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30th July 2003

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Dear Dr Jarrett,

RE: Gosport War Memorial Hospital

Thank you very much for your letter of the 21st July in which you enclosed a variety of data about admissions and deaths of patients in wards in Portsmouth. It must have taken you considerable time and effort to collect together these data.

I have spoken to Dr Reid in order to clarify one or two points. This was most helpful and I now have a reasonable understanding of the data.

The background you have provided is very important. The changes in policy that were either planned or coincidental must inevitably have had a significant impact on the observed mortality rates. In general the data tends to reinforce my impressions, although I will spend a little more time working on them.

Thank you again very much for your help in this matter.

Yours sincerely

Code A

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21st July 2003

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Professor R Baker
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Dear Professor Baker

Re: Gosport War Memorial Hospital

In view of some of the difficulties you have had with the Hospital Episode Statistics, I have collated what manual held data we have. I have some figures for continuing care ward admissions and deaths for our continuing care wards at Gosport War Memorial Hospital, St Christopher's Hospital Fareham, Petersfield Community Hospital, and on the continuing care wards on the two district hospital sites at Queen Alexandra Hospital (George ward) and St Mary's Hospital (Jersey House). We also have a continuing care facility (Jubilee House) which was started many years ago as an NHS nursing home facility.

In 1994 we started to run a stroke service. Initially this was for patients over 75 years of age due to lack of capacity to take younger patients. This stroke service has evolved with time. Initially and certainly up until about 4 years ago we ran rehabilitation services for the stroke service with a two streamed system. Those patients continent of urine (therefore with a good prognosis) were sent to the fast stream stroke rehabilitation service on Guernsey ward at Saint Mary's Hospital. Those patients incontinent of urine and therefore with a higher mortality rate and poorer prognosis of making a good recovery were sent to community hospital beds nearer their place of residence for what was initially called "slow stream stroke rehabilitation". The rationale behind this was to try and use some of our traditional continuing care beds for rehabilitation of those patients requiring a longer period of rehabilitation. These slow stream rehabilitation beds were on Elizabeth and Diana ward

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(Queen Alexandra Hospital), Cedar ward (Petersfield Community Hospital), Daedalus ward (Gosport War Memorial Hospital) and Rosewood ward (St Christopher's Hospital Fareham). The original numbers and nature of the service are summarized in the "stroke service timetable". Elizabeth ward at Queen Alexandra Hospital was also part of the slow stream stroke rehabilitation set up.

Consistently over the years we found that something like 65% of patients on Guernsey ward (our fast stream service) would get home and only a few percent would die. The figures for the slow stream stroke service were very different with about 30 to 40% of patients dying and about 30% getting home. Remember these patients were in general over 75. We did have younger patients pass through the system if beds were available or they went through our general rehabilitation wards. Of course the case mix for the different areas of the health economy were somewhat different. Also the proximity of Elizabeth ward to our palliative care ward (Charles ward) would have meant a greater portion of patients who were dying were moved from Elizabeth ward to Charles ward. There are probably other confounding factors that could make interpretation and comparison of data between different wards difficult.

Many of the beds in the slow stream stroke care facilities were on the same wards as the continuing care beds. There was some ebb and flow of patients between rehabilitation and continuing care. Often patients would be redesignated at some undefined time to continuing care if their rehabilitation progress was very poor indeed. I believe much of this data has been scrutinized by CHI.

I have given you two folders, one containing figures from the stroke service, and one from the continuing care facilities. I would be very happy to try and clarify any data. I have briefly looked at the slow stream stroke care death rate and the continuing care death rate, I have discussed the data with some of my colleagues who are more familiar with the local set up. At Gosport in the mid to late 90's there were slow stream stroke care beds but often there would be an overflow of stroke patients into continuing care beds. Over the years the admission age for the stroke service was reduced. This would have had some effect on the death rates across the service, which seems to be apparent from the data. One can clearly see the effect of Charles ward, our palliative care ward on the Queen Alexandra Hospital slow stream stroke care figures. In 2002 to 2003 there was only 2% death rate but 9% of the patients went for palliative care. There is also a summary sheet of continuing care death rates.

There are a number of changes that occurred around 1994 to 1995 that affected what was happening in our continuing care wards. We started to apply the continuing care criteria, which meant we started discharging patients from continuing care wards to nursing homes or other facilities. This was particularly noticeable in Gosport where they had a large number of continuing care beds anyway. At around 1997/8 the same time there seemed to be more trauma and orthopaedic work being done at Haslar, and again anecdotally medical

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staff working in Gosport noticed an increased number of ward visits to orthopaedics at Haslar. At the same time phase 2 of the Gosport War Memorial Hospital development occurred with the opening of the psychiatric wards which also led to an increased number of referrals and transfers to the Elderly Medicine beds at Gosport. With more people being transferred out of continuing care into the community it is likely that patients who would have died in continuing care would eventually die in a nursing home. Around 2001 Daedalus started taking more general rehabilitation, slow stream and fast stream stroke rehabilitation patients.

Over the last few years there has been difficulty in discharging continuing care patients many of whom have complex problems but are stable. This is part of the national problem with funding nursing home places. This may well have affected death rate in the continuing care facilities.

There was also a definite change in referral pattern to Gosport War Memorial Hospital from January 2000 as a result of the continuing and longstanding negative publicity about Gosport War Memorial Hospital. I myself would not refer a very frail patient who may well die to Gosport War Memorial Hospital. I would try to manage clinical care locally. We have been very sensitive about sending patients near the end of their life down to Gosport War Memorial Hospital for obvious reasons.

I have looked at the ranking of mortality rates in the continuing care wards at various periods and find that the wards on Gosport War Memorial Hospital are scattered in the middle rankings.

As you are aware Portsmouth is a large and complex health economy with a number of unique features. The Department of Medicine for Elderly Medicine is also large with a considerable number of continuing care beds compared to other districts. With time some of these beds were developed as stroke rehabilitation services for the elderly. We also have specialist palliative services, which alters case mix. Like most services ours is protean and evolves rapidly with change in the culture of health provision and government policy. I have made a simple summary of the death rates for the various wards and services with what data I have. It must be remembered that patients move to local hospitals if at all possible to help family visiting. Some wards, such as Diana ward, have closed permanently. The continuing care ward results (CC) may contain (SC – shared care when patients spent a short time in hospital to give families a rest and usually the death rate was low for such activity. Some ward statistics may not have distinguished between "slow stream rehabilitation" and "continuing care" cases.

There are some gaps in the data. I am not sure exactly why this is. There is a limited time for which paper records are kept and some culling of data has occurred. The key office staff who collated the data have retired and our IT manager who set up systems for collecting data has long since moved on.

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The further back the more uncertain the configuration of the service and the less likely there is anyone around who can accurately recall events and department changes. If any more statistics become available I will send them to you. I hope the data is of some help to you.

Yours sincerely

Code A

Dr David Jarrett FRCP
Consultant Geriatrician Code A