Exeter Partnership NHS Trust Records
Preliminary Project Report
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In October 2008, the Exeter Partnership NHS Trust Records project went into its second phase. This preliminary report covers the time period 20 to 31 October 2008. It is organised according to our archival and research goals and outlines my activities during the first two weeks of the project as well as any thoughts on future activities.

I started the second phase of the project with meetings with John Draisey (JD) on Monday, 20 October 2008 and Jo Melling (JM) on Tuesday, 21 October 2008 in order to revisit our archival and research goals and to set a time frame for the forthcoming six months.

Archival activities

As JD stated in the Wellcome application, the archival aims of the project are to:

1) complete the database,
2) identify a sample of 10% to 20% of files for retention, and
3) eventually destroy the remaining files

During our meeting on Monday morning JD showed me a new delivery of patient files the DRO had received from Wonford House. The deposit consists of 32 boxes with between 10 and about 50 patient files each, depending on their size (i.e. contents). Some of the files in this deposit we identified as the missing files in our existing database. We therefore decided that I would proceed by examining the new deposit first, then move on to the remaining files. We also decided that all the files would have to be stored in a certain order, as it will be necessary to retrieve particular files quickly towards the end of the project. We discarded the idea of an alphabetic system in favour of using the reference numbers as keys. As the hospitals under consideration changed their referencing system in the early 1960s (probably around 1963), we will have to group the files into two different categories. Files with both, an old and a new reference number (e.g. files of longstay patients or patients who were readmitted), will be stored under their new numbers. This split of files should not cause any problems, as both reference numbers are stored in the database. Pockets containing documents of two or more admissions will be stored under the most recent reference number. One or two volunteers at the DRO will take care of the manual handling of the files in the strongroom, while I will be working with the newly arrived files. After our meeting I advised one of the volunteers, Jack Hilman, on this task. Since then, he worked already with the deposit over two days last week and made good progress. He will continue with this task one day per week. Towards the later

stages of the project it might be a good idea to store the file from the new deposit with the remaining files in the strongroom rather than keeping them in separate boxes.

Before I started to add new data to the database, I converted it from its original "spreadsheet design" in MS Access into a fully functioning database with several related tables. This design does not only facilitate data input, but also makes the database more powerful to carry out queries. Interrogating the database properly will be important when we want to use the data for preparing research applications and articles. In addition to the information on patient details, admission and discharged information, diagnosis as well as medical history I collected during the first phase of the project, I added two new tables to collect information on drug treatment as well as details of the patient's GP.
I have also created a data entering form to facilitate data input for Eliza Newton who is going to work with the database from January 2009. Eliza has already familiarised herself with the project through my previous progress reports and on Monday, 27 October 2008 I introduced her to working with the files and the database. With two of us working at the database, I think, it might be worthwhile to create a "code sheet" listing the different options I used for certain fields (e.g. abbreviations, etc.), as this will reduce the task of cleansing the database towards the end of the project.
In order to prevent any data loss due to equipment failure, I create a new copy of the database every day. It is currently saved under my account on the DRO laptop as well as on the DRO network drive for back-up reasons. In addition I will burn it to CDs in regular intervals. Once Eliza and I will be entering data, it will be necessary to make the database fully accessible on the network drive only, and it might be a good idea to password-protect it then.

During the past two weeks I dealt with 10 of the newly arrived boxes and examined a total of 306 patient files. 66 of them related to records in our database and provided so far missing information, 250 files were added to the database, increasing it to a total of 2195 records. Given the progress so far, I am confident that by Christmas I will have examined approximately 2,000 patient files. This should include all of the newly arrived files and some of the original files.
The newly added records date back to any time between the 1950s and 1970s. Progress in adding the new records varies according to the clarity of the files and is slowed down by various different layouts of the files. As a general observation it can be said that the more recent files contain less correspondence, but more potential linkage information such as

details of the patient's GP and / or referring psychiatrist, after care reports as well as a patient's social history, providing information on the family background up to the grandparents, living conditions, education, employment, interests and potential previous psychiatric treatment in an institution or as an out-patient. In addition, patients seem to be older on admission and stay in the hospital for a shorter period of time (weeks rather than months).

Research aims:

As the majority of the files will eventually be destroyed, it is paramount to identify our research aims very clearly. In our meeting JM and I identified potential linkages, drug treatment as well as patient / relative correspondence as potential research targets as well as topics for articles. Questions to follow up were as follows:

1) Linkage between institutional care and community care:

- What did community care mean?
- What were the patients' chances of getting out of the hospital?
- Assuming that the move away from large families after WWII went along with a growing intolerance towards the elderly, was there a tendency to use the institution more (though against the government's idea of care)?
- How does the community deal with a growing disinclination to care?
- Who were influential figures in institutional care?
- What affect the everyday care of the patients?

2) Drug treatment

- What drugs did patients receive?
- "Multi-drug therapy"?
- For how long were patients on drugs?

3) Family matters through patient / relative correspondence

- What weight do staff give to the family?
- Is there a primary correspondent? Who?
- Are relatives generally in touch with the GP?
- What is the communication flow? Direction? Style?

- Are there letters written by patients or are patients' experiences mediated through relatives?

While I was examining the patient files I paid particular attention to these questions. As mentioned above, the topic of potential linkages seems much more accessible through the more recent files, as they often contain a wealth of documents on the patient's history and after care.

Drug treatment is a topic that can be examined from the mid-1950s. Entering relevant data, I realised that it is easily possible to identify which drugs the patients were given. It is much more difficult, however, to find out whether patients were already on medication prior to admission (many had been treated as out-patients or seen a psychiatrist before admission). Although most files contain a "Medicine Card", listing the starting date of when drugs were given to the patient, it is not always obvious if patients took several drugs over the same period of time as well as what dosage of a particular drug was prescribed. It is often necessary to search for this information in the doctors' / nurses' notes, which is a time-consuming and not always successful process.

My initial idea, to create a link between the environment of the hospital and how the patients experienced it through patient correspondence, had to be discarded due to the lack of available details. Although particularly the earlier files contain a wealth of letters, hardly any of them is written by the patients. Still, my main interest with regard to a longer-term research project is the patients themselves, and the questions listed above seem accessible for (at least) the earlier files. The files from the 1950s onwards which I have accessed so far do not contain much correspondence. Whether the reason is that patients generally stayed in hospital for shorter periods of time or whether letters were removed from the files, I cannot say. As JM suggested we could use correspondence (in addition to social history, etc.) to investigate in detail the family background for about 4,000 patients and create micro-study tracing the biography with patient career for about 400 with a control group of another 400 without correspondence. In this case it would be helpful to scan or photograph the relevant documents. Apart from helping with these family questions, it would give us an opportunity to try and relate them to digitised correspondence from one of JM's previous projects and it would also make sure that we keep some information of each of the earlier files.

Further proceedings as far as our research aims are concerned are as follows:

1) Short term
   - 04/11/2008: attend "paper bag lunch meeting" at CMH with the aim of presenting our findings to the other members of the CMH in a similar meeting early next year
   - 11/11/2008: attend lecture at CMH
   - 12/2008: revise article "Searching for the patient" for submission early next year
   - 12/2008: come up with idea for potential research project
   - 12/2008 – 01/2009: draft a second article, possibly on drug treatment, and its impact on institutional and community care
   - Round Table with 3 or 4 key researchers in my field of interest to be held early next year
2) Long term
   - 03/2009: submit application for research project in accordance with the Centre's Strategic Award to Wellcome Trust

Next project meeting: Thursday, 20 November 2008 (time to be announced)