, one that harms rather than helps its residents. This rejecting attitude towards the hospitals, however, has also resulted in a lack of concern with what happens to residents who have not yet left the hospital, or with the staff left to care for them until the hospital closes.

To close Darenth Park, the managers of the hospital had several objectives to achieve:

-maintaining the quality of life for residents despite the disruption of ward moves and closures as the hospital contracted and staff changed;

-making effective use of remaining staff and providing satisfactory alternative employment for those who wished to stay on in mental handicap nursing;

-achieving the closure of the hospital within the timescale envisaged and within the financial resources afforded to the hospital.

We now examine how the managers went about working towards these objectives.

Maintaining the quality of life for residents

To manage the physical contraction of the hospital, annual "reduction control plans" were produced by the senior staff at the hospital. The plans, the first of which appeared in April 1984, listed the discharges anticipated over the coming year, based on information supplied by districts about new facilities, and the resulting ward closures made possible by these discharges. Hospital managers had identified those wards which they wished to close first, because the fabric of the building was of poorer quality than that of other buildings, or because they wished to cease using wards above ground level as residents grew older. First, then, there was a plan for ward closures which was based on an assessment of the condition of wards, the needs of the hospital population and the potential for savings on running costs of the hospital.

At the same time, hospital managers recognised that ward moves were usually upsetting to residents, and so they proclaimed a policy that residents would change wards only once before discharge.

We now show what actually happened.

Planning the rundown

Three reduction control plans were produced: 1984, 1985 and 1986. Table 10.1 shows the number of discharges planned for the coming years in each of these plans and therefore the number of residents it was assumed would remain in the hospital. These three plans chart an initial assessment of the pace of discharge, followed by a more optimistic view of the pace of discharged based on the achievement of the first year's target and the wish to speed up discharges. Table 10.2 shows the actual number of discharges which occurred each year, highlighting the slippage which took place in almost every district. Table 10.3 shows the actual rundown of the hospital in terms of the resident population on a monthly basis.

The failure of alternative services to open on time or to provide as many places as planned thus became a serious problem for those planning the closure. There were several reasons for this:

i) Capital schemes fell behind schedule. All districts experienced delays, in some cases quite serious ones, in the building/conversion of accommodation. Building schemes overran; some firms went bankrupt, and new tenders were needed. Several conversion schemes also took longer to complete than had been originally estimated. In retrospect it would have been wiser for planners to have built in much more latitude for delays of this kind.

ii) Unsatisfactory original design specifications caused losses of places or delays. The main residential facility for Dartford & Gravesham, Archery House, was designed for 96 places. When staff came to inspect the completed facility, they realised the impossibility of fitting in furniture, residents and wheelchairs into the four place bedrooms. It took six months to secure the agreement of the health authority to reduce the number of residents to be housed from 96 to 80. In other districts, some group homes required modification when it became known which residents would be living in them. Greenwich, in particular, experienced delays in two projects because of the unsatisfactory space allowances.

iii) Changing district plans. Another difficulty faced by the hospital managers was that planning in districts changed as districts changed their ideas about services they would provide or as region renegotiated responsibilities of districts. The decision of the Darenth Park Steering Group in July 1984 to redistribute the non-catchment residents required some districts to increase and others to reduce planned provision. These changes appeared in the 1985 reduction control plan. The following year's plan caught up with another set of changes mainly around the move towards a greater use of community housing stock and away from purpose-built units: Bexley's decision to drop the redevelopment of the Goldie

Leigh site and provide group homes; Camberwell's to reduce its residential centre from 72 to 42 places; Greenwich's to drop the proposed development on the Royal Herbert site and to substitute a mixture of converted and purpose-built accommodation.

iv) Financial constraints caused some authorities to delay opening facilities that could have been opened on time. A hostel in Bexley had its opening delayed by six months whilst the district tried to get additional funds from region. In Camberwell the district managment team stopped the housing programme because it was unable to contribute additional revenue from mainstream funding, to meet the standards required by the mental handicap unit managers; it was bailed out by an unexpected allocation to London health authorities by the Treasury.

v) The opening of the larger facilities had to be phased to permit residents to move in in small numbers. The 72 residents scheduled to go to Bassetts Village in Bromley were transferred over a four month period. Further, Bromley health authority decided to take into Bassetts its 24 residents then living in Grove Park hospital, leaving more residents in Darenth than the hospital managers had anticipated.

vi) Staffing difficulties. Staffing shortages at Darenth itself meant that Dartford was not able to transfer staff from the hospital to new community facilities, thus delaying the transfer of residents. For other districts, difficulties were experienced in recruiting trained and experienced staff, and this too led to delays in opening new homes.

vii) Unforseen admissions. Darenth Park was closed to short-term and long-term admissions from all districts other than Dartford on the 1st of April, 1984; the managing district continued to use Darenth for short-term care. In addition to these admissions, seven long-term admissions were made when a mental handicap unit particularly for people with a mental illness closed sooner than expected.

The range of these reasons illustrate the virtual certainty that any reduction control plan will not work out as expected. It may not be possible for regional planners to be open or explicit about this in public statements, since it may reduce pressure on districts to progress plans and encourage further delay. Realistically, however, the managers of the hospital needed to take these inevitable uncertainties into account if their own management of the closure was not to be thrown out in a serious way. Regional officers, who kept the hospital informed of districts' plans, tended to take an unwarranted optimistic view of districts' ability to keep to plans.

Ward closures

The rate at which residents were transferred to districts affected the ward closure programme. Hospital managers had several objectives which needed to be balanced in achieving the physical contraction of the hospital: minimising disruption to residents; making effective use of remaining staff; saving on running costs of the hospital; taking out of use the most unsuitable wards; helping districts to bring together residents who would be living together in homes outside; keeping together staff and residents who knew each other.

The overall scheme was for the hospital to contract towards the pavilion wards away from the main buildings (see figure 10.1). This would produce the largest revenue savings on services such as heating and allow maximum ground floor accommodation. Each pavilion ward could accommodate about 24 residents. Table 10.4 shows the number of wards remaining open in April of each year, and illustrates sharply the impact of slippage of district schemes on the hospital. From 1985 onwards, a gap was opened between the number of planned ward closures and the actual number achieved.

Moves by residents

The net reduction in the number of wards remaining open masked the movement that was necessary to concentrate residents in wards and to move towards the pavilion wards only. The movements, closures and reopenings undertaken in just one year, 1986/7, are spelt out in Table 10.5. Table 10.6 shows movements in and out of wards during the last 20 months of the hospital.

This closure and movement of ward changes began in November 1983, when the first two wards were closed, and continued up to two months before the hospital closed. In general, the longer residents stayed in the hospital, the greater the chances of them being affected by ward movements. In 1986/7 residents in 14 out of the 20 wards open underwent major changes, moving to a new ward or seeing new residents from another ward joining them. It is inherent in any closure programme that such disruption occurs. These planned movements were exacerbated by the age and dilapidation of the buildings, which on occasion caused unplanned ward closures. Thus, during the winter of 1985/6, the floor of a special care unit collapsed and residents of wards 33, 3A, 3B and 4B had to be moved at short notice to alternative accommodation because of leaks and contamination of hot water systems. All these changes put an additional work load on the nursing and portering staff that should not be underestimated.

The breakdown of sectorization

It had been part of the strategy recommended by the HAS to bring together in designated wards residents who originated from the same boroughs to facilitate discharges by local authorities (see chapter 5). Readers will remember that it took the hospital almost seven years to achieve sectorization, and that that policy caused a very great upheaval within the hospital that was still recalled in the 1980s. The first ward closures in 1983 placed a small number of residents from one sector in another sector's wards. Over the next few years, this became the norm rather than the exception. Whilst the breakdown of sectorisation made sense in terms of all the reasons for consolidation mentioned above, it also presented some difficulties:

-ward staff needed to prepare residents for discharge to different kinds of services;

-ward staff had to develop working relationships with staff from more than one district;

-it was more difficult for district staff to get to know their residents in the hospital when they were in wards geographically distant;

-residents had fewer opportunities to get to know other residents with whom they would be living.

Shortly before sectorization was officially abandoned the five sectors of the hospital contained residents on the following basis:

-Bromley: 44 Bromley residents, seven residents from another sector and four non-allocated residents. 12 Bromley residents were on wards in the Greenwich/Bexley sector and 23 in the Lewisham sector.

-Greenwich/Bexley: 89 Greenwich/Bexley residents, 15 residents of three other sectors and 14 non-allocated residents. Seven Greenwich/Bexley residents on wards in the Bromley sector.

-Lambeth/Southwark: 72 Camberwell, 24 West Lambeth and 16 N. Southwark residents, and five Lewisham, two Bexley and two non-allocated residents on the sector's wards. In addition, 12 Camberwell residents were on wards of three other sectors, and three N. Southwark residents on Lewisham wards.

-Lewisham and N. Southwark: 25 Lewisham/North Southwark residents, and 23 Bromley, eight Camberwell, one Dartford/Gravesham and 18 non-allocated residents. One Lewisham resident was in the Greenwich/Bexley sector, 21 Lewisham/North Southwark residents in the Lambeth/Southwark sector.

-Dartford/Gravesham: Six Dartford/Gravesham residents, two Camberwell and one non-allocated resident on the wards. One Dartford/Gravesham resident was on a Bromley ward and one other on a Lewisham ward.

Impact on residents

Of the 650 or so residents discharged from the hospital between 1983 and 1988, 65% were kept within the stated policy of no more than one move before discharge. Table 10.7 shows how this varied among the districts. Dartford & Gravesham residents came off best, as they had the highest proportion of residents with no more than one move (85%) and the lowest proportion of residents having made three or more moves (3%). Both Camberwewll and Bromley came off the "worst", with 50% and 55% respectively of their residents having made no more than one move, and 20% and 23% of their respective residents having made three or more moves.

These two ends of the spectrum were fairly predictable. Dartford & Gravesham had its five wards in the pavilion section at the start, so their residents scarcely needed to move at all. Camberwell and Bromley residents were affected by the first set of ward closures in 1983. Some of their residents went directly into the pavilion wards but more went into other wards in the 3-storey blocks and moved again as these wards closed later on, and until others were discharged from the pavilion wards, making room for them there. It was simply not physically possible to keep to the policy. For many, the number of moves necessary was made tolerable by moving groups of residents and staff together, so the adjustment needed was minimal.

A further reason behind ward closures was the concern to keep the hospital safe for staff. The wards at Darenth were spread out over three distinct areas of the hospital grounds. The site was open to the public and once the hospital began to demolish wards, problems with security emerged. A developing concern became the safety of staff on duty at night, and managers needed to ensure that no ward was left isolated when others around it closed.

A necessary corollary of these changes was that the number of residents in most wards increased. In April 1983, the 18-bed wards, mainly wards 2-9, had an average of 11.5 residents; when these wards finally closed toward the end of 1986, the average occupancy had gone up to 16.8 residents.

With so much movement between wards, it became difficult at times to keep track of where residents were in the hospital. Each time residents moved, their personal possessions moved, their medical records and case notes had to be moved, the cashiers had to be informed so they could have access to their bank accounts, and their small coloured tag on the ward charts in the medical records office had to be changed. It wasn't surprising that on occasions, things were a bit chaotic.

Another factor which affected the residents was the physical condition of the wards - poor decoration and lack of resources for entertainment on wards, usually no alternative to telelvision. There was little incentive to redecorate if wards were to remain open only a year. The deterioration was not general - some wards were in quite good condition, others no worse than usual. But with staff shortages and other facilities closing, it meant that many residents spent whole days on wards in unattractive and unstimulating environments.

Besides concerns over the quality of the environment and frequency of ward changes, the quality of life enjoyed by the residents depended on the facilities available to them within the hospital. There was some development and more purposeful structuring of resident training facilities, as the need to prepare residents for a move to the community was recognised. But at the same time, less recognition was given to the need to provide social and recreational activities for the residents, and to retain these until the hospital closed. In the second year of the reduction control plan, two posts were lost through voluntary reducdancies - the manager of the pets' corner and the recreation officer. This avoided compulsory redundancies for other staff. But from the viewpoint of the residents, the loss of these two posts deprived them of activities which gave them considerable pleasure and which got them off their wards into a different social and sociable environment, allowing them to meet and mix with residents with whom they did not live. This was a permanent loss for residents, a gap in their lives during the remaining years the hospital was open. It was not compensated for by any other increase in resources to wards to provide entertainment.

Retention and redeployment of staff

At the time the first reduction control plan was produced, Darenth Park was employing 939 staff, excluding medical and dental staff (WTE of 810.66). A brief profile of the staff is given in Table 10.8.

Personnel managers hoped to rely to some extent on a natural turnover among some staff groups to reduce staff numbers without redeployment or redundancy. Moreover, the relatively high number of part time staff reduced the scale of possible redundancy payments. The age structure showed that 57 staff would reach compulsory retirement age and a further 92 would be of an age to take retirement if they wished (60 years for women and 55 for nurses) by the time the hospital closed.

Planning the reduction

The first attempt to produce a reduction control plan for staffing came in the 1984 plan, shortly after the appointment of two reduction control personnel officers, one for nursing staff and one for all others. This initial attempt at forecasting staffing reductions (and all subsequent plans) was based on the following assumptions:

-standards of care the residents would remain the same;

-reductions in staff would not be pro rata with the scale of discharge: staffing ratios needed to increase, because of turbulence created by changes within the hospital, deteriorating fabric due to lack of maintenance, increasing training needs of staff and residents, and the tendency of receiving districts to take out residents with low dependency first.

The planned reduction of about 44 staff in 1983/4 was achieved by natural wastage. Starting in the following year, however, enforced redundancies became necessary for staff. Despite the need for redundancies, the overall WTE in post at the end of the financial year was 43 under the reduction target.

The major shortfall in staffing was in qualified nurses, 48 under the target figure. The deficiency in qualified nurses was relieved in two ways: employing a larger number of nursing assistants; and increasing the number of qualified staff by encouraging overtime, using agency nurses and creating a nurse bank system with a local job centre. This latter scheme attracted back some nurses who had retired four or five years earlier, but also took on staff moonlighting from other hospitals, willing to do an extra two or three shifts a week. The bank scheme started in March 1985, when overtime and agency staff were already contributing the equivalent of between 15 and 20 qualified staff monthly.

In December 1986 the nursing staff targets were adjusted to recognise the much slower pace of discharge actually being achieved. The revised targets for trained and untrained nursing staff allowed an additional 125 staff members. On this basis, the nursing assistant figures went from being 69 over the target to 23 below; a less dramatic change also occurred in the figures for qualified nurses. This shortage of nursing staff in relation to the optimum staffing level remained more or less until the hospital finally closed.

Despite the frequent statements that the hospital was short of nursing staff and conditions were critical, hospital managers seemed to be able to maintain the situation quite well. Qualified nurses represented 39% of the total nursing staff in April 1984, and in the following years, this figure improved slightly (see Table 10.9).

Redeployment of staff at Darenth

The first step in working out redeployment strategies was to find out staff intentions. The reduction control personnel officers interviewed each staff member individually in 1984, getting some idea about future employment hopes, mobility including car ownership, family commitments and other factors influencing employment potential. These interviews showed that the vast majority of staff wished to stay in Dartford services, even if that meant changing the kind of work they did. Equally, a major proportion of staff were willing to stay until the hospital closed. Nine staff (no nurses) were willing to work elsewhere in Kent, 18 were prepared to travel to London and 65 to Bromley or Bexley. It became obvious that cooperation from other districts would be vital if redundancy for significant numbers of staff were to be avoided.

A meeting of mental handicap unit personnel officers of user districts was set up in August 1984. The purpose was to facilitate the redeployment of staff by establishing channels of communication between the hospital and the districts, and to enlist the aid of other districts in keeping the hospital adequately staffed until it closed, whilst redeploying Darenth staff.

There were three factors working against the potential for staff transferring to other districts. First, Darenth was on the edge of the catchment area, so that staff would face long (and expensive) journeys to work in inner London. Secondly, districts were not always keen to cooperate. They felt initially that their right to choose their employees was being eroded, although all that was wanted was an agreement that Darenth Park staff would be interviewed when they applied for posts in other districts, not that they would be guaranteed a job. There was a feeling in districts, however, that staff from Darenth would not be up to working in the new services; they were "institutionalised".

Thirdly, staff at Darenth were reluctant to apply for jobs. Some believed that the hospital would never close and there would always be some jobs at Darenth. For many, it had been years since they had applied for jobs. It became evident from feedback from early interviews that staff needed help in filling out applications forms, and coaching on how to present themselves in interviews. The personnel officers organised training days for staff to help them understand the process better, and conducted mock interviews to give staff knowledge of and confidence in the interview situation. The counselling role was a major demand on their time.

Personnel officers also had to deal with the failures of Darenth management over the years. There were several instances of staff being kept on when they should have been retired on grounds of ill health. In some departments, poor attendance records were allowed to develop without proper management action. Darenth Park had over the years accepted employees redeployed from other district services whom other managers did not want; they were seen as poor workers for a variety of reasons. These situations now had to be dealt with.

The hospital's principal concern was the loss of qualified nurses, and the DNS at Darenth was eager for other districts to offer nurses posts in the new services provided they remained at Darenth until their residents left. After nurses had been recruited for Archery House in Dartford, districts were invited to hold open days at the hospital when they had the opportunity of explaining the philosophy of care of their new services and the employment opportunities available within it. New difficulties very soon became apparent. Three districts had a non-nursing staff structure which prevented they from paying qualified nurses on nursing salary scales and retaining the same conditions of employment. In addition, several districts were closing hospitals within their own districts and personnel officers from these districts naturally gave priority to staff already employed within that district.

Personnel officers were hoping to redeploy staff not only to the new mental handicap services but to all services where suitable vacancies occurred. This aspiration underestimated the number of service managers who would be involved in such an exercise, and the complexity of establishing new procedures to handle this situation, with Dartford or within the other districts. Eventually, some such transfers were made within Dartford but even there it required major efforts by the personnel officers to see it through.

To counteract the assumption by staff that they could sit it out, take redundancy and then take on some other job until they retired, hospital managers issued a letter to all staff in September 1985 outlining the rundown procedures through which redundancy notices would be issued, based on the principle of 'last in first out'. As part of this process, a reservation of posts scheme was started: managers identified key workers needed until the hospital closed. A post in another hospital was then reserved for these staff, with temporary staff being taken on by the other hospital until the Darenth staff could be released. More than 100 temporary contracts to staff in the district were issued as part of this scheme.

A total of 448 staff were redeployed, just about half the number of staff employed at the hospital in 1983. Of this total, 228 were nurses (excluding 20 retirements), so that 65% of the nursing staff were kept in nursing in the catchment area, the majority in mental handicap nursing. Several nursing auxiliaries left to take up training. In the end, only 7 of the 16 nurses who expressed interest in transferring to Leybourne Grange Hospital did so.

Funding the rundown

Under the region's mental handicap funding policy Darenth lost the equivalent of the average inpatient expenditure per head for every death and discharge from the hospital in the following financial year. This figure formed the target savings which the hospital should have achieved. The resources available to the hospital were controlled separately from the district's allocation, the basis of which was the hospital's 1982/3 expenditure outturn (when the funding policy started), which was subsequently upgraded to reflect annual pay and prices increases.

It was recognised that the amount of revenue savings which the hospital could achieve would not fall in direct proportion to the reduction in the number of residents, for reasons given above. It was the responsibility of Dartford to inform the region of the proportion of the savings target which it felt could have been achieved, taking these factors into account. Because it was bound to be a process of negotiation between region and district, a preliminary figure was initially calculated on an August to July basis to allow negotiations to be completed before the start of the new financial year in the following April. This stopped in 1986 when the target savings were related to discharges in the previous financial year.

The district began this negotiating process with a savings target based on deaths and discharges. This target was then divided into two parts - variable expenditure which it could afford to lose because of the reduced number of residents, and fixed expenditure, which it could not lose if an adequate level of services were to be maintained for the remaining residents. The fixed expenditure became the request for bridging finance from the region (or non-recurring revenue). Table 10.11 shows how these targets worked out over the rundown period.

Expenditure continued at Darenth well after the last residents left the hospital. There was, for a start, the expenses associated with providing temporary facilities at Stone House and Truscott Villas (see following section). There were also the expenses of closing down Darenth Park buildings - making secure, removing furniture and administrative records of various kinds, closing down services - these costs would also be negotiated separately with the region. In each year, the district was successful in convincing the region to reduce the amount of revenue to be handed back because actual discharges did not match planned discharges. The region's main concern was to ensure that the hospital was not 'overfunded' so that money could be transferred to other district services in Dartford. In addition to the revenue support, capital support was also given for maintenance activities associated with ward changes and closures, and additional revenue support for staff training.

The final departures

Forty residents from five districts remained in Darenth Park on the first day of August 1988; 15 had been discharged by the eleventh, leaving 25 for the last day. Five of these residents were discharged to a temporary home within their own district. The remaining 20 were accommodated by Dartford and Gravesham on an interim basis by transferring some to an unused ward at Stone House hospital, a mental illness hospital next to Archery House and to two villas intended for residents from Stone House not yet ready to be discharged.

The move to the hospital went well but the move to the villas was less smooth. The principal administrator at Darenth was on leave and the work of preparing the villas had not been completed on time. Residents and staff arrived to find beds unmade and an inadequate supply of crockery and other items. These were put right immediately but staff in particular felt let down by such a poor ending to the closure programme.

The 20 residents who were temporarily taken on by Dartford belonged to Greenwich, Bexley and Camberwell health authorities. The 6 Bexley and Greenwich residents stayed only 2 weeks. 6 Camberwell residents transferred back to their district at the end of September; one other went to a temporary placement in a staffed group home in Dartford. This allowed the two villas to close. Five men remained on their own ward in Stone House; one woman, originating from Brighton and awaiting a place to be found for her there, was left on a ward on her own.

Conclusion

Two themes stand out from this narrative of the hospital rundown: the importance of good local management, and the complexity of coordination needed to keep the hospital going during this difficult period of time. Hospital managers began with their version of rational-comprehensive planning in the form of reduction control plans, and soon learned the same lessons that colleagues in districts and at the region learned: that a more flexible approach was needed, one which allowed districts to see their interests and needs taken into account, in order to gain any cooperation in managing the rundown. Lindblom's critique of rational comprehensive planning is as appropriate here as it was of district or regional planning.

The experience of closing Darenth Park hospital is also rich in lessons for other authorities.

It demonstrates, for a start, the extent to which the reduction control plans represented an ideal towards which hospital managers worked. But the reality of managing the contraction of the hospital was much more a process of negotiation - with regional officers over funding, with district staff over the pace of discharge, with service managers over redeployment of hospital staff. Each year encompassed a high number of uncertainties, far greater than had been anticipated at the start, centering largely around the districts' capacities to deliver services at the promised time. If this was not met, then all the hospital's plans had to be changed: if residents were not discharged, wards could not close, staff redeployed and savings made. Hospital managers therefore had to devise a series of strategies for coping with the range of possibilities for contraction, depending on the success of districts in meeting discharge dates. This remained true up to the final discharges, which again depended on Dartford improvising interim arrangements for 20 residents whose districts had not yet made provision for them.

Secondly, it challenges the idea that "any fool" can close a hospital. Good managers had difficulty coping with the coordination of actions needed to be undertaken to close the hospital. The frequent change of plans added to the complexity of that coordination. Many of the policies were appropriate but were hard to meet because people or events did not conform to the ideal. Thus no client was to change wards more than once before discharge, but 35% did, for reasons of safety for staff or clients or for economy. Staff were to be given redundancies on the basis of last in first out, but this was modified in practice to take into account personal wishes of staff. And other policies too were modified in practice to take account of human factors or events beyond the control of the hospital. Hospital management during closure is a skilled activity, needing to achieve a balance between competing objectives whilst retaining a commitment to residents and staff.

A further feature of the rundown was the key role played by the regional officers as arbitrator, overseer, and, as a last resort, an enforcer of solutions to problems. It has been shown how often the hospital could only respond to the actions of districts; it had no authority to impose its own requirements on districts. Hospital managers needed the clout of regional officers to help them get district agreement on ground rules for redeploying staff, sorting out numbers of residents to go to each district, resolving problems about non-allocated residents, and finally, getting most districts to stick to a final closure date.

How did hospital managers fare in the two main tasks they had - maintaining the quality of life for residents and ensuring staff were redeployed? For the first task, there can be no hesitation in suggesting it could have been done better. Yet many of the features which contributed to an impovrished environment for many of the residents were present before the rundown began to affect the hospital. It was obvious that some ward staff made a much greater effort to "domesticate" the day areas with plans, pictures, fish tanks, budgies, sociable seating arrangements. The poor quality environment during the rundown was only an extension of the same poor quality environment experienced by some residents for years before. The lack of social and recreational facilities reflected the traditional concerns of the hospital: to make sure the residents were safe, clean and fed; less importance was attached to providing enjoyable experiences for residents. Despite these deficiencies, there was considerable effort made to get residents into the right groups and wards so their discharge went smoothly.

At the end, a very active redeployment programme pursued by the reduction control personnel officers resulted in a much greater number of staff being found new jobs than could have been anticipated five years or so earlier. Redeployment was an especially difficult issue for the hospital, because of the number of districts involved, and the distance some districts were from the hospital, geographically and socially. There were differing opinions between the personnel officers and senior managers as to whether attendance on retraining courses should have been compulsory. It remained voluntary, but some kind of reorientation programme might have helped if started earlier. By and large, the hospital was lucky to have had such skilled personnel officers handling redeployment issues, able to give consistent and independent advice to staff at the same time as they worked towards achieving the objective of minimum redundancies.

Table 10.1 **Planned reductions in numbers of residents**

1984 plan:	1.4.83	1.4.84	1.4.85	1.4.86	1.4.87	
Planned number of residents	724 (actual)	666	562	401	248	
Proposed discharges during year plus assumed deaths	-58	-104	-182	-174	-248	
1985 plan:		1.4.84	1.4.85	1.4.86	1.4.87	
Planned number of residents		689 (actual)	565	328	199	
Proposed discharges during year		-130	-237	-129	-199	
1986 plan:			1.4.85	1.4.86	1.4.87	
Planned number of residents			586 (actual)	450 (actual)	184	
Proposed discharges			-266	-196	-184	
					1.4.87	1.4.88
					312 (actual)	118 (actual)

Table 10.2 The pace of discharge 1983-9 (numbers discharged)

	1983/4	1984/5	1985/6	1986/7	1987/88	1988/89
Deaths	20	27	27	23	8	-
Discharge to replacement NHS facilities	18	49	116	85	186	105
Miscellaneous discharges	23	22	22	13	25	13
Total	61	98	165	122	219	118

Table 10.3 Residents remaining in the hospital on the last day of each month

YEAR	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1978/9	993	990	991	991	997	993	980	976	973	973	971	961
1979/80	956	953	953	952	947	947	943	943	938	936	930	914
1980/1	912	910	903	899	878	871	863	861	861	853	849	846
1981/2	847	841	840	832	822	817	816	814	806	797	783	776
1982/3	776	760	754	752	749	747	737	731	730	728	720	716
1983/4	708	704	705	703	703	699	695	688	683	681	679	677
1984/5	675	673	671	667	660	643	622	615	616	615	605	583
1985/6	576	559	557	553	553	554	549	545	529	471	469	450
1986/7	441	435	422	414	405	392	384	375	371	359	353	345
1987/8	312	297	270	257	250	240	235	214	206	202	184	125
1988/9	114	105	75	40	-							

Table 10.4 **Ward closure 1983-9**

	1.4.83	1.4.84	1.4.85	1.4.86	1.4.87	1.4.88
1984 Plan	33	32	21	9	-	
1985 Plan	33	30	17	12	0	
1986 Plan			20	7	0	
Actual number of wards open	37	33	30	20	15	7

These figures exclude the three shared wards (special needs and infirmary wards)

Table 10.5 Ward closures and movement of residents in 1986/7

Ward 8 - closed June, Greenwich/Bexley, North Southwark and Camberwell residents transfer to Ward 40, 3 Bromley residents to Ward 35/6

40 - reopened June for residents of Ward 8

5B - closed July. Camberwell, West Lambeth and North Southwark residents transfer to Ward 29

28 - temporarily reopened July for Dartford/Gravesham and Camberwell residents, to allow for upgrading of Ward 29

29 - transferred July from Dartford/Gravesham sector to Camberwell and West Lambeth sector

28 - closed August; 5 Dartford/Gravesham residents discharged to Archery House, 2 transfer to Ward 29, 2 Camberwell to 29

41 - closed September to Greenwich/Bexley residents who transfer to Ward 25, reopened to residents of Ward 6

6 - closed September; Camberwell/West Lambeth/North Southwark residents transfer to Ward 41

5A - closed September to Camberwell/West Lambeth, North Southwark and non-allocated residents who transfer to Ward 28

28 - reopened September to residents of Ward 5A

25 - closed September when Dartford/Gravesham children transfer to another hospital. Reopened to Greenwich/Bexley residents of Ward 41

30/6 -closed October, 5 Bromley residents transfer to Ward 25, 5 to Ward 21, 1 Greenwich to Ward 43.

30 - closed November; 5 Greenwich, 2 Bexley, 1 Bromley residents transfer to Ward 28, 1 Greenwich to Ward 26, 2 to Ward 25.

33 - closed February; 4 Bromley residents transferred to Ward 23, 3 to Ward 22, 2 to Ward 20, 1 Bexley resident to Ward 42

Table 10.6 <u>Ward Movements - change of wards by residents</u>

	1987									1988							
WARDS	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr.	May	June	Jul	Aug
19	-1 Res	-2										-2	-1	-2	+3 -3	-4	
20	+6 -3	-1		+9 -10	-3		-1	-2				-7	+9	-2	-6	-5	
21				-1	-1	-1 +2	-2	-2	-2			+4 -4	-1		closed -7		
22	+7 -6	-1		-4	-2	+8		-4	-2	-3		closed -9					
23		-3		-3	-1	+3					-2	closed -1					
24			-1	-3		+5 -1		-1	-1	-2	-2	-11	+3 -2	-1	+5 -3	-7	
25	+4 -2		-6	+1 -3	closed -1	reopens +24		-1					-2	-1	-2	-6	
26						-2		-3	-1	-1	-1	-5	closed				

cont'd next page

Table 10.6 cont'd.

27	-1	-3	-1	-2		-2		-1	-1	+7 -6	-1 -5	closed	
28	-1	-3		-1	+5	-2	-1	-8	-4	closed			
29	+8				-2	-4	-1		+8 -5		-2	+4 -3	-7
31	closed -3												
32	closed -12												
40					closed -1								
41					closed -6								
42			-3		closed								
43	-2			closed -1									

Table 10.7

Residents' moves before discharge

Borough	No moves	1 move	2 moves	3 or more moves
Bexley	17	12	13	8
Bromley	27	45	32	24
Camberwell	19	37	32	26
Dartford & Gravesham	60	49	15	4
Greenwich	44	35	26	16
Lewisham & N.Southwark	22	32	16	8
West Lambeth	1	16	6	3

Table 10.8

Darenth Park Hospital staff in March 1983

Male	27.1% (252)
Female	72.9% (677)
Part time	35.2%
Full time	64.8% (M, FT 94.8%; F, FT 53.7%)

Age:	under 21	89	9.5%
	21-30	181	19.3%
	31-40	242	25.8%
	41-50	223	23.8%
	51-60	165	17.6%
	61-65	38	4.0%
	65+	1	0.1%

Years worked at Darenth Park Hospital:

under 2	219	23.3%
2-5	277	29.5%
6-10	250	26.6%
11-15	112	12.0%
16-20	48	5.1%
21+	33	3.5%

939 staff equivalent to 810.66 WTE

Table 10.9

Staffing at Darenth 1985-88

Qualified nursing staff as a percentage of all nursing staff

	% Qualified Nurses	% Qualified Nurses (inc. overtime, agency, bank staff)
April 1985	38.7	41.5
April 1986	37.9	43.5
April 1987	39.3	42.6
April 1988	40.0	43.8

cont'd. next page

Table 10.9 cont'd.

Resident-Staff ratio

	Staff:Resident* Darenth staff only	Staff:Resident incl. overtime,etc.
April 1984	1:1.6	-
April 1985	1:1.7	1:1.6
April 1986	1:1.7	1:1.7
April 1987	1:1.6	1:1.2
April 1988	1:0.88	1:0.64

*no allowance made for those working nights only, or absence/sickness leave; includes all nursing staff.

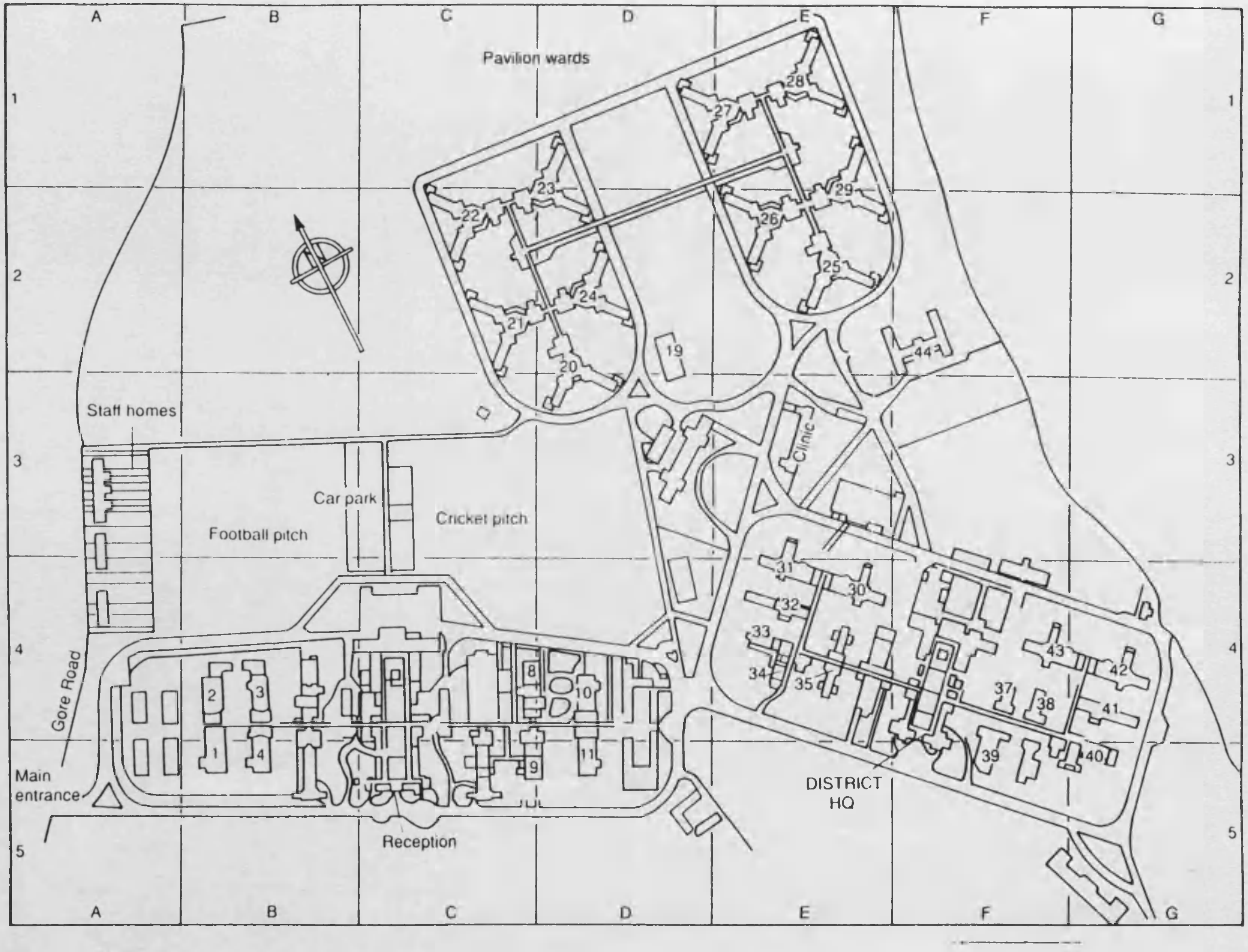
Table 10.10 **Funding the rundown**

	Target Savings £	Savings achieved £	Planned discharges (Nos.)	Actual discharges (Nos.)
83/4	570,372	520,000	58	52
84/5	1,022,736	500,000	130	98
85/6	2,119,415	1,350,000	237	146
86/7	2,252.642	1,250.000	266	104
87/8	5,007,556	2,521,000	184	219
88/9	2,262,000			119

Note: The total of planned discharges does not equal the total of actual discharges because planned discharges are taken from different prediction control plans, as plans of districts changed. The important point is that between 1983/4 and 1987/8, actual discharges always fell short of planned discharges.

Figure 10.1

Darenth Park Hospital Site



Chapter 11

New Homes, New Lives

In Chapter 8, some of the characteristics of the residents who were in Darenth Park in 1980, as assessed by Dr. Lorna Wing, were described. Eight years later, when the hospital had closed and residents were distributed among the seven districts changes in these characteristics had occured. Of the almost 650 residents discharged to places identified by districts, there was a marked increase in the age of the population as a whole - over 8% were now aged 80 or more years, in contrast to 4.1% in 1980. 194 residents had died since 1980, resulting in a marginal increase in the percentage of men over women; in two districts, this imbalance was noticeably greater. The number of residents assessed as totally dependent on wheelchairs had fallen from 122 to 75, although this latter figure will most likely increase, in part because of the ageing of this population; this will become known through Dr. Wing's follow-up assessments. A slight shift occured towards a larger percentage of residents who were socially impaired (see Tables 11.1 and 11.2). These, then, were the residents whose futures were planned by their districts.

Pattern of discharges

Table 11.3 shows the place of discharge of the Darenth residents from 1978 to the time the hospital closed. For the first five years, the pattern of discharge was fairly typical of long-stay hospitals, with discharges being arranged by consultants, nurses and social workers. Some residents went home to parents or other family members. Others went to live in bed and breakfast accommodation in seaside hotels. A few discharged themselves, or just wandered off.

The number of facilities being used in places such as Margate, Ramsgate, Westgate, was actually quite limited. Several of these were owned or being run by former Darenth Park staff, and residents did often go to live in a house where they knew the landlady and other residents. These may have been quite attractive placements initially but nonetheless residents and health authorities or social services would have been faced the range of problems this type of accommodation had: lack of day activities, additional demands for health and social services in these areas without additional funding provided to authorities, problems of what to do if/when the landlady became ill, retired or sold the house.

In 1982, an NHS hostel opened in Greenwich, converted from a former convalencent home for elderly people; this was the first project to take residents as part of the closure programme. Projects planned specifically for the Darenth programme did not begin to come on stream until the second half of this period, when the purpose-built hostels and residential centres began to open. The planning for all these schemes began in 1978 and 1979: Widmore Road (Bromley) opened in 1984; Arnold House (Greenwich) in 1985; Archery House (Dartford) in 1986; Bassetts Village (Bromley) 1987; Bowley Close (Camberwell) in 1988. Regional officers were right to realise that reliance on purpose-built accommodation for the whole of the closure programme would have resulted in a much delayed closure.

The programme of using community housing stock showed a much faster rate of development. The first two group homes were identified in 1982; one opened in Camberwell in April 1983 and the other in Dartford in November 1983. Districts began to plan to make extensive provision in group homes in 1984, and in succeeding years, eight opened in 1985/6, seven in 1986/7, 18 in 1987/8 and 13 between April and 12 August 1988.

About 25% of the residents died in the hospital. The initial assumption that about 30 residents would die or be discharged under ordinary discharge programmes each year proved reasonably accurate. The reduction in the number of places needing to be reprovided in the community did come to match more closely the number of places according to *Better Services* norms.

Since 1983/4, when districts began to actively take responsibility for the discharge of residents, private and voluntary homes continued to be used but for more specific reasons: specialist services; the family had moved; the resident wished to return to a locality previously lived in. Other residents, besides those in Greenwich, were transferred to the care of local authority social services departments as they settled in hostels for people with a mental handicap or a mental illness, or in elderly persons' homes, or in adult care or family placement schemes. Table 11.4 lists the establishments and local authorities involved.

The place of discharge was not necessarily the place in which the resident remained. Some placements did not work out - people did not get on well together. Some decided for other reasons they wished to live elsewhere. Bromley health authority transferred the first group of residents discharged to a hostel to minimally staffed group homes after a few years' experience of community living. Other residents in all authorities were able to move to more independent types of facilities because they were able to develop their abilities after coming out of Darenth.

Table 11.5 shows the net changes which took place between the time of discharge and September 1988. About 10% of the residents had moved to different types of accommodation after discharge. This does not include moves within the same category of accommodation.

Ultimately, about 40% of the residents were accommodated in small group homes in the community, 25% of the residents in residential centres and about 13% in hostels. As two of the three residential centres and both hostels were divided into self-contained houses or flats for no more than eight residents, the vast majority of Darenth residents found themselves living in accommodation very different from the hospital.

New lives in the community

So far, we have discussed what kinds of accommodation available to residents in the community. Important as this is, it is not as important as the opportunities that were presented to them for acquiring new skills, experiencing new environments and activities and generally learning how to become members of the community. Questionnaires were completed by care staff, and occasionally by residents themselves, for just over 100 residents, which dealt with the activities undertaken and the services used by these residents.

The aim in selecting these residents was to ensure that residents of all degrees of handicap and residing in a reasonable spread of types of accommodation were included in the study. These aims were only partially achieved. To assess degree of handicap, we relied on Dr. Wing's assessment of residents in Darenth Park in 1980, as this was the only means of comparability across all districts. But these assessments were now eight years out of date, and we found in the sample many more people with mobility and general health problems than had been anticipated.

Secondly, in order to get some impression of how residents were coping with their new lives, it was important to allow a reasonable period of time to elapse after their move to the community and administering a questionnaire. Here, the fact that discharges were delayed, and that many of those with challenging behaviour were among the last to be discharged, some going into temporary accommodation, that it was not possible to include some of those selected for the sample because there had not been a suitable interval for them to settle in the community.

The sample, then, is not representative. It does not include residents in private or voluntary accommodation; we did not get permission for these residents from the home owners/managers. With one exception, the sample contained only residents who remained the responsibility of the NHS, with or without the intervention of housing associations. However, the types of placements represented in this study are typical of all but 46 placements of residents discharged after 1984.

Previous chapters had illustrated the extent to which the types of facilities made available at the close of the hospital differed from those proposed at the start of the project. This change began with the report of the Jay Committee (Cmnd.7648, 1979), was boosted by the publication of *An Ordinary Life* (King's Fund Centre, 1980), and was finally encouraged by the DHSS *Care in the Community* (DHSS, 1983). Along with the use of ordinary housing, policy and practice began to spell out other aspects of service provision which quality services should consider: individual service plans, integrated health, social and education services, supports for establishing social networks.

It is the type of accommodation which has come to symbolise service models. This was in part because accommodation was the first and necessarty step towards securing the presence of people with a mental handicap in the community in non-stigmatizing housing, and in part because it was the easiest aspect of normalization to fulfill.

At the same time, research and evaluative studies were beginning to demonstrate that it was possible to care for people even with a severe degree of mental handicap in the community in a way which was no less effective than hospital care, and in some respects more successful in that it stimulated a higher degree of skills, development and appropriate behaviour. Several small scale studies showed that adaptive behaviour, IQ and skills development occurred to a greater degree in smaller, more normalized environments (Locker *et al.*, 1984, MacEachon, 1983, Conroy *et al.* 1982, Selzer, 1981, Witt, 1981, Thompson and Carey, 1980, Race and Race, 1979).

A major study in the UK was conducted in Wessex RHA, evaluating the changeover from total health service reliance on hospital care to the creation of 25-place community units and then smaller group homes in communities. The principal finding of the first phase of the study was that community units were feasible alternatives to hospital care, showing that gains in skills such as feeding, washing, dressing, appropriate social behaviour were greater among adults and children living in community units than in hospital (Smith *et al.*, 1980). Researchers went on to examine precisely the same issues for clients living in small group homes and again found higher levels of staff-client interaction, appropriate client behaviour and lower levels in inappropriate behaviour were achieved in small group homes than in larger community units or institutions (Thomas *et al.*, 1986) and higher levels of participation in activities (e.g. Saxby *et al.*, 1986).

Many of the studies, however, admit that while community units or group homes seem to facilitate appropriate changes in clients, it is not clear how much should be attributed to size of unit and how much to other factors, such as staff training and support, commitment to philosophy of care, client mix and others. Bella (1976) reviewed various studies, concluding that care is generally more adequate in smaller units but small units also demonstrate considerable variation in standards of care, a conclusion reached by Pratt *et al* (1980) as well. Changes in the environment do not seem to make much difference to clients' lives unless accompanied by other changes. Dalgleish (1983) examined some of the Sheffield Development project units and concluded that the physical environment had been improved in the newer units but that the actual management practices within the units had not changed very much so that the social environment still resembled that of large institutions. Tyerman and Spencer (1980) compared a new purpose-built ward and a superficially upgraded one and found in the new ward higher levels of positive activities and lower negative behaviour, such as inactivity, but little change in communication and interaction, and fewer self-care skills; they pointed to the need for more rigorous self-help training programmes.

A move to the community, in itself, seems to be ineffective in providing means for clients to interact with non-handicapped people and develop social contacts and friendships away from the staff (Schalock and Lilley, 1986; Evans *et al.*, 1987).

The observations of the different types of accommodation and the reports of clients' activities fit very well with the results of research discussed above. In general, greater efforts towards implementing ideas about normalization were found in group homes or in units run as group homes, but some examples were found in all types of accommodation. It was also evident that homes in which staff had considerable experience of working with people with mental handicap, a greater commitment to normalization and/or a more confident personality, efforts at implementing services based on principles of normalization were more consistent and seemed more successful. This observation may do no more than reflect the immaturity of the service infrastructure: training, management support systems, monitoring. The houses are in place but the service as a whole needed developing.

Residential centres: Three districts had residential centres, Archery House with 80 places, Bassetts with 72 places and Bowley Close with 42 places. Bowley Close, in Camberwell was managed by the Southwark Mental Handicap Consortium; the other two were directly managed by their health authorities.

Archery House in Dartford was the first to be designed and had a more traditional health service style, the least like ordinary housing. The majority of its residents, although having more privacy than they did in Darenth, were still sharing rooms with two others. Breakfast is prepared in the houses, but other meals were brought in from a central kitchen; some of the laundry was also done outside the houses. The centre was located on a site between two other long-stay hospitals (one now closed), with a housing estate a short distance behind, and a local council refuse dump in front (possibly to be turned into a leisure centre at some time in the future). With the day centre on site as well, residents looking out the window saw only other residents or staff. A trip off-site needed to be well-planned, including ordering a taxi. Some staff still wore nursing uniforms.

Bassetts Village, in Bromley, consisted of nine houses in three rows of three. Each house was self-contained and managed as if located on its own in the community. Care staff were expected to attend to all household tasks in additional to providing assistance to residents. The houses had a mixture of single and double bedrooms, kitchen, living room, dining room, bathrooms and staff office. All meals were prepared in the house, with residents helping in whatever way they could. Residents were encouraged to answer the phone, the front doorbell and spend time with visitors to the house. Residents were given reward money for helping out around the house, as a means of giving them more money to spend than they would have from their DHSS personal allowance. The houses were located in the midst of a residential area, but were quite a walk from the local shopping centre.

The third residential centre, Bowley Close, was designed as a series of self-contained bungalows. These were equipped in a similar way to the houses in Bassetts Village. Also as in Bassetts, care staff were responsible for seeing that all household tasks were carried out, preferably with the residents. Each house also had a housekeeper, in recognition of the relatively older age range of residents living in Bowley Close, and because of the high degree of disability of some of the residents. Although the centre was located quite close to shops and public transport, these were all uphill from the centre, making it especially hard for the elderly residents.

Thus, in two of the districts, despite having a much larger number of people with a mental handicap living together than they would have wished, the philosophy of care was asserted by structuring the operational policies to manage each house as if it existed on its own. Staff were all assigned to a particular house and not shuffled around. Residents were encouraged to actively help run the house and at the least, to look after their own clothing and clean their bedrooms. Most residents got off site at least once a week, and many much more frequently than that. Obviously those able to use public transport got out much more often and further afield.

One feature common to all three residential centres was the lack of space within the houses. Eight residents was a large number of adults to be in a room at one time and eight seating places, plus a few side tables and a TV took up the entire living room. Little allowance seemed to have been made for staff also to be present and although the houses were built to wheelchair standard and thus should have had more room, the common rooms seemed cramped. The centres were built at a time of rising inflation, and were required to keep within a cost limit which, because it was not adequately uplifted for inflation, meant that the space allocation could only be 70-75% met.

Each house tended to have two to three staff on duty during the day, although one house visited had four staff. What did vary considerably were the number of residents who stayed at home during the day. In one centre, at least half the residents in one home went to the day centre five days a week, and several others went two or three times a week for half days. In another centre, most residents went to the day centre two days a week, because the centre was not yet fully staffed. In the third centre, residents went over to the day centre for specific sessions of activities which interested them: needlecraft, yhoga, adult literacy, communications groups. One 72-year old woman went to six classes a week - domestic skills, fitness for living, needlework, social club, music and movement, and art.

Each residential centre had on site a day centre, varying from 90 to 120 places. These had been planned in recognition of the unlikelihood that local authorities would be able/willing to make places in their own day centres available. The centres proved difficult to manage and to staff and were deeply resented by local authorities who felt, quite rightly, what they offered was exactly the same as in their own day centres. Moreover, staff working in mental handicap services saw these day centres as institutionalising care in the community; residents lived on the same site as their day centres. In reality, transport problems made this the more reasonable solution for getting residents who lived in homes in the residential centres out of the house during the day, but it violated the principle that people should live, 'work' and take recreation in different locations. Realism also had to recognise that without the day centre as a possible form of occupation, it was not easy finding other ways of spending time usefully during the day.

Besides going to the day centre, residents had other ways of spending their time. Several went to church or synagogue regularly. Almost all went shopping, many several times a week. One person went horse-riding regularly. Others like to potter about and do things around the home - washing up, making cups of tea for others, dusting and tidying their own rooms. Some went for walks in the neighbourhood. Most residents had a very similar range of activities to other people who were retired or lived on low incomes.

Hostels: The Darenth project included three purpose-built hostels. One in Bexley was designed as three self-contained houses side by side, and they functioned as three group homes. The second, located in Greenwich, consisted of four self-contained flats with a suite of staff offices and a large social room. The third hostel in Bromley had two flats and a house. Besides the purpose-built hostels, two other hostels used premises converted from other purposes. One hostel, with 30 places, was in what had formerly been a convalescent home in Greenwich for elderly people. The second older hostel was in a large Victorian house with quite extensive grounds; this house had been attached to Leybourne Grange hospital. When Darenth Park hospital took on the Bromley catchment area, this home was transferred from the hospital to Bromley health authority.

The two purpose-built hostels had quite different atmospheres, and served different functions. The one in Greenwich was a home for life for its residents. It had a largely older resident group; in the flat visited, five of the eight residents were aged 70 or more. However, even the eighty-year old got out to the shops at least once a week, as well as several times over a six month period to cafes, restaurants and accompanied others on outings. Those residents able to use public transport went to a more distant shopping centre, to a drop-in centre, visited friends living nearby or in other districts and went to various sporting events. Most people had had a week's holiday in the past year.

One resident found himself a job washing up in a nearby pub. This had been work he had previously done before he entered Darenth. He was "adopted" by the publican who gave him some money and a hot meal daily. He became one of the staff and found a circle of friends for himself.

The second purpose-built hostel had a different mission. It was to prepare its first 24 residents for moving on to more independent living arrangements in minimally staffed houses. At the time of the visit to the hostel, one group had already moved out and considerable visiting went on between the house and some residents of the hostel. Speaking with staff and looking through staff diaries of daily activities, the impression gained was of considerable activity - going places by public transport, going to sessions at a day centre, innumerable trips shopping out to local shops (one man liked to go out each morning for his newspaper to a small shop down the road), cooking, baking, helping with all household chores, a lot of visiting among the three flats. Staff also did individual work with residents, going out shopping with just one resident, taking them out for a meal. Residents were beginning to develop their own interests and several were quite capable of pursuing these themselves - horse riding, swimming, local Gateway clubs. Group outings took place to Biggin Hill, to the west end of London, theatre or meals out together. Several residents went to church weekly.

Staff were also involved in counselling residents. One woman resident had a temper and staff spent time talking to her about this, about learning to recognise when she was getting angry and ways of dealing with it; understanding how her outbursts of anger affected others in the flat and spoiled things for herself and for others; praising her when staff could see she was trying to control her anger. There was a period when she did not want to take any medication and this affected her behaviour; staff worked with her so she could come to see for herself the importance to her of taking the prescribed medicine.

In the established hostel in Bromley, there was a mixture of women residents, some of whom had lived there for many years, having come from Leybourne Grange, and others who began moving in from 1983 onwards. After consultation with neighbours, the hostel began accepting male residents in 1987. Of the twenty Darenth residents discharged to the hostel, only two were in their forties, and six in their fifties. The average age was 61.6 years, with the eldest being 83 years old. Despite their ages, residents could not have too many mobility problems because there was very little ground floor accommodation and the upper storey of the house was on different levels. The hostel had a total of 31 residents, but staff had tried to create smaller groupings with their own sitting rooms and dining areas, for a more intimate atmosphere.

Residents got out to local shops fairly frequently. They went to the district's day centre for specific classes, to the local Gateway club and were taken to London to see the Christmas lights. They used the local hairdressers and bought their own clothes in the local shops. The staffing ratio was fairly low (13.8 staff for 31 residents) reflecting that this was a more able group. It was ageing, however, and this began to make more demands on staff for support.

Despite the low staffing levels, it was still possible for staff to take out most residents on their own once every week or two - this would usually be a trip to a local shopping centre, to browse in shops, pick up knitting wool, get a haircut and have a meal out. Transport was another factor which limited the ability of staff to get out more with the residents.

One of the assets of the hostel was the several acres of land it had - an orchard and the remains of a kitchem garden including derelict greenhouses. Some horticultural work had alrady been started involved the residents, and there were plans to expand this which would involve bringing in other people to work with the residents.

Group homes: Group homes varied in size from two to eight residents. The majority of group homes which made use of existing housing stock had three to five place. In many of these homes, the staffing levels were quite high - eight staff for four residents was not unusual. In several homes, still higher staffing levels were found, when those houses were known to have residents with difficult or challenging behaviour - 3:1 or, in one instance, 5:1; these staffing levels were supported in part from additional funds made available from region on a tapering basis through the special development team for residents with challenging behaviour. At the other end of the spectrum, some houses had staffing ratios of 7 staff to 5 residents or in one house, 5 staff to 7 residents; these were houses in which the residents had high levels of skills.

For most residents it took some time to get used to living in small terraced houses, as contrasted to the vast wards at Darenth. In a few houses, residents adjusted very quickly to living in the community; residents in one group home in Dartford demanded to go to the local pub the third night in the house. Some residents at the start spent practically no time in their bedrooms whilst others hardly ever came out. After a few months, most began to find a balance and appreciated having private space. The women in particular liked being able to arrange things the way they wanted in their bedrooms and often decorated the rooms with pictures of the royal family or small objects they picked up in local shops.

Almost all residents were involved in household chores, although those with very severe handicaps were able to do the least. Even with quite handicapped people, staff found things they could do and helped them to do it - pressing the button to heat up the kettle, or filling the kettle, putting a tea bag in a cup, pouring milk, taking plates from the table to the sink. In some cases it looked a bit like tokenism. The resident was really paying no attention to what he or she was being asked to do, and even if guided in certain activities, gave no recognistion that he or she was involved in doing something.

When asked what more was needed to provide a better life for clients, staff responded by suggesting more organised day activities and social opportunities for making friends, more purposes to go out of the house. A number of clients went to ATCs one or two days a week. Others had structure created in their week by developing a routine:

Monday afternoon: collect money from the post office
Tuesday morning: swimming
Wednesday morning: laundry
Wednesday afternoon: clean bedroom
Friday morning: shop for food

Sunday morning: church

The activities which the residents got involved in may not have seemed very elaborate or perhaps exciting, but they were ones which represented a change from life in Darenth. Many of the staff in districts spoke with pride of the new skills acquired or exercised by their residents, contrasting these strongly with the very much more limited range of skills residents seemed to possess in the hospital. One resident, who had a number of severe disabilities, now began to express preference for what he wore, what he ate, what music he listened to; this ability and willingness to exercise choice was seen by staff as a major accomplishment, perhaps the more so because staff at Darenth had indicated that nothing could be done with that resident.

Another resident, blind, with almost no speech, had not left her ward at Darenth for many years. One of the most difficult tasks the staff had was to get her used to being taken outside the ward, travelling in a car or bus - she took months to adjust to that so she could physically leave the hospital. At the end of two years living in the community, she was learning to speak, she rode in cars or buses with no fear, she enjoyed walking in the street, she fed herself and chose music to listen to . She still had many needs not yet being met, but there could be little doubt that her life was more varied and interesting and pleasurable to her than before.

Nor was it always easy for residents to learn to think for themselves; "why ask me? You're the nurse, you know what I want" was the standard response for months from one resident when asked whether he wanted tea or coffee.

This fairly rosy picture needs to be balanced by pointing out there were some residents for whom the move to the community was not felt as an improvement, and others for whom the staff had been much less successful in finding ways of engaging their attention or motivating them. It was evident that in some homes visited, there was uncertainty as to what could be tried with residents. Staff tended to feel uneasy if residents were just sitting in front of the television but had no alternatives to offer at that time.

New lives in the community?

This brief review of the activities and life styles of people living in the various forms of accommodation has indicated that settling people in the community and finding ways of integrating them into local community life proved to be more difficult than ensuring they had places to live in the community, lessons also learned in a project in Sheffield (Booth *et al*, 1990). Some gains from moving to local communities were easy to achieve whilst others would obviously take much longer, and might prove not to be achievable for everyone.

Some things changed for the better immediately: residents' physical appearance improved rapidly within weeks of leaving the hospital. Their clothing was now clean, 'age-appropriate', suitable in style and size. It was also personal to them; there was no sharing of underwear, outer garments or hairbrushes. The quality of their hairstyles also improved; many of the residents no longer looked radically different from other people in the community. Other aspects of their environment also improved. There was a much higher degree of privacy; except for the residential centre in Dartford, no residents shared a bedroom with more than one other person, and many had bedrooms of their own. The quality of their food, eating arrangements, choice of food also improved; for some, mealtimes became a social occasion.

However, the move to the community soon bagan to identify other gaps in services and in the infrastructure of service manmagement which needed to be developed in order for residents to fully live in the community and be part of it. What were the issues which district staff and especially staff assigned to work with residents in their homes, needed to resolve? Two separate but parallel sets of isses had to be tackled. The first was more general, relating to the management of the service:

how to relate staff training and supervision to the philosophy of care;

how to ensure facilities and services were meeting objectives and maintaining quality;

how to engage clients and carers at all levels of service planning;

how to maintain a client-focussed service in the face of financial and professional pressures.

The second set of issues was concerned with delivering services to individual service users. Examples of these issues include:

how to plan services for individuals, identifying their potentials and relating these to activities;

how to motivate service users to express their own preferences and views about what happens to them;

how to enable service users to take reasonable risks to encourage growth and confidence;

how to find/create opportunities for people with a mental handicap to meet with and form relationships with people without similar handicaps;

how to create genuine work and recreational opportunities for people with severe handicaps which were not segregated from the community.

In the early stages of community based services, staff working with residents by and large found themselves alone in attempting to grapple with such issues, with little support from service managers in some instances, and without the resources or authority to come up with solutions. In one district, these issues were discussed and managed in a fairly systematic although limited way throughout the development phase of the new services; most other districts were beginning to face up to these issued by the time Darenth closed.

Conclusions

'Ordinary life' was interpreted as living in a house that was very much like all other houses in the street, but it was soon apparent that this was only a necessary but not sufficient condition for residents experiencing community living. They needed to be supported and enabled to use facilities in the community, and to achieve that, services had to be much more sensitively, purposefully and individually developed.

That these issues began to be considered quite late in the life of the Darenth project illustrated the extent to which the whole of the project, as conceived of by regional officers and implemented by district staff, was seen as a capital exercise. Even when regional officers found ways of modifying planning relationships with districts to take into account districts' perceptions of service provision, the emphasis remained on bed reprovision; districts simply had more flexibility to chose the kinds of bed spaces they wanted - "ordinary houses" rather than residential centres.

The way the Darenth project established itself contributed to the strength of this approach. First, there was the sense of urgency of closing the hospital to meet the Blue Circle deadline. It was obvious that this could not happen without all residents being relocated and therefore re-accommodation became a prime objective.

Secondly, it was also obvious that no district (or area health authority at that time) had sufficient interest in closing the hospital or sufficient authority over other districts to bring about the closure. Regional officers saw a natural role for themselves in this multi-district situation. This was supported by the new NHS planning system which had identified a strategic coordination role for regions. Regional officers could fulfill this in the Darenth project by identifying a service model and coordinating its implementation.

Thirdly, the principal resources which regional officers had at their command were capital and additional revenue. They exercised control over the capital programme, decided which projects were acceptable and could get some compliance from districts that way. The control they had over the capital progamme allowed them to feel they had some control over the Darenth project

Lastly, the tradition of planning in the NHS was of capital planning (Ham, 1981, Klein, 1983), and the expertise in planning, such as it was, lay at the regional level. In the Darenth project, regional officers fell back on a traditiional role of reorganising services on a more rational (calculated) basis of population norms and buildings. Local mental handicap needs were identified in terms of the *Better Services* norms for residential and day services, and these were then related to the buildings needed.

Thus, the pressures of time and tradition account for the capital planning approach to the project favoured by regional officers. An alternative would have been a service planninig approach to service development. Service planning would have had a different starting point. It would have begun by examining the values underlying a philosophy of care and by understanding how these would have affected the kinds of services the service users would need in order to realise the values identified for the service. This approach is close to what Elmore called "backward mapping" (Elmore, 1980). Whilst Elmore is concerned with policy making and effective implementation, the principle is similar: if a service or a policy is to be delivered in a particular way, it is necessary to understand what resources and behaviours are likely to achieve that outcome and to work upwards within an organisation to ensure that financial and service policies support the desired outcome.

In the end, district staff managing mental handicap services did take up issues relating to the infrastructure of their services so that they could begin to deliver services to meet residents' needs. In most districts, it was staff working with clients in the houses who were involved in formulating new policies for how services would operate; not only could they best identify the issues, but the new policies had to be acceptable to and workable by those staff at the service delivery level.

Previous chapters demonstrated how the model of planning used by regional officers affected the success of the Darenth project in achieving the objective of closing the hospital. In this chapter, the model of planning was shown to have been able to deliver new services only in part: it provided new facilities but was inappropriate to provide new service policies which could support service users in making new lives for themselves in the community.

Table 11.1 Age of residents in 1988

Age	Bexley	Bromley	Camberwell	Dartford/ Gravesham	Greenwich	Lewisham/ N.Southwark	W.Lambeth	Total (Nos)	(%)
0- 9	-	-	-	-	-	-	-	-	
10-19	-	-	1	-	-	-	-	1	(0.2)
20-29	9	1	12	21	5	5	-	53	(8.2)
30-39	15	20	26	22	31	21	3	138	(21.3)
40-49	14	13	18	22	16	14	3	100	(15.5)
50-59	6	14	14	24	20	9	1	88	(13.6)
60-69	5	29	20	20	23	13	10	120	(18.5)
70-79	2	30	15	14	19	11	4	95	(14.7)
80-89	-	19	6	6	8	6	4	49	(7.6)
90+	-	1	2	-	-	-	1	4	(0.5)
Male	31	64	72	78	72	45	15	377	(58.2)
Female	20	63	42	51	50	34	11	271	(41.8)

Table 11.2

Physical & Sensory Handicaps

(Client discharged to Districts only)

	Bexley	Bromley	Camberwell	Dartford/ Gravesham	Greenwich	Lewisham/ N.Southwark	W.Lambeth
Wheelchair	7	10	17	25	6	9	1
Blind	-	2	1	9	4	4	2
Deaf	-	-	1	-	1	-	-
Blind & Deaf	-	-	2	1	2	1	-

Behaviour

	Bexley	Bromley	Camberwell	Dartford/ Gravesham	Greenwich	Lewisham/ N.Southwark	W.Lambeth
1	19	23	32	26	28	17	2
2	9	19	19	30	19	12	2
3	6	24	11	15	21	18	7
4	12	53	42	43	50	29	15
Not assessed	5	8	10	10	4	3	-

Table 11.3 Place of Discharge

	78/79	79/80	80/81	81/82	82/83	83/84	84/85	85/86	86/87	87/88	88/89	Total
Death	41	29	33	30	33	20	27	25	18	8	–	264
Self-discharge	6	3	2	4	–	–	–	1	1	1	–	17
home (1)	6	4	1	3	3	3	1	2	1	–	–	24
Seaside town	8	12	5	4	3	–	1	3	–	4	–	40
Boarding out (2)	1	1	–	–	2	–	2	1	1	2	–	10
Privately run home	2	6	4	–	1	2	3	–	4	7	4	33
vol. home council	1	–	–	1	–	2	2	1	3	2(7)	1	13
flat	2	2	1	1	2	–	–	–	1	–	–	9
IA MH inst. 3	–	2	–	2	–	4	–	2	1	–		14
IA OPH/MI	1	1	1	4	5	1	–	–	–	3(3)	1	17
other MH hosp.	2	2	–	1	1	–	3	1	–	1	1	12
other hosp	1	2	2	–	1	–	–	–	–	7(4)	6(4)	19
Grove Park	1	1	31	24	16	4	2	3	3	4	–	89
NHS hostel	–	2	–	20	11	5	45	23	29	22(5)	2	159
NHS Res Centre	–	–	–	–	–	–	–	58	24	92	14	188
Staffed Grp home	–	–	–	–	–	14	7	28	17	50	33	149
training/ inter (9)	–	–	–	–	–	–	–	–	–	15	57	72
misc. (8)		2	–	1	2	2	1	1	–	–	–	–9
Total	77	65	82	94	82	52	98	146	104	219	119	1138

cont'd. next page

Table 11.3 cont'd.

NOTES

(1) includes parents, sisters, brothers, aunts/uncles

(2) usually private landladies within district or SSD Adult Placement

(3) includes 1 sheltered flat for elderly

(4) includes 4 discharges to MIETS

(5) includes 1 place in Hounslow DHA

(6) includes 1 place in MIETS and 4 in a private hospital

(7) includes a sheltered flat run by a voluntary organisation

(8) Miscellaneous

78/9 - addresses not identifiable
80/1 - " " " "
81/2- residential schools
82/3 - 1 address not identifiable
1 prison
83/4- prison
84/5- emigration to Australia

(9) Interim/training facilities

1988/89 interim/training facilities includes 37 intrim places in the receiving districts and 20 intrim places in Dartford provided when the hospital closed. Of those, 6 transferred to their remaining districts within two weeks, and by the end of September.

Table 11.4

Residents placed in local authority establishments

(i) Catchment area:

Bexley	-	6 residents in mental handicap hostels
	-	1 resident in mental health hostel
Bromley	-	1 resident in mental handicap hostel
Greenwich	-	1 resident in mental handicap hostel
Kent	-	1 resident in mental handicap hostel
	-	1 resident in home for the elderly
Lambeth	-	2 residents in homes for the elderly
Lewisham	-	1 resident in mental health hostel
	-	3 residents in mental handicap hostel
Southwark	-	1 resident in mental handicap hostel
	-	2 residents in homes for the elderly
	-	1 resident in sheltered flat for the elderly

(ii) Out of catchment area:

Tower Hamlets	-	1 resident in mental handicap hostel
Camden	-	3 residents in a home for the elderly
East Sussex	-	1 resident in hostel
Islington	-	1 resident in home for the elderly
Bedfordshire	-	1 resident in home for the elderly
Kensington & Chelsea	-	1 resident in home for the elderly

(iii) Residents discharged from Grove Park Hospital placed in local authority establishments

Bromley	-	8 residents in mental handicap hostel
	-	1 resident in home for the elderly
Lewisham	-	9 residents in mental handicap hostels
Greenwich	-	2 residents in hostels

Table 11.5

Residents' moves after discharge: initial placements/Sept. 1988 placement

Residential centres	Bexley	Bromley	Camberwell	Dartford/ Gravesham	Greenwich	Lewisham/ N.Southwark	W.Lambeth
Residential centres		51*/47*	33/40	98/72			1/1
NHS Hostels	21/20	69/34			68/53		
P/V	2/3	4/4	5/5	4/14		10/7	5/7
Staffed group homes	23/23	-/25	49/53	27/18	-/13	45/45	10/10
Independent	-	-/2	-	-/9	-/2	1/4	2/2
Family placement	-	1/1	1/1	-/8	2/2	-/1	-
MIETS	-	2/2	1/1	1/1	-	-/1	-
Other hospital	-	-	6/6	-	2/2	2/1	2/1
LA Hostel	5/5	-	-	-	-	6/4	-
Grove Park	-	-	1/-	-	-	15/13	-
Misc.	-	-/1	2/2	1/1	2/2	1/1	2/1
Deaths	-/1	-/11	-/-	-/9	-/6	-/3	-/1
Interim/training	1/-	-	15/5 (1)	1/1 (2)	44/38 (3)	-	4/4

Notes:

* The residential centre accommodates 23 residents discharged from Grove Park Hospital

1. No plans yet for three clients
2. This client will move to a residential centre

3. These clients will move to staffed group homes

Chapter 12

Conclusions

This study has been concerned with an opportunistic attempt to bring about change in traditional mental handicap services. It began as a move towards implementing the fairly modest recommendations of *Better Services for the Mentally Handicapped* but ended, 10 years later, as a service development which cast aside links with past services and fully aligned itself with the radical change in ideology underlying contemporary services for people with mental handicaps.

In bringing about such change, regional and district staff used the planning systems available to them, one for health services planning and a second for joint planning with local authorities. This study has thus focussed on the capacity of these planning systems to achieve what was demanded of them. The intellectual foundation of these planning systems was a rational comprehensive model of decision-making, based on assumptions about how organisations work and how they work with other organisations. This chapter will review how successful this planning model was in the Darenth project, and looking forward, whether any of the lessons learned during 14 years of joint planning have been incorporated in the new arrangements for health and local authorities working together under the NHS and Community Care Act (1990).

Rational comprehensive planning

A rational comprehensive model of planning, as embodied in the NHS planning guidance of the mid-seventies, saw planning as a technical or instrumental activity: what was the best (i.e. most efficient) way of achieving a given objective? It assumed objectives were given and shared throughout an organisation (or between organisations); because objectives were shared, plans would be carried out when they had been agreed by the various parties (Glennerster *et al*, 1983, Webb and Wistow, 1986).

In particular for health service planning, rational comprehensive planning was thought to be an appropriate means of working towards other objectives. It would allow long-term objectives to be identified in relation to health needs, and services developed in light of their contribution to such long term objectives, overcoming the tendency of health services planning to concentrate on immediate issues. Secondly, it would encourage an expansion of boundary considerations to enable services which contributed to a common goal to be considered together. Coordination was a key function in leading to greater efficiency - providing the most effective services at the most economic cost (Challis *et al*, 1988). Rational planning contributed to this end by bringing together services and functions serving the same client group, working towards comprehensive and seamless service provision, regardless of which agency provided the service.

The experience of the Darenth project shows how inappropriate these kinds of assumptions were in relation to regional officers planning new services with districts and districts working with their corresponding local authorities. On almost every point, rational comprehensive planning failed to deliver the advantages intended.

Failure to deal with conflicting objectives: Neither planning system, health services or joint planning, could function with competing or differing objectives held by participants. In chapter 6, we showed how regional officers, district officers and local social services staff and voluntary organisations held different views on the pace at which change should take place, the scope of the planning exercise, and the priority attached to developing services for Darenth residents as contrasted to those in the community for whom no services were available.

There were also major differences initially about the type of service wanted; regional officers tended to favour quasi-institutional developments, based on the *Better Services* recommendations and the need for speed. Local social services staff, CHCs and others favoured a greater emphasis on small group homes, later associated with the emerging ideology of "ordinary life". The planning system had no way of resolving such divergent views. Because of these differences in views about basic features of the Darenth project, the guidelines issued by the Steering Group did not achieve the acceptance of the compromise model of care they recommended.

No incentives for cooperation: Rational comprehensive planning assumed that plans, once agreed, would be implemented because that was the way the system was set up to operate; an implementation gap did not exist (Dunsire, 1978). However, reality in the Darenth project was quite different; the first four years of planning failed to gain support and participation from three of the eight districts. Regional officers were unable to get districts to comply with the guidance issued by the Steering Group, and had neither sanctions nor incentives to bring districts to the planning exercise if they chose to go their own way. Districts did not want funding from region if it were tied to a service model they disliked; region had no means of sanctions against districts for not supporting the project that would not rebound on patients in some way.

Local authorities and health authorities were no more successful in pursuing cooperation/collaboration until it became possible to transfer mainstream revenue funds across. In retrospect, it was naive of regional officers to assume local authorities would be willing to accept responsibility for the 40-50% of Darenth residents whom various surveys showed would be capable of living in local authority-supervised accommodation without being funded to do so. Reliance on the goodwill of local authorities to expand their services because such people did not need health care completely ignored the political cost of increased expenditure to a local authority. Only when it became possible to transfer funds with responsibility was any cooperation achieved.

Sanctions against region: Rational comprehensive planning failed to take into account the power of those at different levels of participation to block actions they did not like (Lipsky, 1980). Local authorities could point to green chain or other planning regulations (ignored on other occasions) if they did not like region's proposals for developments. CHCs, who saw their role as external critics, were more than willing to delay agreements to service changes if these did not take into account their views. Professional staff at a local level caused delay by proffering contrary advice to that of region about models of care. Rational comprehensive planning assumed that authority and power were distributed in parallel to the hierarchy; reality showed that in some instances, power and authority for participants at lower levels of hierarchy could be incommensurate.

Changing circumstances: Rational comprehensive planning was shown to have no means of coping with changing circumstances: different economic climate of public expenditure; different methods of funding; new ideologies; interests of new staff (Braybrooke and Lindblom, 1963). A project lasting ten or so years is bound to require more than just fine-tuning from time to time; chapter 5 highlighted the many significant changes made to thinking about and planning new services by the participants in all the authorities involved in the Darenth project over the years it lasted.

Rational comprehensive planning coped with changeing circumstances only by repeating the cycle of identifying alternatives, evaluating, choosing. Instead, what the Darenth project found was that Lindblom's approach of disjointed incrementalism met the needs and capacity of the project to plan to a much greater extent. Problems were tackled and resolved when they were identified as blocking further progress; planning remained fluid and robust enough to take on board change generated from within the project or by external events whilst still working towards the achievement of the overall objective. It was possible to turn many of the external changes to the advantage of the project, using events such as new government policies as opportunities to, for example, close a mental handicap hospital for children (originally not included in the Darenth project) or tap into Housing Corporation finance by learning to work with housing associations. Gradually, participants, and especially regional officers, learned that they did not need to, and could not, work out all details at the beginning, and then spend years implementing; planning and implementation began to work together, ensuring that what was planned was implemented and what was possible to implement got planned.

Joint planning as a means of shifting the balance of care: Rational comprehensive planning assumed that health and local authorities could jointly arrive at an agreement of the types of services needed, who was best placed to provide them, and for transfers of responsibility and client to be picked up because what was agreed was in the best interests of clients. What the Darenth experience revealed was that, in many instances, the health authority was reluctant to transfer funding, even when they could; that health authority staff were eager to develop their own services, even when what they developed was clearly very close to services local authorities provided or could provide; and that sharing responsibility for services jointly was seen as a messy situation. Stronger than the best interests of clients were the interests of staff and organisational viability.

A different planning model

District, regional and some local authority participants in the Darenth project gradually found ways of working together which were productive and acceptable to all parties involved. These new methods of interorganisational cooperation and collaboration represented a very different picture of planning and implementation from that of rational comprehensive planning and were a direct challenge to the traditional "top-down" view of implementation (e.g.Dunsire, 1978). Here, the political rather than technical element is emphasized, recognising the centrality that for something to change, someone has to make something happen.

Shared vision: A prerequisite for collaboration was the development of a shared philosophy of care (Tyne, 1982; Webb, 1986; Brazil *et al*, 1988). The first stage of the Darenth project achieved only half its task because there was dissent about the model of care which should have been provided. Initially, a few districts identified "ordinary life" as the model of care upon which their services were to be based; other districts followed as new staff came into post. With new staff at the regional level as well, regional officers too began to understand the new model, accept that it was feasible to provide services in this new way and find ways of supporting the efforts of districts to create such new services. A shared vision meant a shared vocabulary, shared goals, a shared understanding of acceptable service provision and a shared commitment to see new services brought into operation. At the end of the project, regional officers and the Darenth districts were united in defending the new services against other districts who claimed it was too expensive.

Adequate resources: Bringing about change requires committing resources, time and energy to making it happen (Pressman and Wildavsky, 1973; Bardach, 1977). The experience of Darenth showed that until management time at the region was identified, through new staff appointments and through a greater commitment of those already involved, to resolve problems which had built up; until time was allowed for discussing and agreeing a new philosophy of care, and for districts to express their interests; until commitment of senior staff towards the new mental handicap units was secured, very little progress was made. Likewise, as was shown in chapter 7, until districts also invested resources in local senior management staff, in negotiations with local authorities at a senior level, in creating working groups to see through specific tasks, very little progress was made at the district level. The management of change needs to be adequately resources in several ways before change can be brought about.

Incentives: Regional officers soon found how useful it was to be able to offer incentives to get cooperation from districts which, if left to their own devices, might have acted differently. The funding policy was a financial incentive by guaranteeing dowries without further negotiation; it achieved the region'a goal of getting people out of hospital, and the district's of being paid for taking people out of hospital. The Darenth project itself was seen by many as opportunity to develop new local services and thus create a new management unit within districts; it meant conforming to the region's timetable, for example, but allowed districts to expand their local service provision. And, by recognising the right of districts to decide service models for themselves rather than conforming to the Steering Group's model, that freedom was an incentive for districts to participate; it became an opportunity for creative service development, in the forefront of ideology.

Similarly, in relations between local authorities and their health authorities, financial incentives of being fully funded for new service provision, organisational incentives of expanded activity, budgets and persononel, and the opportunity of being seen to be among the leaders in new types of services, all played a role in encouraging some local authorities to collaborate in the Darenth project.

Negotiation rather than commands: The second half of the Darenth project illustrated how much more effective negotiations were, as a method of achieving compliance and resolution of blockages, than was reliance on hierarchical structures. Negotiation generated a sense of shared ownership of both problems and resolutions, both between regional officers and districts, and between district health authorities and local authorities. Negotiation gave scope for local interests to be taken into account, for different approaches to services to be developed in different localities, and for different paces of changes to be acceptable whilst still allowing the overall timetable to be met.

This active process of negotiation which went on within a general framework of broad objectives clearly fits Abell's view of organisations reaching collective decisions through bargaining and influence among different groups of staff (Abell, 1975).

In other instances, more aggressive bargaining went on over which agency would provide services and thus over control of resources; the negotiations in Greenwich as to whether local health services were really the best agency to provide for the Darenth residents who did not require constant nursing care ended with the boundary between health and social services being shifted, and with funding being handed over. In this case, the conflict was settled by negotiations in which health services lost some of its "domain", but its legitimacy was confirmed in its remaining sphere. More was at stake than a practical arrangement as to who would provide care; this decision also reflected a shift in ideology about services, clients and agencies (e.g. Benson, 1975).

The experience of the Darenth project thus provided little support for government policy aimed at shifting the balance of care, within the NHS and between health and local authority services. In 1983, the government allowed funds to transfer from health to local authorities for the care of people coming out of long stay hospitals; that provided some incentive towards collaboration but as much for health authorities with private or voluntary organisations as with local authorities. It also created a further imbalance, between people in hospital and those in the community; funds were now available to provide services for those coming out of hospital, but there were no earmarked funds for those who had remained in the community, often with quite inadequate services, or none at all.

Caring for People: new arrangements

The government's response to this, and to other problems of developing community care on a more extensive scale than before, was to set up an inquiry into problems of community care. Both the Audit Commission report (1986) and the Griffiths report (1988) argued for structural reforms as the only way forward: financial incentives to provide community-based rather than residential care, and organisational incentives to make collaboration between statutory agencies and betwen them and the private/voluntary sector more fruitful and frequent. Without such changes, community care would continue to be somewhat chaotic, representing poor value for money, and providing an inadequate range of services to some, and none to others.

The more radical changes recommended in *Caring for People* (Cm 849, 1990) were therefore an indirect admission that fourteen years of joint planning had largely failed to achieve the shift in service provision it was intended to bring about. The new arrangements represented new working relationships for health and local authorities, but with a clearer set of responsibilities for each authority. We now examine the extent to which these new measures would be of help to hospital closures.

Local authorities given a clear lead to provide social care: This formal allocation of responsibility for social care provision - accommodation, day care and domiciliary services, support to carers - attempts to eliminate situations where health and social services authorities think the other agency should be responsible for providing a particular service.

We have shown that in attempts at joint planning, those authorties which were serious about joint planning had tried to clarify the boundaries between organisations, and had come to a variety of agreements themselves on on which authority would provide what services (see chapter 9). Sharing responsibility for service provision was uncomfortable for agencies; it left too much confusion about each one's responsibilties, and resentment by local authorities when they thought local health services were providing services they could provide but for lack of funding. Placing lead responsibility with local authorities for the social care elements of community care thus goes some way towards ensuring the clarity of responsibility which several of the authorities in the Darenth project tried to create for themselves. As we shall see later, there are still some areas of ambiguity, and the need for joint planning has by no means been eliminated.

The lead responsibility for local authorities, coupled with other measures, such as the publication of annual community care plans, is intended to increase the accountability of local authorities for ensuring community care services are available for their residents. However, it is not clear that this measure will make any difference to authorities involved in hospital closures; it addresses a different problem, of responsibilities for people already in the community. The local authorities in the Darenth project were firm all in claiming that they needed funding from the health service to take on responsibility for long-stay hospital patients even after they had moved to the community. Without clear financial incentives, local authorities were and are unwilling to act for long-stay hospital residents.

Separation of purchaser and provider: The identification of two functions, of purchaser for the assessment of local needs, and of provider to provide services to meet those needs, parallels the reforms which are taking place in the NHS, although these are being less rigorously pursued in social services. Assessment of local needs will be aggregated on the basis of trends arising from individual assessments, consumer wishes, noted gaps in services, and so on. Once needs are identified, it will be up to the social services department to provide services using their own staff or to "purchase" service from other agences, private, voluntary, or the NHS. The intention was to make social services departments' principal function one of strategic planning, with ultimately its provider activities declining in importance to the overall work of the department. As in the NHS, it was assumed by central government that sharing responsibility for needs assessment and service provision had allowed the provider side to dominate service planning; the voice of the consumer and the concept of efficiency (and perhaps effectiveness) were overwhelmed by service provider interests. Purchasers would be able to shop around for other providers, either at more economic costs or for more creative service provision.

The evidence of the Darenth project supports this approach to some extent. The separation of purchasing (identifying needs and then deciding what services were needed to meet those needs) and provision of services did result in a wider range of options being considered, with more emphasis on supporting the independence of the residents. Three DHAs in the project had local hospital-based mental handicap services. It was evident that the services they planned for their Darenth residents were strongly influenced by the interests of their existing workforce;

they were the only districts which proposed a nursing structure for residential services (although other districts allowed nurses to continue on a nursing grade parallel to remaining staff on A &C grades). Over the years, two of these three districts modified their service model to make it more flexible and less traditional; in Dartford, the tradition of a nursing model of care was still dominant even after Darenth closed.

In those districts which did not start the Darenth project with provider interests, the services planned reflected to a much greater degree the new service philosophy. These districts offered more choice to their clients for living arrangements, and were more willing to consider services from a variety of agencies. So the research does suggest that where assessment and provision are the responsibility of the same authority, there is a tendency for provider interests to restrict consideration of alternative forms of service provision. And, the experience of establishing working relationships with housing associations and consortia did enable health authorities to act as purchasing authorities, showing how such arrangements could operate, even if on a modest scale.

Assessment and case management: Local authorities are given responsibility for conducting an assessment of an individual's need for social care, including residential or nursing home care, designing a package of care to meet those needs and ensuring services are provided. Assessment is to be more than a determination of eligibility for a particular service. It is to be undertaken for people whose needs are complex (they would require many different types of services) and would probably require services from more than one agency. The objective of assessment is to determine whether individuals could remain living in their own homes with support, and if not, what type of residential care would be most appropriate.

Following assessment, a case manager should be apppointed, to ensure that clients get the services they need, and that the provision of services is monitored. Case management is an important componant of the new procedures for community care because it is the means by which people will be kept in the community with a range of services to care for them, rather than receiving the simpler option of residential care.

The Darenth project has little to contribute to determining whether this aspect of the new legislation will be helpful. In some districts, something like case management was beginning to be developed towards the end of the research, and in these instances, the programmes developed for clients appeared to be more varied and imaginative as well as more focussed on giving them specific types of experience or learning particular skills. What evidence there is, then, lends support to this approach of assessment of needs and case management as the means of ensuring appropriate service delivery.

Encouragement of private and voluntary sectors: Local authorities are, at the same time, encouraged to work more closely with private and voluntary organisation, not only for residential care but for the whole range of services which could be required by clients. Social services authorities have been given strategic planning role: identifying needs and services required to meet those needs, but working towards divesting themselves of many of their direct provision of services and encouraging the development of voluntary organisations to make service provision. Central government saw social services departments as monopoly providers; competition of service provision would, it was hoped, promote choice and efficiency.

Participants in the Darenth project would have found merit in such proposals. The Darenth project gave a considerable boost to the involvement of housing associations in providing housing services for people with severe handicaps, something of which they had little previous experience. The hospital closure, here and in other part of England, created a new market for housing associations. The development of consortia was also a direct offshoot of the "ordinary life" philosophy; a new managing agency was needed to take houses out of NHS (or local authority) hands and work directly with housing associations, distancing the statutory agencies even further from the housing side of new services.

The Darenth experience, however, perhaps suggests that in inner city areas at least, there will be few private or voluntary residential homes for statutory agencies to use. The reasons for this, it would seem, relate to the size of houses available in this kind of area, and in London at least, the cost of housing and the cost of adapting it for people with restricted mobility. Aside from housing associations, there was little contact with other voluntary agencies, and no private homes used within the catchment area. Further, the consortia established were in reality dominated by the statutory agencies; without their support and funding, they would not have got started and would have found it hard to have kept going. Besides residential services voluntary organisations provide other types of services such as respite care, day centres, helping people to find employment or employment training; these are not yet so numerous as to be able to cater for the numbers of people who require such services.

Health authorities to collaborate with local authorities

and family health service authorities to produce joint community care plans: Despite the clarification of the lead responsibilities of local authorities, central government still recognised that joint planning would still be necessary. Those for whom it has in the past been most difficult to provide community care still require a coordinated range of services from several agencies; even the new arrangements could not eliminate the need for joint involvement with clients having complex needs.

The lead given to local authorities in initiating assessment of people with such complex social and medical needs included calling on medical and nursing inputs to assessments. Local authorities are required to involve health authorities and voluntary organisations in the production of community care plans, and with health authorities in particular, to reach agreements on which services will be provided by which authority. Planning agreements or joint plans are to be the means by which such issues as common goals, agreed policies for assessment, case management, resources for community care and quality standards are to be established.

Some form of joint planning is thus seen as a continuing necessity. What is new is the attempt to define the scale and scope of such plans, and to place them in a framework of resources available to each authority, to focus on outcomes rather than process. The form that joint planning is to take has therefore changed considerably, and has become linked with how authorities are to work together beyond the stage of planning.

The Darenth project generated very little joint planning or collaboration and there is no reason to assume that the new injunctions about joint planning will necessarily be anymore successful; all the old problems will remain. Authorities will have their own priorities for services and for resource utilisation. They will favour service developments by their own staff over those of other organisations, and have their own perceptions of clients' needs. They will be reluctant to become involved in joint situations because of the ambiguity and uncertainty of responsibility which that generates.

What may improve the capacity of organisations to reach agreement is their newly established contracting procedures, for these most closely approximate the way in which authorities in the Darenth project reached agreement with each other. As we showed in chapter 9, there was little collaboration but in three instances, general agreement was reached on which agency should provide the whole or a major part of local mental handicap services; these three instances showed a shift to local authority with funds following this shift. The same effect could now be achieved with much less public controversy by one agency contracting the provision of services from another. It is possible that deals will be struck locally in which one agency will buy out the service responsibilities of other agencies. What we know is that altruism will not be the basis for this to happen; enlightened self-interest is more likely to lead towards such agreements.

Transfer of social security funds to local authorities: As a means of funding the development of community and domiciliary services to maintain people in their own homes, local authorities will have transfered to them the "care" element of social security funds currently used to maintain people in residential and nursing homes. This will become available to fund community services if these are seen as more appropriate, thus ending the perverse incentive of residential care in private and voluntary homes being seen as a free (or almost free) service for local authorities.

To further diminish the difference in levels of benefits available according to the nature of the accommodation, all people who are dependent on public funds to maintain themselves in private or voluntary residential or nursing homes will be eligible for income support and housing benefit at the same level as they would be had they remained in their own homes.

These measures should go some way to alleviating the recognised difficulties in developing community services by local authorities and in supporting the lead role of local authorities as the planner and purchaser of community care services. By transfering funds to local authorities and giving them the lead responsibility for assessing the appropriate services for clients, the ability of health authorities, or private or voluntary bodies for developing residential services without local authority consultation is eliminated, a source of considerable concern to local authorities after *Care in the Community* circular. These measures also highlight the effectiveness of financial incentives; central government has been surprised as the speed at which local authorities have moved to divest themselves of direct management of homes for elderly persons, coming quickly to management arrangements with housing associations in order to maximise the social security contribution to meeting the running costs of those homes. These new management arrangements were pioneered in the Darenth project by health authorities.

This new arrangement, however, would have little impact on hospital closures. The amount of money available is now capped. Local authorities might feel no incentive to contribute to the cost of people they see as the responsibility of the health service, especially if clients coming out of hospital were in competition with residents of the community for the use of a limited resource. Hospital residents may therefore do worse under this arrangement than they did before.

Caring for People provides resolutions to many of the issues for which joint planning was unable to tackle. It succeeds in transferring funds to local authorities without taking it from health service activities. It eliminates a bias towards residential or nursing home care. It provides a new framework for joint planning: It clarifies roles and responsibilities of the main authorities, and provides a means by which they may be held publicly accountable. It places clients, and where they exist, their carers, more centrally in the processes by which needs are determined and services developed.

It also represents a retreat by central government from offering guidance on the levels of provision which health and local authorities should make available; community care services are now clearly seen as a matter to be settled by local purchasers, in relation to the amount they wish to spend on community care and all the other services for which they are responsible. The recommendation for a Minister of State for community care was rejected, although monitoring of community care plans will be carried out by the Social Services Inspectorate which may inform the Secretary of State of the need for directives if key objectives are not being met; RHAs will continue to monitor DHAs and FHSAs. The Department of Health also refrained from prescribing local consultation processes on community care plans.

The requirement for community care plans to be published may prove to be an effective means of generating more widespread knowledge and support for community care services. Community care issues will now be debated in a much more political atmosphere, unable to be hidden among other services as before. What remains to be seen is the amount of funds available for further development of such services. The general pressure on both health and local authority services currrently being experienced is leading to a loss of local authority services for the main priority groups.

Bibliography

Abell, P. (ed) (1975). *Organizations as Bargaining and Influence Systems.* London, Heinemann.

Alaszewski, A. (1986). *Institutional Care and the Mentally Handicapped.* London, Croom Helm.

Allen, P. Pahl, J. & Quine, L. (1990). *Care Staff in Transition: The Impact on Staff of Changing Services for People with Mental Handicaps.* London, HMSO.

Allison, G.T. (1971). *Essence of Decision.* Boston, Little, Brown and Company.

Audit Commission (1986). *Making a Reality of Community Care.* London, HMSO.

Audit Commission (1987). *Community Care: Developing Services for People with a Mental Handicap.* London, HMSO.

Banks, G.T. (1979). Programme Budgeting in the DHSS. In Booth, T.A. *Planning for Welfare.* Oxford, Basil Blackwell and Martin Robinson.

Bardach, E. (1980). *The Implementation Game: What Happens After a Bill Becomes A Law.* Cambridge, Mass., The MIT Press.

Barrett, S. and Fudge, C.(eds) (1981). *Policy & Action: Essays on the Implementation of Public Policy.* London, Methuen.

Barrett, S. and Hill, M. (1984). Policy, Bargaining and Structure in Implementation Theory: Towards an Integrated Perspective. *Policy and Politics*, 12(3), 219-240.

Barton, R. (1959). *Institutional Neurosis.* Bristol, John Wright.

Belknap, I. (1956). *Human Problems of a State Mental Hospital.* New York, McGraw-Hill.

Benson, J.K. (1975). The Inter-Organisational Network as a Political Economy. *Administrative Science Quarterly*, 20(2), 229-249.

Birenbaum, A. and Seiffer, S. (1976). *Resettling Adults in a Managed Community.* New York, Praeger Publishers.

Bone, M., Spain, B. & Fox, M. (1972). *Plans and Provision for the Mentally Handicapped.* London, George Allen & Unwin.

Booth, T.A. (ed) (1979). *Planning for Welfare.* Oxford, Basil Blackwell and Martin Robinson.

Booth, T.A. (1981a). Collaboration between Health and Social Services: Part I, A Case Study of Joint Care Planning. Part II, A Case Study of Joint Finance. *Policy and Politics*, 9(1), 23-49; 9(2), 205-226.

Booth, T.A. (1985). *Home Truths.* London, Gower.

Booth, T.A., Simons, K. & Booth, W. (1990). *Outward Bound: Relocation and Community Care for People with Learning Difficulties.* Open University Press, Milton Keynes.

Braddock, D. and Heller, T. (1985). The closure of mental retardation institutions I & II. *Mental Retardation*, 23 (4), 168-76; 23 (5), 222-30.

Bradley, V. (1976). Policy termination in mental health: the hidden agenda. *Policy Sciences*, 7 (2), 215-24.

Braybrooke, D. and Lindblom, C.E. (1963). *A Strategy of Decision-Making: Policy Evaluation as a Social Process.* New York, Free Press.

Brazil, R., Etherington, & Georgiou, N. (1988). Innovation in Joint Planning and Joint Management. In Wistow, G. and Brooks, T., *Joint Planning and Joint Management.* London RIPA.

Bresnan, M. (1988). Insights on site: Research into Construction Project organizations. In Bryman, A. (ed), *Doing Research in Organizations.* London, Routledge.

Brolin, D. and Wright, G.N. (1971). Implementing Rehabilitation Recommendations for the Mentally Retarded. *American Journal of Mental Deficiency*, 75(5), 586-592.

Brown, G.W., Bone, M., Dalison, B. & Wing, J.K. (1966). *Schizophrenia and Social Care.* Oxford, Oxford University Press.

Brown, P.(1985a). The Transfer of Care: *Psychiatric Deinstitutionalization and its Aftermath.* London, Routledge and Kegan Paul.

Brown, P.(ed)(1985b). *Mental Health Care and Social Policy.* London, Routledge and Kegan Paul.

Brown, R.S.G. (1976). Collaboration Between the NHS and Local Government. *Local Government Studies*, 2(2), 15-25.

Brown, R.S.G. (1979). *Reorganising the National Health Service: a Case Study in Administrative Change.* Oxford, Blackwell.

Bryman, A. (ed) (1988) *Doing Research in Organizations.* London, Routledge.

Buchanan, D., Boddy, D. and McCalman, J. (1988). Getting in, Getting on, Getting Out and Getting Back. in Bryman, A. (ed). *Doing Research in Organizations.* London, Routledge.

Burgess, R.G. (1984). *In the Field: An Introduction to Field Research.* London, George Allen & Unwin.

Cameron, J.M. (1978). Ideology and policy termination: restructuring California's mental health system. *Public Policy*, 26 (4), 533-67.

Campaign for Mentally Handicapped People (1978). *Encor: A Way Ahead.* London, CMHP.

Carley, M. (1980). *Rational Techniques in Policy Analysis.* London, Heinemann.

Cattermole, M., Jahoda, A. & Markova, I. (1988). Life in a Mental Handicap Hospital: The View From the Inside. *Mental Handicap*, 16(Dec), 136-139.

Challis, L.,Fuller, S.,Henwood, M.,Klein, R.,Plowden, W., Webb,A., Whittingham, P. & Wistow, G. (1988). *Joint Approaches to Social Policy.* Cambridge, Cambridge University Press.

Chu, F. and Trotter, S. (1974). *The Madman Establishment: Ralph Nadar's Study Group Report on the National Insititute of Mental Health.* New York, Grossman.

Cm 555 (1989) *Working for Patients.* London, HMSO.

Cm 849 (1989). *Caring for People.* London, HMSO.

Cmnd. 1604 (1962). *A Hospital Plan for England and Wales.* London, HMSO.

Cmnd. 1973 (1963). *Health and Welfare: The Development of Community Care.* London, HMSO.

Cmnd. 3975 (1969). *Report of the Committee of Enquiry into the Allegations of Ill Treatment and other Irregularities at the Ely Hospital, Cardiff.* London, HMSO.

Cmnd. 4683 (1971). *Better Services for the Mentally Handicapped.* London, HMSO.

Cmnd. 5055 (1972). *National Health Service Reorganisation.* London, HMSO.

Cmnd. 6233 (1975). *Better Services for the Mentally Ill.* London, HMSO.

Cmnd. 7357 (1978). *Report of the Committee of Enquiry into Normansfield Hospital.* London, HMSO.

Cmnd. 7468 (1979). *Report of the Committee of Enquiry into Mental Handicap Nursing and Care* (Jay Report). London, HMSO.

Cmnd. 8173 (1981). *Growing Older.* London, HMSO.

Cmnd. 9674 (1985). *Government Response to the Second Report from the Social Services Committee 1984-85 Session: Community Care.* London, HMSO.

Conroy, J., Efthimiou, J. & Lemanowicz, J. (1982). A matched comparison of the developmental growth of institutionalized and deinstitutionalized mentally retarded clients. *American Journal of Mental Deficiency*, 86(6), 581-7.

Dalgleish, M. (1983). Assessment of residential environments for mentally retarded adults in Britain. *Mental Retardation*, 21(5),204-8.

Dearlove, J. (1973). *The Politics of Policy of Local Government: The Making and Maintenance of Public Policy in the Royal Borough of Kensington & Chelsea.* London, Cambridge University Press.

Deutsch, A. (1940). *The Mentally Ill in America.* New York, Columbia University Press.

DHSS (1970). *Reorganising the National Health Service.* London, HMSO.

DHSS (1973). *A Report from the Working Party on Collaboration between the NHS and Local Government on its Activities to the End of 1972.* London, HMSO.

DHSS (1976a). *Priorities for Health and Personal Social Services.* London, HMSO.

DHSS (1976b). *The National Health Service Planning System* (The Blue Book). London, HMSO.

DHSS (1977a). *Joint Care Planning: Health and Local Authorities.* HC(77)17 and LAC(77)10. London, HMSO.

DHSS (1977b) *Priorities in Health and Personal Social Services: The Way Forward.* London, HMSO.

DHSS (1980). *Mental Handicap: Progress, Problems and Priorities.* London, DHSS.

DHSS (1981a). *Care in Action.* London, HMSO.

DHSS (1981b). *Care in the Community: a Consultative Document for Moving Resources for Care in England.* HC(81)9, LAC(81)5. London, DHSS.

DHSS (1981c). *Report on Community Care.* London, HMSO.

DHSS (1983a). *NHS Management Enquiry Report* (Griffiths Report). London, HMSO.

DHSS (1983b). *Getting Mentally Handicapped Children Out of Hospital.* DA(83)3. London, HMSO.

DHSS (1983c). *Care in the Community.* HC(83)6, LAC(83)5. London, HMSO.

DHSS (1984). *Health Services Development: Collaboration between NHS, Local Government and Voluntary Organisations.* HC(84)9. London, HMSO.

DHSS (1988). *Community Care: Agenda for Action*(Griffiths Report). London, HMSO.

Donges, G.A. (1982). *Policymaking for the Mentally Handicapped.*Aldershot, Gower.

Donnison, D.V. (1975). *Social Policy and Administration.* London, Allen & Unwin.

Downs, A. (1967). *Inside Bureaucracy.* Boston, Little, Brown & Co.

Dror, Y. (1964). Muddling Through - "science" or "inertia". *Public Administration Review*, 24(3), 154-57.

Dunham, H.W. and Weinberg, S.K. (1960). *The Culture of the State Mental Hospital.* Detroit, Wayne State University Press.

Dunsire, A. (1978). *Implementation in a Bureaucracy.* Oxford, Martin Robinson.

Edgerton, R.B. (1971). *The Cloak of Competence.* Berkeley, University of California Press.

Edgerton, R.B. and Bercovia, S.M. (1976). The Cloak of Competence - Years Later. *American Journal of Mental Deficiency*, 80(5), 485-497.

Elmore, R.F. (1980) Backward Mapping: Implementation Research and Policy Decisions. *Political Science Quarterly*, 94(4), 601-617.

Etzioni, A. (1967). Mixed- Scanning: A "Third" Approach to Decision-Making. *Public Administration Review*, 28, 385-92.

Evandron, M., Falkingham, J. & Glennerster, H. (1990). The Personal Social Services: Everyone's Poor Relation but Nobody's Baby. in Hills, J. (ed). *The State of Welfare: The Welfare Stater in Britain since 1974.* Oxford, Clarendon Press.

Evans, G.,Todd, S.,Blunden, R.,Porterfield, J. & Ager, A. (1987).
Evaluation: the impact of a move to ordinary housing. *British Journal of Subnormality.* 33(1), 10-18.

Eyman, R.K., Borthwick. S.A. & Miller, C. (1981). Trends in Maladaptive Behavior of Mentally Retarded Persons Placed in Community and Institution Settings. *American Journal of Mental Deficiency*, 85(5), 473-477.

Eyman, R.K., O'Connor, G., Tarian, G. & Justics, R.S. (1972). Factors Determining Residential Placements of Mentally Handicapped Children. *American Journal of Mental Deficiency*, 76(6), 692-698.

Faludi, A. (ed) (1973). *A Reader in Planning Theory.* Oxford, Pergamon Press.

Freeman, H. and Farndale, J.(eds) (1963). *Trends in the Mental Health Services.* Oxford, Pergamon Press.

Friend, J.K.,Power, J.M. & Yewlett, C.J. (1974). *Public Planning: The Inter-Corporate Dimension.* London, Tavistock.

Gibbons, F.X., Sawin, L.G. & Gibbons, B.N. (1979). Evaluations of Mentally Retarded Persons: "Sympathy" or Patronization? *American Journal of Mental Deficiency*, 84(2), 124-131.

Gill, M. and Thrasher, M. (1985). Problems in Administering Community Policing: Some Lessons from Implementation Analysis. *Policy and Politics*, 13(1), 37-52.

Glennerster, Howard (1975). *Social Service Budgets and Social Policy*. London, George Allen & Unwin.

Glennerster, H.,Korman, N. & Marslen-Wilson, F. (1983). *Planning for Priority Groups*. Oxford, Blackwell.

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Harmondsworth, Penguin.

Greenblatt, M.,York, R & Brown, E. (1955). *From Custodial to Therapeutic Patient Care in Mental Hospitals*. New York, Russell Sage Foundation.

Gregory, R. (1989). Political Rationality or 'Incrementalism'? Charles E. Lindblom's enduring contribution to public policy making theory. *Policy and Politics*, 17(2), 139-153.

Grob, G.N. (1983). *Mental Illness in American Society, 1875-1940*. Princeton, Princeton University Press.

Hall, P., Land, H., Parker, R. & Webb, A. (1975). *Change, Choice and Conflict in Social Policy*. London, Heinemann.

Ham, C. (1981). *Policy-Making in the National Health Service*. London, Macmillan Press Ltd.

Ham, C. and Hill, M. (1984). *The Policy Process in the Modern Capitalist State*. Brighton, Wheatsfeaf Books Ltd.

Hammersley, M and Atkinson, P. (eds) (1983). *Ethnography*. London, Tavistock.

Hayek, F.A. (1976). *The Road to Serfdom*. London, Routledge & Kegan Paul.

Henkel, M., Kogan, M., Packwood, T., Whitaker, T. & Youll, P. (1989). *The Health Advisory Service: An Evaluation*. London, King Edward's Hospital Fund.

Hitch, C.J. and McKean, R.N. (1960). *The Economics of Defence in the Nuclear Age*. Cambridge, Mass., Harvard University Press.

Hood, C. (1976). *The Limits of Administration*. London, Wiley.

House of Commons (1985). Second Report of the Social Services Committee, *Community Care*. HC.13. London, HMSO.

Hull. J.T. and Thompson, J.C. (1980). Predicting Adaptive Functioning of Mentally Retarded Persons in Community Settings. *American Journal of Mental Deficiency*, 85(3), 253-261.

Hunter, D.J. (1980). *Coping with Uncertainty: Policy and Politics in the National Health Service.* Chichester, Research Studies Press.

Hunter, D.J. and Wistow, G. (1987). *Community Care in Britain: Variations on a Theme.* London, Kings Fund.

Jeffrae, D. and Cheseldine. S. (1982). *Pathways to Independence.* Sevenoaks, Hodder and Stoughton Educational.

Jones, K. (1960). *Mental Health and Social Policy 1845-1959.* London, Routledge and Kegan Paul.

Jones, K. (1972). *A History of the Mental Health Services.* London, Routledge and Kegan Paul.

Jones, K. and Fowles, A.J. (1984). *Ideas on Institutions: Analysing the Literature on Long Term Care and Custody.* London, Routledge and Kegan Paul.

Jones, K. with Brown, J.,Cunningham, W.J., Roberts, J. & Williams, P. (1975). *Opening the Door: A Study of New Policies for the Mentally Handicapped.* London, Routledge and Kegan Paul.

King, R.D., Raynes, N.V. & Tizard J. (1971). *Patterns of Residential Care: Sociological Studies in Institutions for Handicapped Children.* London, Routledge and Kegan Paul.

King's Fund Centre (1980). *An Ordinary Life.* London, King's Fund Centre.

Klein, R. (1983). *The Politics of the National Health Service.* London, Longman.

Korman, N. and Glennerster, H. (1985). *Closing A Hospital: The Darenth Park Project.* Occasional Papers in Social Administration, No. 78. London, Bedford Square Press.

Korman, N. and Glennerster, H. (1990). *Hospital Closure.* Milton Keynes, Open University Press.

Lee, K and Mills A. (1982). *Policy-Making and Planning in the Health Sector.* London, Croom Helm.

Leedham, I. (1988). *Output Evaluation in Practice: Research Methodology with Special Reference to Services for People with Learning Difficulties.* Discussion paper 606/2, Personal Social Services Research Unit, University of Kent at Canterbury.

Lindblom, C.E (1959). The Science of Muddling Through. *Public Administration Review.* 19(2), 79-88.

Lindblom, C. (1963). *The Intelligence of Democracy.* New York, Free Press.

Lindblom, C.E. (1979). Still Muddling, Not Yet Through. *Public Administration Review*, 39(6), 517-526.

Lipsky, M. (1980). *Street-Level Bureaucracy.* New York, Russell Sage Foundation.

Locker, D., Rao, B. & Weddell, J.M. (1984). Evaluating care for the mentally handicapped adult: a comparison of hostel, home and hospital care. *Journal of Mental Deficiency Research*, 28, 189-98.

Lynn, L.E. (1987). *Managing Public Policy.* Boston, Little, Brown & Co.

MacEachron, A.E. (1983). Institutional reform and adaptive functioning of mentally retarded persons: a field experiment. *American Journal of Mental Deficiency.* 88(1), 2-12.

Malin, N.A. (1982). Group Homes of Mentally Handicapped Adults: Residents' Views on Contacts and Support. *British Journal of Mental Subnormality*, 28(54), 29-34.

March, J.G. (1982). Theories of Choice and Making Decisions. *Society*, 20(1), 29-39.

Martin, J. (1984). *Hospitals in Trouble.* Oxford, Blackwell.

McGrath, M. (1988). Inter-Agency Collaboration in the All-Wales Strategy: Initial Comments on a Vanguard Area. *Social Policy and Administration*, 22(1), 53-67.

McKean, R.N. (1958). *Efficiency in Government through Systems Analysis.* New York, John Wiley & Sons Inc.

Morris, P. (1969). *Put Away: A Sociological Study of Institutions for the Mentally Retarded.* London, Routledge and Kegan Paul.

National Council for Civil Liberties (1951). *50,000 Outside the Law.* London, NCCL.

National Development Group for the Mentally Handicapped (1976). *Mental Handicap: Planning Together.* London, HMSO.

National Development Group for the Mentally Handicapped (1977). *Mentally Handicapped Children, A Plan for Action.* London, HMSO.

National Development Group for the Mentally Handicapped (1980). *Services for Mentally Handicapped People - Unfinished Business.* London, HMSO.

New Concepts for the Handicapped, Inc. (1982). *Getting to Know You.* Wisconsin, distributed in the UK by CMH.

Nixon, J. (1980). The Importance of Communication in the Implementation of Government Policy at Local Level. *Policy and Politics*, 8(2), 127-144.

Nocon, A. (1989). Forms of Ignorance and Their Role in the Joint Planning Process. *Social Policy and Administration*, 23(1), 31-47.

Novick, D. (ed) (1965). *Program Budgeting.* Cambridge, Mass., Harvard University Press.

O'Connor, G., Justice, R.S. and Ward, N. (1970). The Aged Mentally Retarded: Institution or Community Care? *American Journal of Mental Retardation*, 75(3), 354-360.

O'Connor, N. and Tizard, J. (1956). *The Social Problems of Mental Deficiency.* Oxford, Pergamon Press.

Oswin, M. (1974). *The Empty Hours.* London, Allen Lane, the Penguin Press.

Parker, R.A. (1988). An Historical Background to Residential Care. In Wagner, Lady, *Report of a Committee on Residential Care.*
Vol. 2, London, HMSO.

Parston, G. (1980). *Planners, Politics and Health Services.*London, Croom Helm.

Peters, T.S. and Waterman, R.H. (1982). *In Search of Excellence: Lessons from America's Best Run Companies.* New York, Harper Row.

Popper, K.R. (1962). *The Open Society and its Enemies.* London, Routledge and Kegan Paul.

Pratt, M.W., Luszcz, M.A. & Brown, M.E. (1980). Measuring dimensions of the quality of care in small community residences. *American Journal of Mental Deficiency*, 85(2), 188-94.

Pressman, J.L. and Wildavsky, A.B. (1973). *Implementation*. Berkeley, University of California Press.

Race, D.G. and Race, D.M.(1979). *The Cherries Group Home: A Beginning*. London, HMSO.

Ramon, S. (1985). *Psychiatry in Britain: Meaning and Policy*. London, Croom Helm.

Raynes, N.V., Sumpton, R.C. & Flynn, M.C. (1987). *Homes for Mentally Handicapped People*. London, Tavistock Publications.

Rein, M. (1976). *Social Science and Public Policy*. Harmondsworth, Penguin.

Renshaw, J., Hampson, R., Thomason, C., Darton, R., Judge, K. & Knapp, M. (1988). *Care in the Community: The First Steps*. Aldershot, Gower.

Robb, B. (1967). *Sans Everything*. London, Nelson.

Rochester, C. (1987). *Southwark Consortium (1984-87)*. Unpublished report to Cambridge House.

Rosenhead, J.(ed) (1989). *Rational Analysis for a Problematic World*. Chichester, John Wiley & Sons.

Russell, O. (1985). *Mental Handicap*. London, Churchill Livingstone.

Sabatier. R. and Mazmanian, D. (1979). The Conditions of Effective Implementation: A Guide to Accomplishing Policy Objectives. *Policy Analysis*, 5(4), 481-504.

Sargent, T. (1979), Joint Care Planning in the Health and Social Services. In Booth, T.A., *Planning for Welfare*. Oxford, Basil Blackwell/Martiin Robertson.

Saxby, H., Thomas, M., Felce, D. & De Kock, U. (1986). The use of shops, cars and public houses by severely and profoundly mentally handicapped adults. *British Journal of Mental Subnormality*, 32(2), 69-81.

Schalock, R.I., Harper, R.S. & Genung, T. (1981). Community Integration of Mentally Retarded Adults: Community Placement and Program Success. *American Journal of Mental Deficiency*, 85(5), 478-488.

Schalock, R.I. and Lilley, M.A. (1986). Placement from community-based mental retardation programs: how well do clients do after 8 to 10 years? *American Journal of Mental Deficiency*, 90(6), 669-76.

Schmidmeyr, B. and Welch, R.G. (1971). Attitudes of Institutional Employees towards Resident-Oriented Activities of Aides. *American Journal of Mental Deficiency*, 76(1), 1-4.

Scull, A. (1979). *Museums of Madness: The Social Organisation of Insanity in 19th Century England.* London, Allen Lane.

Scull, A. (1984). *Decarceration: Community Treatment and the Deviant - A Radical View.* New Brunswick, N.J., Rutgers University Press.

Sedgwick, P. (1982). *Psycho-Politics.* New York, Harper & Row.

Segal, W.P. and Aviram, V. (1978). *The Mentally Ill in Community-based Sheltered Care.* New York, John Wiley.

Selzer, G.B. (1981). Community Residents Adjustment: The Relationship Among Environment, Performance and Satisfaction. *American Journal of Mental Deficiency*, 85(6), 624-630.

Sharkey, S. and Barna, S. (1990). *Community Care: People Leaving Long-stay Hospitals.* London, Routledge.

Shatzman, L. and Strauss, A.L. (1973). *Field Research.* Englewood Cliffs, N.J., Prentice-Hall.

Silverman, D. (1985). *Qualitative Methodology and Sociology.* Aldershot, Gower.

Simon, H.A. (1947). *Administrative Behavior.* New York, Macmillan Co.

Simon, H.A. and March, J.G. (1958). *Organisations.* New York, Wiley

Skultans, V. (1978). *English Madness: Ideas on Insanity 1580-1890.* London, Routledge and Kegan Paul.

Small, N. (1989). *Politics and Planning in the National Health Service.* Milton Keynes, Open University Press.

Smith, G. and May, D. (1980). The Artificial Debate between Rationalist and Incrementalist Models of Decision-Making. *Policy and Politics*, 8(2), 147-161.

Smith, J., Glossop, C., & Kushlick, A. (1980). Evaluation of alternative residential facilities of the severely mentally handicapped in Wessex: client progress. *Advances in Behaviour Research and Therapy*, 3, 5-11.

Solesbury, W. (1981). Strategic Planning: Metaphor or Method? *Policy and Politics*, 9(4), 419-437.

Stanton, A.H. and Schwarz, M.S. (1954). *The Mental Hospital*. New York, Basic Books.

Sutter, P., Mayeda, T., Call, T. Yanagi, G. & Yee, S. (1980). Comparison of Successful and Unsuccessful Community Placements of Mentally Retarded Persons. *American Journal of Mental Deficiency*, 85(3), 262-267.

TAPS (1990). Unpublished Results of Research on the Closure of Friern Hospital.

Thomas, M.,Felce,D., DeKock, U., Saxby. H. & Repp, A. (1986). The activity of staff and of severely and profoundly mentally handicapped adults in residential settings of different sizes. *British Journal of Mental Subnormality*, 32(1), 82-92.

Thompson, T. and Carey, A. (1980). Structured normalization: intellectual and adaptive behavior changes in a residential setting. *Mental Retardation*, 18(4), 193-97.

Tillett, A., Kempner, T. & Wills, G. (eds) (1970). *Management Thinkers*. Harmondsworth, Penguin Books.

Titmuss, R.M. (1963). Community Care: Fact or Fiction. In Freeman, H. and Farndale, J. (eds) *Trends in the Mental Health Services*. Oxford, Pergamon Press.

Tizard, J. (1964). *Community Services for the Mentally Handicapped*. Oxford, Oxford University Press.

Tizard, J. and Grad, J.C. (1961). *The Mentally Handicapped and their Families: A Social Survey*. Oxford, Oxford University Press.

Townsend, P. (1962). *The Last Refuge*. London, Routledge and Kegan Paul.

Tredgold, A. (1908). *Mental Deficiency*. London, Balliere Tyndale.

Tyerman, C. and Spencer, C. (1980). Normalised physical environment for the mentally handicapped and its effects on patterns of activity, social relations and self-help skills. *British Journal of Mental Subnormality*, 26(5), 47-54.

Tyne, A. (1982). Community care and mentally handicapped people in Walker, A. (ed), *Community Care: The Family, the State and Social Policy*. Oxford, Basil Blackwell/Martin Robertson.

Van Meter, D.S. and Van Horn, C.E. (1975). The Policy Implementation Process: A Conceptual Framework. *Administration & Society*, 6(4), 445-488.

Wagner, Lady (1988). *Report of a Committee on Residential Care*. Vol. 2, *The Research Reviewed*. London, HMSO.

Walker, A. (ed) (1982). *Community Care: The Family, the State and Social Policy*. Oxford, Basil Blackwell/Martin Robertson.

Webb, A. and Wistow, G. (1986). *Planning, Need and Scarcity*. London, Allen & Unwin.

Weber, M. (1964). *The Theory of Social and Economic Organisation*. New York, The Free Press.

Welsh Office (1982). *Report of the all-Wales Working Party on Services for Mentally Handicapped People*. Cardiff, Welsh Office.

Wertheimer, A. (1986). Mental handicap: Where do they go from here? *Mental Handicap Bulletin*, 61(2).

Wildavsky, A. (1966). The Political Economy of Efficiency. *Public Administration Review*, 26, 292-310.

Willcocks, D., Peace, S. & Kellaherr, L. (1987). *Private Lives in Public Places*. London, Tavistock.

Willer, B. and Integtliate, J. (1981), Socio-Environmental Factors as Predictors of Adjustment of Deinstitutionalised Mentally Retarded Adults. *American Journal of Mental Retardation*. 86(3), 252-255.

Wing, J.K. and Brown, G.W. (1970). *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals, 1960-1968*. London, Cambridge University Press.

Wing, L. (1984). *Annual Report for the DHSS*. London, MRC Social Psychiatry Research Unit.

Wing, L. (1989). *Hospital Closure and the Resettlement of Residents: The Case of Darenth Park*. Aldershot, Gower.

Wistow, B. (1982). Collaboration between Health and Local Authorities: Why is it Necessary? *Social Policy and Administration*, 16(1),

Wistow, G. (1983). Joint Finance and Community Care: Have the Incentives Worked? *Public Money*, 3(2), 33-38.

Wistow, G. and Brooks, T. (eds) (1988). *Joint Planning and Joint Management*. London, RIPA.

Wistow, G. and Hardy, B. (1985). Transferring Care: Can Financial Incentives Work? *Public Money*, 5(3), 31-36.

Witt, S.J. (1981). Increase in adaptive behavior level after residence in an intermediate care facility for mentally retarded persons. *Mental Retardation*, 19(2), 75-9.

Wolfensberger, W. (1972). *The Principle of Normalization in Human Services*. Toronto, National Insititute on Mental Retardation.

Wright, J. and Sheldon, S. (1985). Health and Social Services Planning. *Social Policy and Administration*, 19(3), 258-272.