Health Matters

Gibraltar Health Authority

Annual Report 2001

Health Matters

Gibraltar Health Authority

Annual Report 2001

Acknowledgements

This is a combined report on the health of the people of Gibraltar in the calendar year January to December 2000 and on services delivered to them by the Gibraltar Health Authority during the same period. Very occasionally, where appropriate, the financial year April 2000 to March 2001 has been applied.

The term 'Authority' means 'Gibraltar Health Authority' throughout the report.

This report is not the work of one person, and on behalf of the Authority, I am grateful to acknowledge the contributions of the following persons to the content of the Annual Report:

Mr. E. Lima	*Chief Executive*
Mr. Joe Catania	*Director of Operational Services*
Dr. M. Maskill	*Hospital Medical Director / Consultant physician*
Mr. K. Pizarro	*Dental services Co-ordinator* *Principal, School of Health Studies*
Mr. A. Sene	*Consultant surgeon*
Mr. P. Armon	*Consultant obstetrician*
Dr. S. Benady	*Consultant paediatrician*
Dr. A Correa	*Consultant anaesthetist*
Dr. J. Coogan	*Consultant psychiatrist*
Dr. S. Barber	*Consultant elderologist*
Mr. M. Haroon	*Consultant ophthalmologist*
Dr. K. Farrell	*Associate Specialist - ENT*
Dr. T. Biedrzycki	*Consultant pathologist*
Dr. G. McColl	*Clinical psychologist*
Dr. W. Fitzpatrick	*Primary Care Co-ordinator*
Mrs. M.C. Lia	*Hospital Services Manager*
Mrs. R. Suissa	*Primary Care Manager*
Mrs. Y. Marsh	*Clinical Nurse Manager - Primary Care*
Mr. J. Alvez	*Clinical Nurse Manager - Theatre*
Mr. E. Baglietto	*Clinical Nurse Manager - KGV Hospital*
Mrs S. Rhoda	*MacMillan Nurse*
Mr. A. Montero	*Laboratory Manager*
Mrs. A. Teuma	*Senior Radiographer*
Mrs. C. Vinent	*Senior Physiotherapist*
Mr. A. Loddo	*Speech & Language Therapist*
Mrs. C. Richardson	*Senior Dietician (locum)*
Mr. W. Guillem	*Prescription Monitoring Unit Adviser*
Mrs. C. Bonavia	*Finance Manager*
Mrs. A. Grant	*Personnel Officer*
Mr. J. Easter	*Health Promotion Officer*
Mrs. R. MacGuire	*Medical Records Officer*

I also acknowledge the efforts of Stephen Perera, graphic designer, in producing the document from draft form to the finished state in a very short time and Stephen Escudero, photographer, for always being available at short notice.

Dr. Vijay Kumar, Director of Public Health

Contents

The Hon. Dr. B. Linares, Minister for Education & Health

FOREWORD

By The Hon Dr B Linares, Minister for Education & Health

After a lapse of many years, our Government renewed the practice of publishing a detailed Annual Report on behalf of the Authority. This not only enables the Gibraltar Health Authority to inform the general public concerning all areas of health care in Gibraltar, but also demonstrates the Government's genuine commitment to transparency and accountability in all aspects of our health services.

The first point I wish to make is that I am confident that the great majority of all those employed in the Health Services (doctors, nurses, professionals, technicians, industrials, etc. - our own people, who depend for themselves and their families on these very services that they are called to provide) all share my commitment to provide the most caring and efficient service to our people and that they will support me in correcting any failure on the part of the system or on the part of some individuals who can let us down in our efforts to look after our community to the best of our ability and resources.

Since 1996, there have been radical improvements in Gibraltar's health services. The Government has, amongst many other improvements (some of which are recorded in this Annual Report), commissioned and substantially implemented a General Review of health services, together with a Nursing Review. We have established the Elderly Care Agency, created a new Primary Care Centre and established a School of Health Studies running a wide range of courses to train local staff, including a Diploma Course for Registered General Nurses validated by Sheffield University (and I am pleased to report that the progress of the School of Health Studies since its inception in September 1999 can only be described as impressive). We have regulated private practice and facilitated a complaints procedure.

The creation of a new hospital in Gibraltar has been long overdue. St. Bernard's Hospital dating back to 1830 had given of its best many years ago and many of the problems and difficulties we face today are due to the physical and logistical limitations of the Hospital - indeed, it speaks of highly of our staff, that in spite of these limitations and constraints, the wards and other hospital facilities are maintained in such excellent condition, particularly as regards cleanliness and hygiene.

We look forward to the New Hospital covering an area of 30,000 sq. metres (as opposed to 9,300 in St. Bernard's) wards with 200 beds (as opposed to 160) and 3 operating theatres (as opposed to one). The New Hospital is intended by this Government to be a state of the art facility which will be the pride of our community.

But we are determined that this exciting project should also serve as a catalyst, so to speak, in generating heightened expectations, renewed attitudes and more ambitious sights striving for **Standards of Excellence in our Health Services** - a new era in Health Care in Gibraltar.

For this purpose we shall soon be in a position to announce a detailed charter in the form of an overall development plan setting out broad aims and specific objectives, marking short-term, medium-term and long-term targets in the development and improvement of medical and health services in Gibraltar as a form of protocol for the operation and functioning of the new hospital.

Much of this general developmental plan, in terms of the short-term and medium-term changes and reforms will come into effect well before we move into the New Hospital. We often hear cries "something will have to be done about our health services". However justified or unjustified these appeals may be, those making them in good faith will not be disappointed!

(Left to right)
Dr. Vijay Kumar, Director of Public Health
Mr. J. Catania, Director of Operational Services
Mr. Ernest E. Lima, Chief Executive

INTRODUCTION

By Ernest E Lima, Chief Executive

This is the fourth consecutive annual report of the Gibraltar Health Authority and continues on the objective of informing the public about the health and health care of the local population on an annual basis.

As in previous years, there are many features in the report worthy of comment, but I shall highlight just a few.

This report is divided into two main sections. The first of these is the public health report on the population of Gibraltar. The rest of the report is dedicated to the functions of the various departments within the Authority and is subdivided into five major headings. Statistical data are set out at the end of the report.

The public health report observes that life expectancy in Gibraltar continues to improve, with the mean age of death having risen to 73 years (males) and 79.3 years (females). The fall in risks to early life continues this year with some of the lowest mortality rates. These factors are a positive indication of the health of the population. Health awareness and developments in the medical services generally have been two major contributing factors.

One of the most pressing objectives for the future development of our health services has to be the expansion of computerisation into the field of clinical data. Details of the historical and current approach to this area are set out at the end of the section on the primary care services.

Continuing education and professional development are vital to the growth of our health services and the School of Health Studies has maintained its commitment to this goal. The School has worked closely with all departments to identify and provide for current and future training needs. Additionally, as part of the manpower planning for the future, our Personnel Department keeps in contact with Gibraltarian students who are studying for health professions in the United Kingdom.

The planning of a new hospital brought a new challenge for the staff. They have greeted this with enthusiasm, excitement and a tremendous sense of commitment. The wide process of consultation covered all users including patient support groups and voluntary organisations. My sincere thanks to all. Here I have to highlight the efforts of my Deputy, Joe Catania, Director of Operational Services. His contribution throughout the whole process and at all levels has been invaluable. We owe him a great debt of gratitude.

I also have to acknowledge and express my gratitude to all the staff of the Health Authority for their hard work, their commitment and dedication. I would also like to thank all those persons and voluntary organisations who have given invaluable assistance by providing donations, services or support with the aim of improving our service to the patients.

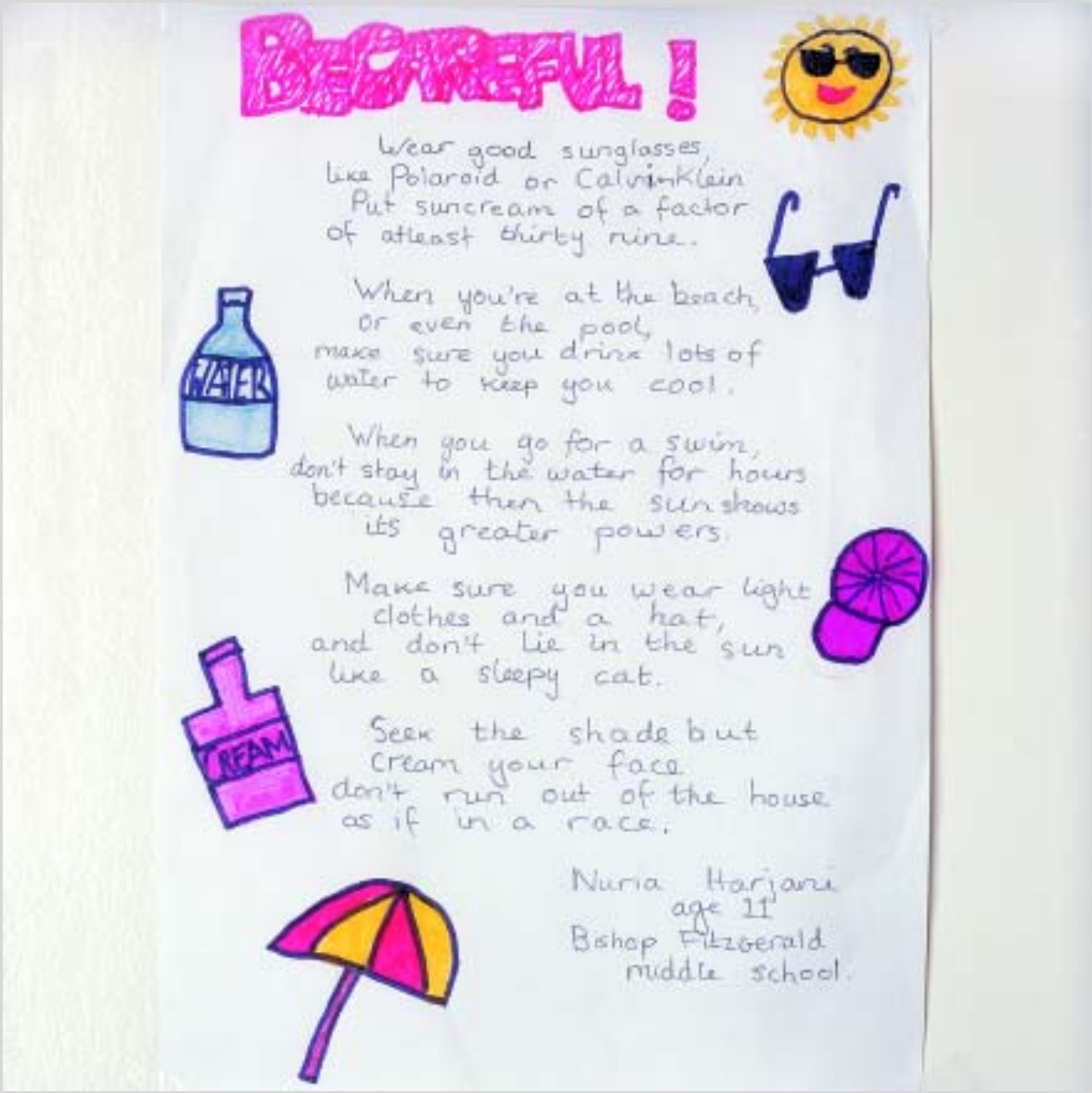
Finally, I would also like to thank Dr Vijay Kumar for the major role he has played in the production of this report.

Section 1

Public Health Report

Free blood tests for the public on Diabetes day

Public Health



Sun Awareness campaign

PUBLIC HEALTH

Vital Statistics

Population

The Government Statistics Office has estimated the resident population for Gibraltar on 31 December 2000 to be 27,033. This figure once again represents only a relatively minor shift from that of the previous year, the bulk of the shift being attributable to a reduction in non-British residents by over 200 persons (about 8%). The overall sex distributions are virtually unchanged.

Children numbering 6,102, accounted for 22.6% of the total population in 2000, a small increase over 1999, and this continues the trend seen since the last census in 1991.

Age distributions are not provided by the Statistical Office and it is not possible to be certain whether the population is ageing in absolute terms or in relation to other relevant populations.

Births

A total of 409 live births were registered in Gibraltar during the year 2000, of whom 191 were females and 213 were males. Of these, 360 births occurred in the resident population giving a local birth rate of 13.3, a figure that still continues the downward trend commented upon in previous years and seen since 1992.

Teenage pregnancies continue to rise, 28 births as against 22 last year. Also there were two mothers aged 15 this year, as against one last year. Clearly these figures merit concern.

At the other extreme, 14 births (3.4%) occurred in mothers aged 40 years or older, with the oldest mother being 42 years. The modal age of all mothers was again 26 years. The General Fertility Rate for the civilian population is calculated to be 72.3, which is higher than for the previous year and one of the highest rates in Europe.

Deaths

Life expectancy in Gibraltar continues to improve, with the mean age of death rising in both males and females each year. The mean ages at death in 200 were 73.0 years (males) and 79.3 years (females), whereas in 1999 they were 69.5 years (males) and 78.9 years (females).

The fall in risks to early life continues this year with some of the lowest mortality rates. There were two intra-uterine deaths (both due to heart defects incompatible with life), but otherwise there were no stillbirths or neonatal deaths, giving a perinatal mortality rate of 4.9. One infant died of asphyxiation, giving an infant mortality rate of 2.5.

The total number of deaths in 2000 at all ages in the resident population was 233, of which 116 were males and 117 were females. The overall death rate was 8.6, compared to last year when it was 9.9 (267 deaths).

The main causes of death are listed below (more details are in the tables).

Cause	*2000*	*1998*
Cardio-vascular (Heart) diseases	*39%*	*30%*
Malignant diseases (Cancer)	*26%*	*25%*
Cerebro-vascular diseases (Stroke)	*8%*	*13%*
Respiratory (Chest) diseases	*6%*	*12%*
Infections	*2%*	*5%*
Degenerative diseases	*10%*	*4%*
Injuries & Poisoning	*4%*	*2%*
Other causes	*5%*	*9%*
ALL CAUSES	*100%*	*100%*

Myocardial Infarction continues to rise as the single most common cause of death, followed closely by **Cancers**. As before, **Lung cancer** continues to reign at the top, being responsible for over one in six cancer deaths (9), followed closely by cancers of the **lower bowel** (8) and the **breast** (6).

While it is a striking observation that the top two causes of death are both associated with smoking as their principal risk factor, it is regrettable that one can only presume the contribution of tobacco, as Gibraltar collects no statistics on tobacco consumption among the local population.

As noted in last year's report, the recording of contributory illnesses, for example diabetes, in the death certificates is variable. Once again it appears that about 11% (24 deaths) had **diabetes** noted as a contributory cause. Table (11) confirms that the risk of dying of a heart attack is indeed greater among the diabetic population.

These observations greatly depend upon the quality and accuracy of **death certification**. In order to improve data quality, a monthly clinical audit of every death certificate was commenced from November 2000, jointly undertaken by the consultant pathologist and the director of public health. Corrections are recorded in the computerised register and will be used for future analysis. The audit also hopes to identify systematic errors. Lessons learnt will be made part of the continuing training of doctors.

'Premature' mortality

The minimum equitable health goal of any society should be for all its members to achieve the mean life expectancy of that society. As the mean age at death in Gibraltar exceeds 70 years, allowing for some margin, any death under 65 should be regarded as "premature" mortality.

Of the 233 people who died this year, 43 (18.5%) were under 65 years. Again 15 persons died of heart attacks

under the age of 65, the youngest being 45 years of age. Accidents and injuries accounted for 14% (6 deaths) in this younger age group, as against 4% for all the rest. In fact all these 6 persons died below the age of 30 years, a tragic waste of young life.

Infectious Diseases

Laboratory confirmed notifiable infections

Continuing the precedent set in last year's report, only laboratory confirmed infections are considered in this section.

The number of cases of laboratory confirmed notifiable infection rose from 233 in the previous year to 242 in 2000. The number of cases of Food poisoning continues to increase year on year. This year, although there was no outbreak of **Salmonella**, there were still 58 reports, a rise of 50% over 1998. However, the biggest increases were in Campylobacter infections.

Campylobacter infection notifications have risen steadily in the last three years - from 69 (in 1998) and 73 (in 1999) to 92 (in 2000). Campylobacter infections are caused through poor food hygiene, usually due to the consumption of poorly cooked chicken, unpasteurised milk or unchlorinated water. It can also be got from pets who may have diarrhoea.

There was a small increase in **Rotavirus** infections, during the first quarter of the year.

Cryptosporidiosis

There was an unexpected outbreak of cryptosporidiosis during the late summer months of 2000.
Cryptosporidiosis is a diarrhoeal disease caused by a protozoan parasite called Cryptosporidium. It is usually transmitted through contaminated water supplies. The parasite is resistant to chlorination, and if established, Cryptosporidium contamination can be very difficult to eradicate.

Twenty cases of Cryptosporidiosis enteritis were reported, two striking features being the age of persons affected (predominantly toddlers) and the geographical association with the pools in the Camp Bay area. It was deduced from the information available that the source was most likely to be from one or more of the three paddling pools in the area rather than the swimming pools. The Environmental Agency took scrapings of the water traps, which when analysed by a specialist UK laboratory, successfully demonstrated cryptosporidium cysts in samples taken from the NAAFI and Dolphin pool traps, thus confirming the source of the outbreak. As no more cases were reported and since the outbreak took place at the end of the bathing season, no further action was required other than the thorough clean up of the pools, which was ensured by the Environmental Agency.

Drinking water supplies were not contaminated at any point.

Multi-Resistant Staphylococcus Aureus (MRSA)

Efforts to keep MRSA (multi-resistant staphylococcus aureus, an organism resistant to most antibiotics), out of Gibraltar continue. It is resident in most major UK hospitals.

This year 18 cases of MRSA infection were reported. Of these 10 infections were acquired from St. Mary's Hospital, 2 infections from Leicester Royal Infirmary, 2 infections from Guy's Hospital, 2 infections locally and 2 infections whose source was unknown. Public concerns had also been raised about other hygiene deficiencies in St. Mary's Hospital and in late summer, a delegation of senior officers from that hospital visited Gibraltar to learn about the issues at first hand. Once again, the officers were reminded of the critical need for advance notification of MRSA infections before transfer to Gibraltar. The officers appeared sympathetic and agreed to follow up the matter, but to date notification continues to be erratic.

There is still a lot of misinformation in the public mind about MRSA. The isolation precautions taken by the staff have - perhaps understandably - led some members of the public to conclude that they are dealing with a dangerous and virulent germ, a fear aggravated by unfortunate media labels such as "superbug". The MRSA bug is actually no more dangerous than its ordinary variants - its importance mainly lies in the reduced options for therapy it offers if infection is established. A person with MRSA infection (provided his clinical condition is safe) is better off at home than in hospital. Overuse of antibiotics actually encourages the growth of MRSA.

Other infections

An outbreak of Scabies was reported at St. Bernardette's residential unit. Staff were immediately trained and controlled the outbreak successfully.

Single cases of Hepatitis B, whooping cough and yersinia infections were reported this year. There were 4 cases of tuberculosis.

Waste disposal

In May this year, the incinerator closed down, creating a crisis for the disposal of clinical waste. A plan to despatch clinical waste for processed landfill in Spain took a few weeks to organise, causing a temporary stockpiling problem and public anxiety. This has been resolved, but the relatively high cost of this method of disposal will invariably mean that alternative solutions will have to be explored in the future.

Isolation

Opportunity was taken during the design phase of the new hospital to ensure that there will be adequate facilities for isolating people with contagious illnesses. While a separate isolation unit will not be feasible, the new hospital design provides for four distributed, but purpose built isolation rooms.

The air-conditioning system was also carefully specified to minimise the risk of transmission of infections like Legionellosis.

Immunisations

Routine Programmes

During the year 2000, there were no changes to the internationally standardised immunisation programmes for children but in the new year 2001, a programme to immunise all children against **meningitis C** infection is under way. Despite the effectiveness of the **MMR (Measles, Mumps, and Rubella)** vaccine, the programme continues to be impeded by adverse publicity. A summary of the most recent research evidence was presented in last year's report and the position has not changed since then.

The annual winter **Influenza** vaccine campaign continued this year.

Other Immunisations

Opportunities for other vaccination programmes are continually reviewed. **Tuberculosis** has declined over the centuries and current annual notifications range from about 0 to 5 a year. However, since Gibraltar has strong population movements with countries of high prevalence (like India and Morocco) and students travel abroad to cities of high prevalence (like London), immunisation (BCG) is increasingly desirable.

In endemic countries, BCG vaccination is given to all newborn babies. Up to recent times, the UK has conducted a schools-based programme, which immunises children at about 13 years of age. This is less effective than universal immunisation of newborn babies. The success of the vaccine, which is near 100% at birth, falls to 50% by the age of thirteen. Side effects are also fewer in the newborn and pre-vaccination testing is not necessary. For these reasons, a neonatal BCG immunisation programme was planned for Gibraltar. However, since then, a worldwide shortage of BCG vaccine has forced cancellation of the BCG programme in many countries (including UK) and the postponement of the immunisation programme in Gibraltar.

The shortage of the tuberculosis antigen has also extended to testing materials. The department used up its last stocks of antigen for tuberculosis testing in 2000 and currently, it is not possible to offer skin tests for the relatives of persons with newly diagnosed tuberculosis.

Demand for **occupational immunisation** from all sectors of the population continues to grow, following increasing public recognition of workplace risks and statutory employer responsibilities, but the departments ability to cope with this demand is very limited. As an immediate measure during 2000, initial doses of occupational immunisation were given to police officers, ambulance officers and staff in the Elderly Care Agency, but more systematic provision will have to await the development of an occupational health service.

Cancer Registration

The Cancer Registry, which began in September 1999, completed its first year of data collection. The measures for systematic notification, entry and validation are now proceeding satisfactorily. In order to ensure consistent data quality throughout the first year, the Director of Public Health met monthly with the consultant pathologist to audit the procedures. In order to hasten future prospects of analysis, it was agreed to add up to three years of retrospective data to the Register under strict quality control.

In this report a summary of the cancer notifications for 1999 and 2000 is published (Table 12). It should be pointed out that care has been taken to apply international conventions on confidentiality to the table, whereby any figure that is below 5 or otherwise identifiable or imputable, is withheld from publication. It is hoped that this will reassure members of the public that the Registry takes the protection of their identity seriously, while discharging its obligation to inform society on trends in cancer incidence. Further analysis of the data is not possible at this stage.

Health Promotion

After a hesitant start, following the appointment of a new Health Promotion Officer, the department has had a very active and busy year. The Health Promotion Group has continued to meet monthly throughout the period.

Significant events and campaigns

The following were the key events and campaigns of the year:

No smoking Day, March 2000

No Smoking Day took place on Wednesday 8th March 2000 with a display at the Piazza and was a great

success. The local response to the campaign was satisfactory and the general public gave their full support. Many individuals approached the table for information on how to quit smoking. Some members of the public, asked again about the prospect of a smoking cessation clinic in Gibraltar, which would provide further information and support for those who really want to quit smoking. People stressed that the costs for buying a week's supply of nicotine patches were much more than that of a week's supply of cigarettes, and felt that this area needs strengthening. The Gibraltar Health Authority is considering developing a Smoking Cessation clinic.

Bug Busting Day, April 2000

"Bug busting" is the popular description for the eradication of lice from children's hair. People are still only vaguely aware that "wet combing" is the preferred method of removing lice and is superior to the use of medicated shampoos. Further, this simple technique is not always properly practised, resulting in re-infestation with lice. In order to promote the practice, Bug Busting Day was organised and took place on Friday 7th April 2000. The campaign, which was jointly funded by the Gibraltar Health Authority and the Department of Education, involved the distribution of over 8000 combs accompanied by educational and instructive literature to children through all the schools in Gibraltar. The campaign was well received and was a great success. There were some logistic problems with demand for combs exceeding the supply. Nurseries have also requested to be included in future campaigns.

Fun Walk May 2000

Heart disease remains the major cause of death in Gibraltar as elsewhere in the western world. The increasing incidence of diabetes mellitus is also a matter of concern. Regular exercise is a key element in the prevention and management of these disorders. However, exercise need not be boring and when done in company can be very exhilarating. To promote this concept, a Fun Walk was organised and took place on Wednesday 17th May 2000. About 150 T-shirts were sponsored by Flora and. 175 small bottles of water were donated by Anglo Hispano. About 30 people walked from start to finish and more individuals joined the function at the end of the walk at the Open-air Theatre where Health Minister Dr Bernard Linares officially launched the new logo of the Health Promotion Group. The event was publicised in the Gibraltar Chronicle and GBC radio but regrettably live coverage of the event by the Press and Television was noticeably lacking.

Walk to School Day May 2000

The Fun Walk was followed soon after by a further event with a similar message, but this time aimed at children. The Walk to School Day took place on Wednesday 24th May 2000. A poem competition was launched and all schools took part. There were three winners and each received a voucher for sports equipment. The winners received certificates and gift vouchers for redemption at local shops.

Sun Awareness Campaign, June/July 2000

The Sun Awareness Campaign was planned to follow on the same lines as last year, but was seriously threatened by the sudden withdrawal of the commercial sponsors at the last minute. Fortunately, the Department of Education stepped in to provide transport, display boards, tables, stools and personnel to man the beaches. The campaigners visited Catalan Bay, Eastern Beach, Camp Bay and displayed a stand outside Safeway. Newall Holdings kindly seconded one of their trainees to help the public with technical information on sun protection products and donated samples of products (such as sunscreens) and publicity materials (such as beachballs and umbrellas). Safeway also provided samples of some of their products and Marble Arc contributed towards tee shirts.

A leaflet titled 'The Sun & You', which had been produced entirely locally by the Health promotion Group was well received at the beaches by the public, who commented that it felt 'professional and precise'.

The Gibraltar Chronicle gave excellent coverage to the campaign with a series of articles, inserts and a journalist's report from the beaches. Regrettably, the response from the television media was again lukewarm, as they did not televise the campaign. They also failed to screen a video that the Health Promotion Group specifically produced for the campaign and submitted for screening well in advance.

Mental Health Day, 10th October 2000

Mental Health Day is an international event and the Health Promotion Group set up a display on a site opposite the cathedral together with the support of Psychological Support Group, staff from the KGV Hospital and the Community Mental Health Team.

As part of the campaign to educate the public and health care professionals on mental health, two open lectures were organised on successive evenings at the Garrison Library. Mr Joseph Serra (sponsored by the Psychological Support Group), senior lecturer from the Royal Free Hospital spoke about stigma and Dr Graham McColl, Clinical Psychologist from the GHA spoke on interpersonal communication, listening skills, and non-verbal communication. The attendance

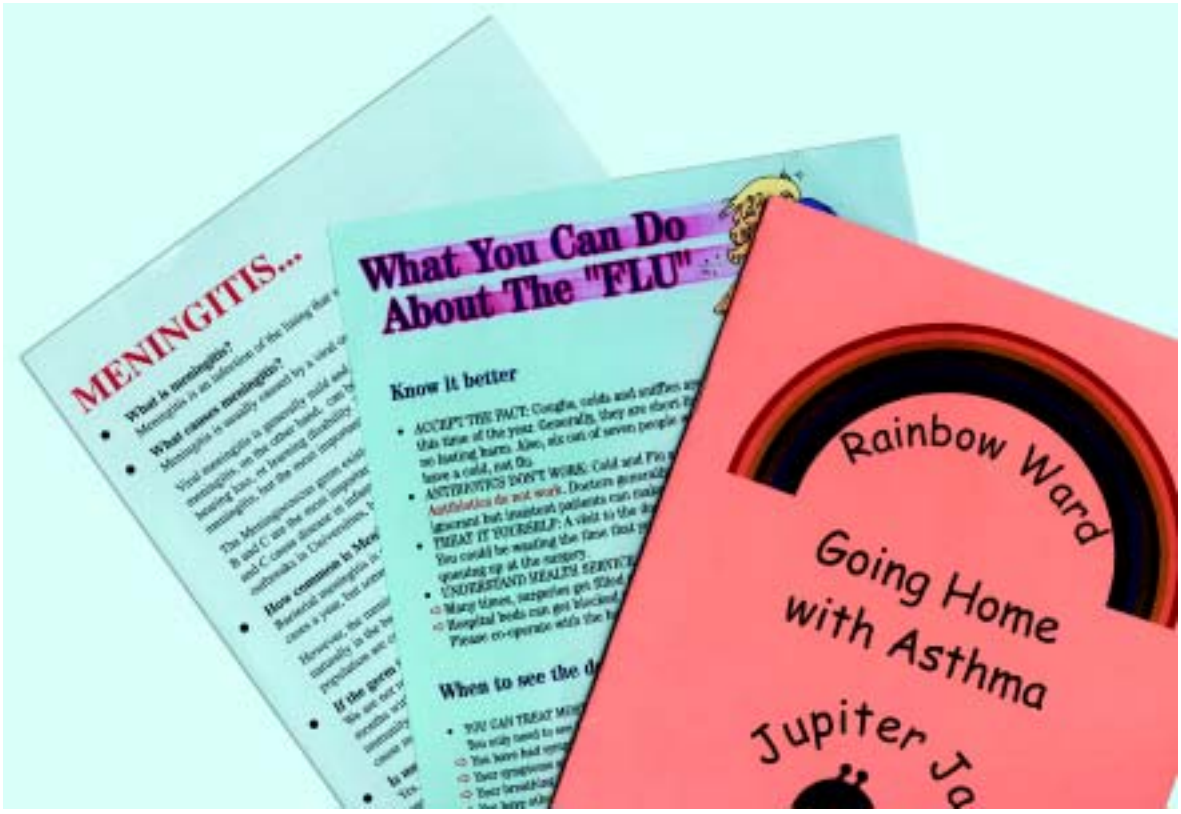
at these lectures was very good and standing room had to be created. Health professionals attending the lectures were also issued attendance certificates.

World Aids Day, December 2000

World AIDS Day took place as usual on 1st December 2000. The Friend for Life (formerly the Alfred Ramirez) Trust manned a stand opposite the Cathedral, which unfortunately ended early due to rain. The Trust produced an article for the Gibraltar Chronicle and the stand was televised by GBC TV.

Gibraltar Inter-Agencies

The Gibraltar Inter-Agencies continued to have a full programme and the Health Promotion Group jointly participated in some events. Child Safety Day was one of these, with a series of events and displays at the Piazza, offering literature from the DTI, demonstrations on cardio-pulmonary resuscitation in infants, children and adults by St John's Ambulance and opportunity for the public to practise 'hands-on' on mannequins. The stand was visited by His Excellency the Governor, who also took part in practising resuscitation. Public interest was great and it was encouraging to see many children at the stand. Regrettably, Press response was poor, with Gibraltar Chronicle and GBC not covering the event, despite being informed.



Section 2

Report on Health Services

Training for the future

Primary Care Services

Treatment room at the Primary Care Centre

PRIMARY CARE SERVICES

Medical Services

The development and expansion of primary health care services has continued during the past year. These include areas such as Speech Therapy with the appointment of a new speech & language therapist operating from the Centre. The appointment of a Geriatrician should have a significant impact in care of the elderly in the community. The general practitioners will be working in close liaison with the appointee in developing services for the elderly.

Access to a full radiology service continues to enhance primary care as it increases patient satisfaction, reduces waiting times and delivers efficient health care. The 'Users Forum' has been very active in providing feedback on patients' needs and views on the quality of service and helping the department plan for the future.

The year 2000 also saw the extension of the Phlebotomy (Blood-taking) Clinic to include Fridays.

The role of the Primary Care Co-ordinator is to facilitate and promote the development of primary care, a task which could not be achieved without the continuing support of medical, nursing, paramedical and administrative colleagues. There has been a great improvement in the service provided by the receptionist staff in the past year. This has already improved public confidence and satisfaction with primary health care.

Heads of Department meetings are held on a monthly basis at the Centre. These meetings have proved very useful in resolving inter-departmental problems and have played an important role in building a unified team spirit. The general practitioners also meet every month, which has helped in formulating general practice policy.

Emergency doctor clinics

The Emergency Doctor clinic is an essential component of good quality and responsive primary care, yet this service is under considerable strain. Attendance at these clinics is growing out of all proportion, with the emergency doctor sometimes seeing 80 to 100 patients in the time that most doctors would see 20-30 patients, yet most doctors agree that the majority of attendees are not real "emergencies". People use this clinic inappropriately for many reasons - sometimes one may sympathise with a patient needing only a repeat prescription who tries to avoid an unnecessary appointment, but there are others who for convenience exploit the open access of this clinic to bypass the waits associated with routine appointments. This is not only an abuse of the system, but reduces the time that the doctor can devote to true emergencies.

The Gibraltar Health Authority is reviewing a number of different approaches to address this problem. Some examples are :

- Nurse Triage: A system where a trained specialist nurse first assesses which patients genuinely need to see the Emergency Doctor. All other patients could be directed to the non-emergency system or even be directly given the advice they need for minor ailments. This requires nurse practitioner training and public education to be effective.
- Telephone Advice line: The UK NHS has recently pioneered a service called NHS Direct where a person can call a Freephone line for advice from a trained specialist nurse. This is claimed to have reduced doctor workload in some places but not in others, and it is still under evaluation.
- Repeat prescriptions: These form a significant part of the doctor's workload, yet many "regular" patients do not need a full consultation every time. A separate system to automate this work efficiently-but with due care and safety can be considered when computerisation of prescribing has been achieved.
- Joint arrangements with the Hospital for separating minor illnesses and emergencies.

Professional development

At present all referrals by general practitioners are subjected to internal clinical audit every six months. It is hoped to develop and expand clinical audit to all departments within the primary care system. Discussions will continue with the Principal of the School of Health Studies to develop appropriate professional development and continuing education for all primary care staff.

General practitioners attended the following courses in 2000 :

- 5 general practitioners attended accredited post graduate courses in the UK.
- 4 general practitioners attended courses held locally - organised by the school of health studies.
- 2 general practitioners attended a Major Incident Medical Management course - organised by the Royal Naval Hospital.

Planned developments

- Re registration of all patients is a great forward step that will make it possible to define practice sizes, organise workloads fairly, reduce waiting times, offer patients more choice, enable doctors to develop special interests, provide continuing care, promote family medicine and lead to several other benefits such as better management and rational planning.
- More secretarial support is needed to support the 13 general practitioners, 3 dentists and all the other health care staff in the Primary Care Centre. This will assist the typist tremendously and speed up the

process of medical referrals improving patient care.

• A physiotherapy service based at the Primary Care Centre, would greatly enhance the service for ambulant patients and relieve the hospital.

• Greater opportunities for general practitioners to refer directly to visiting specialists from UK, such as the cardiologist, plastic surgeon, neurologist etc. is being considered with a view to speed up patient care. A direct access facility for general practitioners to refer to the Echocardiography service is under development.

• Location of more specialist clinics at the Primary Care Centre is under consideration. Currently a dermatology clinic is planned and others may be added.

• The planned introduction of a computerised health information system has been deferred for good reasons, but it is hoped that this will gather momentum again soon.

Nursing services

Community Services

The number of Macmillan nurses increased from two to three. Vacancies created by the transfer of one full-time staff nurse and the resignation of one part-time staff nurse have now been replaced and one staff nurse who had left for the UK on a course returned early. A staff nurse from St. Bernard's Hospital will be promoted to Sister grade at the Community Services on successfully completing the course in UK

The Gibraltar Health Authority is considering an increase in the complement of assistant nurses in community services, as patient case-load in this area increases.

School Health Service

The nurses in this section continue to provide the dual function of being the immunisation nurses as well as the school nurses. The immunisations provided by the nurses span all age groups, whereas the school work broadly covers all aspects of childhood development and illness prevention. The nurses divide the working week equally to provide School visits (5 Sessions) and Immunisations (5 Sessions).

During the months of October / November the usual influenza prevention programme was conducted, and approximately 1,500 persons were immunised during the Thursday and Friday afternoon special clinics.

Child Health Clinic

In view of the rising administrative responsibilities, the Child Health Clinic and School Health Service have made a request for clerical support provision to be made, perhaps to be shared between them.

Clinic Section

The need for a computerised or automated referral service from general practitioners to hospital departments is being considered to alleviate the task of tracking referral letters currently performed by the nursing staff, who record names, addresses, source, destination and other relevant details. This year a total of 1356 referral letters was channelled through the clinic Sister.

Dental services

The last two years have led to an expansion in the services provided by the dental department. The targets proposed in last year's report, in retrospect, seem to have been optimistic and this year there is therefore a need for reassessment of services, for prioritisation of services based on clinical need and for consolidation. The dental department now provides a comprehensive range of treatment and if demand continues to expand over the next twelve months, the need for increased human resources will have to be assessed, helped by planned audit of the current services.

Dental Nurses

The complement of dental nurses has now increased from two to four and this has certainly improved the service provided to the patients. It has however not been possible to have their training approved as proposed in last year's report, but it is hoped that there is no further delay and that this will be reflected in next year's report.

Videoconferencing/Telemedicine

The Red Cross was very generous in its donation for the purchase of the Telemedicine Unit. The unit has now been installed in the dental department and is now an integral part in the provision of tertiary care in the department. Regular clinics have been organized with Cardiff Dental Hospital for the treatment of children with severe growth problems affecting their jaws. The response from patients has been very favourable and the service has been well received.

Digital radiography

The patients are already benefiting from the installation of this equipment within the dental department. The clinician is now able to determine the need for a radiograph, take the radiograph and view the radiograph, all in one visit without the

patient having to attend the hospital/clinic on a number of occasions.

Fourth surgery

This surgery is now in regular use for the carrying out of minor surgical procedures thereby ensuring a 'sterile' field.

Patient education

The need to educate patients on the use of the clinic is critical in ensuring the smooth running of the clinic and effective use of clinical time. Emphasis will have to be placed on late arrivals and patients who fail to attend. The latter can on certain sessions account for more that 25% of the patients. This results in wasted time and with an added strain on the service and the staff when rebooking.

Computerisation of records

The department has Management support on the need to computerize all dental records. Efforts are being made currently to determine which system best addresses the departmental needs.

Integration of services

Working within the same clinic has resulted in a better service for the patient and improved communication between the clinicians. The current system will need to be assessed and deficiencies in the system rectified.

The dental department is committed to developing a partnership with the patient so that, through a process of auditing and patient education, rights as well as responsibilities can be addressed.

Palliative Care / Macmillan Liaison

This service was set up three years ago in conjunction with the Gibraltar Society for Cancer Relief. Its main aim is to provide advice and support for all carers, both professional and non-professional, to control pain and other unpleasant symptoms of advanced disease. In addition, support is given to cancer patients receiving treatments here and in the UK. The department works closely with all specialities in St. Bernard's and has strong links with the community nursing service.

The statistics for the year 2000 are shown in Tables (47-49).

The level of interventions with these patients ranges from 'one off' advisory sessions with staff to regular and on-going patient assessment, treatment and evaluation.

Practice developments.

A new delivery system for 'round the clock' symptom control has been introduced; namely the 'Springfusor' syringe pump. Most wards and the community nursing service are now using this equipment.

A pain control chart specifically for palliative care has been created and has proved to be a useful assessment and monitoring tool.

Discharge planning for palliative care patients has been improved by the introduction of discharge letters. These improve communication between the hospital and community staff, thus helping to ensure safe and successful discharges.

The department now has input into the education of student nurses.

This year the department has worked closely with the School of Health Studies to deliver a two-day cancer care course and a three-day management of lymphoedema course. The cancer care course was part funded by the Gibraltar Society of Cancer relief. Lecturers from the Royal Free and Royal Marsden Hospitals in London taught a multi-disciplinary audience.

As a direct result of the lymphoedema course a 'link' group has been formed which hopes to develop an improved service by raising awareness and standards of care delivered by professionals who come into contact with patients suffering from this condition.

The Primary Care Centre

In the 1999 Annual Report it was noted that the Primary Care Centre was nearing its completion and the golden opportunity that it provided to improve the standards of care. In the 2000 Report, it was confidently stated that not only had the new Primary Care Centre provided the expansion that had been desperately lacking but that it had potential for improvements in the standards of care. In this year's Annual Report one may proudly say that the Primary Care Centre provides an excellent service.

In retrospect, the past year has seen a major process of settling into the new environment. This had led to many teething problems, but insofar as these have been tackled and resolved, on the whole, the experience has been positive.

A major significant change has been the implementation of straight-through counter hours for the administrative staff from 8.15 a.m. to 4.00 p.m. (3.00 p.m. on Fridays) and a straight-through appointments telephone from 8.30 a.m. to 3.30 p.m. (3.00 p.m. on Fridays). The implementation of a "forced calling" system has successfully resolved a major issue which was the cause of many complaints. Clerks who will receive the incoming calls directly to

their headsets now man the appointment telephone on a permanent basis (as would a telephone operator). The system has been programmed to queue waiting callers on-line, allowing calls to be put through in chronological order.

Information Systems in Primary Care

History

As early as 1987, the *Medical Review* recommended immediate steps "...to introduce comparatively cheap and small scale computing applications in both primary and secondary care facilities..." The **Registrations** computer was set up in the Health Centre, to record patient-identity details, but with no capability for making appointments, writing prescriptions or keeping case records, etc. Over the years, without firm procedures for updating records, this Register became inaccurate and laden with obsolete records, making it unusable.

In 1993 an option appraisal recommended the purchase of Egton Medical Information System (EMIS) as the preferred product, but lack of funding meant that the project remained shelved for several successive years.

In 1996, the second Medical Review again emphasised "the urgent need for IT implementation...", recommending that "...implementation should initially be in the Primary Care system." The process for implementing EMIS was accelerated and finally government funds were allocated in 2000/01 for its procurement.

In May 2000, the Director of Public Health convened a **Primary Care User Group** consisting of doctors and administrators to prepare the ground for EMIS implementation. The Group following a product demonstration, gained a general impression that while it could improve the functioning of the PCC, its implementation would require investment of time, learning and - crucially - IT support. Responding to management request for technical support to sustain such a major project, the Minister approved the appointment of a full time **Project Manager** to oversee EMIS implementation.

Local EMIS appraisal

Concerned that there had been very little exposure of the potential users to EMIS software, the Director of Public Health organised a 3-day visit by an EMIS representative with the following objectives

- To assess and reconfirm technical and resource assumptions;
- To introduce EMIS to as many PCC (and other GHA) staff as possible;
- To explore scope for special functionality

McDonald Consulting, who had been appointed by the **New Hospital Steering Group** to provide consultancy to the Gibraltar Health Authority on information systems development in the proposed Europort hospital, were briefed to advise the Authority. The Steering Group had earlier recognised that the opportunity to integrate all aspects of health information should not be missed.

During the visit, the following feedback was received from various different stakeholders:

- **Hardware suppliers**: EMIS Hardware and software specifications were standard and could be procured in Gibraltar. EMIS would be easy to implement and maintain provided manpower was available. Space was identified at the PCC for the server and cabling.
- **Reception staff**: The EMIS User interface was quite straightforward and although familiarisation would take time, this could be overcome by training and support. The simplicity in making appointments was welcome, but tighter access controls were needed to avoid chaos. There was no facility for serving queue numbers, which was disappointing.
- **Doctors**: EMIS offered a good range of tasks and functions, but would consume a lot of time which could not be made good without additional manpower (+2 general practitioners). The drug formulary, the intelligent 'learning' function and the ability to attach images were valued highly. The limitations in prescription printing were disappointing.
- **Nurses**: There seemed very little functionality of interest to nurses, but it was explained that this would be made available as an add-on (undemonstrated) module at no extra cost.
- **Management**: The cost of the EMIS product was broadly within the envelope. However, additional costs would be incurred in employing the Project Manager, 6 more site licences and training. It was noted that although EMIS could drive display boards, the existing boards would need to be replaced at substantial cost.
- **McDonald Consulting**: Overall, EMIS did not impress.

From a technical point of view, although tried and tested through its years of use, EMIS was now quite obsolete and superseded by newer technology. EMIS software cannot inter-connect directly with other software packages indicates that it may be unsuitable for the Authority's enterprise-wide data-sharing plan. Observations and feedback noted from staff at the Primary Care Centre showed some serious deficiencies from the expected requirements.

The advice was that the Authority should not proceed with EMIS. It should instead carry out a requirement

analysis for Primary Care immediately, and then review current options for a product. This need not slow down the development of the Authority's health information strategy but would make the direction clearer, not only for Primary Care software, but also when evaluating hospital and specialist departmental software.

Management decision

The report of the IT consultant identified a number of technical and functional flaws in the EMIS product that had been previously unrecognised. In particular, it was revealing to note that since the original appraisal had been made several years ago, the EMIS product had developed slower than expected, to the extent that modern features essential for a GHA-wide strategy were now absent. This would indicate that a re-appraisal was necessary.

Nevertheless, to test the current state of the market, McDonald Consulting were asked by the Director of Public Health to identify and report briefly on alternative Primary Care software packages within a similar cost bracket to that of EMIS. Their rapid appraisal survey showed that a number of such packages are available, which are cheaper, more adaptable and more powerful than EMIS.

With this advice, the Gibraltar Health Authority Management Board decided to halt the procurement of EMIS software. Macdonald Consulting were tasked to report by September 2001 with a needs analysis of Primary Care and option appraisal of alternative, better integrated solutions. The goal remains to implement suitable primary care information systems at the earliest feasible opportunity.

Secondary Care Services

Medical investigation unit

SECONDARY CARE SERVICES

Consultant expansion

There have been many changes in the Consultant staff during the year 2000. The GHA has replaced outgoing consultants as well as increased the number of consultants. This expansion will continue in order to maximise the exciting improved facilities in the new hospital.

Following the retirement of Dr. Montegriffo in 1999, the post of consultant psychiatrist had remained unfilled except for a six month period during which Dr. Batten was in post. Although a number of very able locum consultants intermittently provided the service, the loss of continuity was beginning to affect staff and patient morale and the appointment of Dr. John Coogan was a welcome one. Dr. Coogan was previously a consultant at the Maudsley Hospital in London, before which he served in the British Forces in Germany.

Dr Robert Kay retired as consultant pathologist after 10 years with the Authority. In his place, Dr Tadeusz Biedrzycki was appointed. Dr Biedrzycki is primarily a histopathologist and previously served as an NHS consultant in Bury St. Edmunds for 14 years.

The above two appointments were essentially replacements to existing posts, but Gibraltar Health Authority broke new ground when Dr Stephen Barber was appointed Consultant Elderologist (also known as consultant geriatrician or consultant in care of older people). This post had never existed before and is part of the wide ranging changes recently introduced to the care of older people. Dr. Barber's appointment is also unusual in that he is employed by the Gibraltar Health Authority but works predominantly with the Elderly Care Agency. His role is to lead the improvement of medical services for older people (in Mount Alvernia and the community), the establishment of a Day Care unit for rehabilitation and promoting health for older people in the community. Dr Barber will also attend acutely ill older people at St Bernard's Hospital.

Another new post created in 2000 was that of a second obstetrician and gynaecologist. However, recruitment was not successful and a consultant was not appointed. Efforts will continue to fill the post in 2001.

The consultant radiologist Dr. Rassa's appointment ended in 2000. The Authority arranged with two Spanish radiologists from Algeciras to provide a responsive service on a job-share basis and this has proved popular with doctors, radiography staff and patients alike. However, efforts will be resumed next year to recruit a full-time consultant.

The Gibraltar Health Authority has managed to recruit good quality consultants during this year but this has not been without difficulty, as trained and experienced consultants in many specialities are in short supply and in considerable demand in the United Kingdom. However, careful reforms instituted by the Authority to amend the terms and conditions of appointment, to modernise the job descriptions and to bring interview procedures in line with best practice have begun to bear fruit and the Gibraltar posts now attract a high calibre of applicants.

The Gibraltar Health Authority intends to continue with its strategic manpower development, which will involve recruiting additional consultants in key areas of need such as Anaesthetics, Orthopaedics and General Surgery. If these can be timed to precede the opening of the new hospital in the year 2003, this will maximise the advantage derived from the new facility and improve speed and quality of care.

Child Health

The nursing complement in Rainbow Ward has been strengthened by the employment of specialist paediatric trained Staff Nurses from the UK. This has allowed for 24 hour cover of the ward by Paediatric trained staff.

The department has aimed at continued professional development of staff through talks and lectures from resident and locum consultants.

There were 967 admissions to Rainbow ward last year compared to 939 in 1999.

Medical	*392*
Surgical	*271*
Ear, Nose, Throat	*83*
Orthopaedics	*70*
Plastic Surgery	*13*
Eyes	*8*
Gynaecology	*1*

A weekly outpatient clinic for sick children is held weekly in Rainbow Ward as well as two outpatient clinics for follow up of ward patients .

The care of children with diabetes continues to develop within the department. Multidisciplinary outpatient clinics are carried out, away from the hospital environment. Recently a parents support group has been formed to enhance the service and a multidisciplinary in-service course in childhood diabetes has been organised for GHA staff.

There were 1453 routine examinations of babies in the infant Welfare Clinic. In addition 225 children with a variety of problems were seen, mainly in Dr Benady's Monday clinic. These comprised 196 babies and 29 children of school age.


LAXMI LTD
AWARENESS
AWARENESS

Women and Mothers

Staff in both obstetrics and gynaecology have worked hard and well together to continue the high standard of care provided in the Department.

The department was greatly set-back by the sudden illness of the sole consultant obstetrician and gynaecologist and his indisposition for over three months, during which period locum consultant cover was required. This absence from the Department has also meant that a complete set of statistics - particularly for Outpatient attendances and Gynae matters - have not been kept as in previous years.

A longstanding deficiency will soon be corrected when the second consultant gynaecologist takes up his post in 2001.

There were 379 live births (including 7 sets of twins) in 2000 in the Department including 90 Caesarean sections and 22 operative vaginal deliveries. Two unavoidable intra uterine deaths occurred, both associated with heart defects - adding to the list of congenital abnormalities in recent years published in last year's report. There were no neonatal deaths but 7 other abnormalities including 2 Trisomys, an Atrial Septal Defect and a case of congenital hypothyroidism. Perhaps the time has come to research this matter.

General Surgery and Urology Services

The department of general surgery provides for surgical treatments of a wide range of conditions. The department also offers treatments of disorders of the urogenital system (Urology).

Table (35) shows the number of operations carried out by the department over the last eight years. It should be noted that these cases were mostly done under general anaesthesia, with a few being done under spinal or epidural anaesthesia. The figures do not include operations done under local anaesthetic. Surprisingly the largest number of cases was carried out in 2000 i.e. – last year. This is difficult to explain but may be due to increased demands on the department as a result of an increase in the number of referrals.

Table (36) shows the number of Urological procedures carried out in the same period. The average number of prostatectomies carried out is 29 per year. It should be noted that the vast majority of these are transurethral resections (i.e., performed through a telescopic device called a resecting cystoscope) and very few are open. The transurethral resection of the prostate was in many ways the original major operation to be performed through a minimally invasive ("keyhole") procedure.

It should be noted that counts of the transurethral resection of the bladder tumour represents only the first operation of a series where the tumour or wart inside the bladder lining is resected and removed. Subsequent procedures - follow-up cystoscopies and cysto-urethroscopy with diathermy - are included under minor operations, as they are usually done as day-cases.

It is a matter of interest that there have only been two open operations for urinary stones, as the vast majority are referred for extra-corporeal shock-wave lithotripsy or for minimally invasive surgery. Paediatric urological operations are not included in this table except for circumcisions.

The figures also show an overall increase in the number of operations carried out under general anaesthesia. The impression of the surgeon is that general practitioner referrals, complaints and patients' expectations are also on the increase.

In achieving this work, particular thanks are due to the nursing staff on the wards and in theatre for the contribution they have made.

Anaesthetics

Anaesthesia

The year 2000 saw quite a few changes in this department. Funds were made available for the upgrading of anaesthetic machines and monitoring equipment. In addition, the purchase of an electric blanket to keep patients warm was approved. Two new anaesthetic machines complete with full monitoring were obtained and delivered in early May 2001.

As far as anaesthetic numbers go, a total of 2,406 operations were performed during the year 2000. This is the total, and includes both those done under general and local anaesthesia. This figure is about 170 more cases than were done in 1999, or five times those done in 1980, when Dr. Correa first started in Gibraltar. With the number increasing every year, it is becoming almost necessary for a second theatre to become available but unfortunately the lack of space does not permit this. Perhaps with the advent of a new, bigger hospital, the problems of theatre space and times will be something of the past.

Intensive Care / Coronary Care

The number of patients requiring intensive care from the surgical point of view has only increased marginally in proportion with the increase in cases undergoing surgery. However when the five available beds have to be shared with cardiac/medical patients, very often the five beds available are not enough.

Again intensive care has benefited from increased funds and in 2000, two Siemens ventilators and two portable Draeger machines were obtained for the ITU. This giving a total of 3 Siemens, 2 portable Draegers, one portable Bear and another Bear

machine. The Bear machines will progressively be phased out.

The Pain Clinic

The Pain Clinic was started in January 1999, initially by bringing patients to the operating theatre to be seen and then the consultant paediatrician's office was made available for use on Mondays and Tuesdays. Currently the old orthopaedic clinic is being refurbished to house the clinic.

The clinic saw 316 patients in 2000, 75% of whom were new patients; the rest being reviews. In addition, there were about 100 in-patients who were admitted for further treatment e.g. epidural injections or various nerve blocks. The majority of these patients were referred from the Primary Care Centre and by far the main complaint was of backache, either due to disc lesions or to generalized osteoporosis. There was one case of Autonomic Sympathetic Dystrophy and two cases of post-herpetic neuralgia.

On-demand Obstetric Epidural Service

This is a service which is greatly needed in Gibraltar, especially now with the increase in obstetric staff. However, numbers of anaesthetists have not kept pace with the increase in other specialties and this is an issue which the Authority is now reviewing.

Operating Theatres

The Operating Theatre is a unique environment within the hospital. Staff working here have to devote enormous personal commitment and skill, to put up with long hours, cope with monotonous waits, make themselves available flexibly and yet react expertly to life-threatening situations, often during unsocial hours. All this is very demanding and in addition, regularly encroaches upon the personal lives of staff, which sometimes makes it less attractive as a place of work. The smooth running of such a department is often made possible only by the goodwill of the staff.

Cancelled operations

Cancelled operations can lead to a lot of wastage in addition to creating tension and strain for all concerned. A Cancellation Register was set up to audit and record details about every operation cancelled and to understand why operations are cancelled.

Between February 2000 and December 2000 there were in total 128 cancellations. Operations are cancelled for a variety of reasons and Table (34) lists the common causes by specialty.

It is striking that an equal number of operations was cancelled by patients, as those cancelled by the hospital because of bed problems. The Authority will obviously keep under review opportunities for improving the use of bed resources and theatre time, but the amount of time lost due to reasons outside the Authority's control amounts to over one-third of the total. Clearly if the Authority is to provide an efficient service, such wastage must be reduced and for this, the co-operation of the public is necessary.

Emergency Operations

During January to December 2000 a total of 174 emergency operations were performed. These were accommodated as follows :

- Performed outside scheduled theatre hours 105
- Appended to requesting Specialty's own list 30
- Interrupted the list of another Specialty 29

Tables (28) to (33) give fuller details of these operations.

New Equipment

The department has obtained vital equipment, which will improve patient care.

a) A new Pack Autoclave to sterilise instruments before surgery.

b) Autoclavable Telescopes, which will reduce the usage of caustic substances like glutaraldehyde.

c) A comprehensive range of sterilisation packing products. Because of the non availability of nylon film there was no option but to go for disposable non woven paper sheets for the packing of instruments. In Orthopaedics, particularly, the theatre is now fully equipped with disposable products ensuring full protection of patients, the surgeon and theatre staff during surgical procedures.

d) A new oil free Compressor has been installed. Piped compressed air is now delivered to the operating theatre giving the necessary power to man the air drills used in orthopaedic surgery. It will also be possible to enhance this facility by installing bacterial filters and dryer to the compressor, which will deliver medicinal compressed air and drive the ventilators.

Ophthalmology

The year 2000 has been another busy year for the Ophthalmology (Eye) department.

During the period 25 May 2000 - 30 March 2001, the following statistics describe the considerable volume of work produced by this specialty :

• Out-patient: approximately **3350** patients were seen in **134** routine clinics.

• Casualty: **656** patients were treated

• Ophthalmic surgical procedures: **177** operations were performed, including cataract, glaucoma, squint, lacrimal procedures and adnexal surgery. Most of these cases were operated in the outpatient facility using local anaesthesia.

• Laser procedures: A total of **92** procedures were performed.

Staffing

It is encouraging to report that at last progress is being made in the staffing of the unit. The department had been pressing for some time for an **Orthoptist** to be appointed. Orthoptists perform visual screening in the pre-school and primary school children. They are also involved in the management of squint and amblyopia. A qualified orthoptist joined the Gibraltar Health Authority this year offering her services in a voluntary capacity, while being based in the Primary Care Centre. Capitalising on her excellent work throughout much of the year, a part-time post has been created for 2001. Soon an out-patient eye clinic will be set up, thus delivering two clinical sessions in the ophthalmic department and three sessions in the community. It is hoped that the post will become full time in the very near future.

In 2000 the Authority also approved the appointment of a part-time **Optometrist**. This post will be filled in 2001 and greatly improve the Primary Care ophthalmic service.

The department has three **nursing** staff who carry out duties that in the UK would be deemed appropriate for ophthalmic nurse practitioners.

Future developments

Prevention of **blindness** is a top priority. Routine **visual screening among children** to identify visual defects at an early stage is an important aspect of ophthalmic care. Screening for glaucoma and diabetic retinopathy is also long overdue. Both these diseases are silent destroyers of eyesight and if treated in good time, this can be prevented. In order to publicise the matter, the department held a glaucoma awareness week in Gibraltar this year in conjunction with the Gibraltar Society for Prevention of Blindness and the International Glaucoma Forum.

The next priority is to set up a **diabetic screening service** using retinal photography. A request for a fundus digital camera has already been made and it is hoped that this will be purchased in the near future.

The health service is making slow but sure progress in the provision of comprehensive ophthalmic care for the people of Gibraltar and the department wishes to record its thanks to the Authority for their support in realising this goal.

ENT services

During the year, the following work was undertaken by this specialty:

• Out-patient: approximately **2263** routine ENT out-patients were seen in the clinics.

• ENT surgical procedures: **198** operations were performed

The department continues to pursue the policy of careful personal attention to ENT disorders. Many patients are followed up regularly until their condition is deemed stable and in no further need of specialist attention.

There have been problems this year due to the difficulty with surgical bed allocation for routine operations. Despite great efforts made by the administration to fit patients in wherever possible, there has no doubt been a decrease in the number of elective surgical cases. The planning of elective cases has been more difficult, because of the increasing demand on in-patient beds.

Mental health Services

Changing times

The appointment of Dr. John Coogan (Consultant Psychiatrist) brought an end to the difficult period that the Mental Health Service experienced last year. The Mental Health Service is committed to bringing about the necessary changes to modernize the product it delivers to its users.

Changes have begun taking place at a slow but steady pace. Such changes cannot be simply imported (e.g from the UK), but need to be developed around Gibraltar's unique local culture. In mental health care particularly, it would be inappropriate to impose models of illness and care that emanate from a different culture altogether, as this would doom it to failure from the very onset. Rather, good practices elsewhere should be used as a guideline to inform local practice.

It is also equally important that change should have the ownership of all those involved in the service. Consideration has to be taken of the needs and views of the users, carers and the Gibraltar community at large.

However, given these caveats, Gibraltar is at an advantage as it has the will to modernise mental health care for its people by absorbing good lessons from others.

Mental health team

Community care

As with most modern mental health services, the emphasis is community care. Two Registered Mental Health Nurses have been allocated to the Community Mental Health Team (CMHT, formerly CPN), complementing the existing staff at the unit in Coaling Island. This is run in very close liaison with the inpatient service unit, to ensure continuity of care. However, there must also be the development of an infrastructure to provide seamless care to people with mental illness. Close links and co-operation with other primary care services, Housing Departments, Employment Agencies, Support Groups Social Services and other organisations, will be essential. A caring society is of particular importance to mentally ill patients. It can hardly be expected for people who have experienced mental illness to integrate fully into their society with ease if they are not valued as ordinary human beings.

Hospital beds

It is planned that the number of inpatient beds at KGV will be reduced. A substantial number of these beds have through the years, been taken up by what are considered to be inappropriately placed patients, who require considerable physical nursing care, perhaps to the detriment of the mentally ill patients and contributing to the institutionalisation process of the longer-term inpatients. The aim is to place these patients appropriately, thereby reducing the number of psychiatric beds on the lower floor of the unit. As beds are vacated and space becomes available, it will be possible to refurbish and develop one of the wards into four rehabilitation flats that will operate independently from the wards. Here patients will undergo a rehabilitation program in preparation for discharge to community.

Staffing

The current manpower level remains supplemented with contracted Mental Health Nurses from UK. However, the plan is to eventually fill these posts with trained Gibraltarian RMN nurses, as cultural integration is important. The current development of the Community Mental Health Team (CMHT) will demand extra resources in the medium term, to allow this new system to run in parallel with the existing one. Eventually, the bed reduction within the hospital, will enable shifts of manpower resources to meet service requirements.

Organisation

The Mental Health Service has developed a Management Team, accountable to the Management Board of the Authority. The team is chaired by Dr. Coogan and comprises of mental health carers from different disciplines.

A Mental Health Promotion Group has also been developed with the aim of enhancing mental health awareness in Gibraltar. It is understood that effective change can only come about with the education of users, carers and the general public. The schools, through the education system, are an important target, together with general public education. During World Mental Health Week (2000), two public talks on Mental Health were delivered at the Garrison Library and these were fairly well attended. Similar events are planned for October of this year. A substantial number of mental health staff actively participate in the promotion of Mental Health.

Mental health review

The Gibraltar Government commissioned a Mental Health Review, the report of which is in the process of being released within the service. The report's recommendations will undoubtedly have financial implications and will need careful reading.

Psychiatry

The Consultant Psychiatrist has been in post only since mid-October 2000 and so this report concentrates on the latter part of the report year. The past six months have seen numerous changes in the Mental Health Services. Perhaps the most important has been the emphasis placed on the enhanced Community Mental Health Team (CMHT) at Coaling Island. The CMHT had to build on the foundations of the original team and was expanded to allow more intensive nursing input to be provided to patients once they had left hospital. The aim is to prevent relapse and re-admission to hospital with those suffering long term mental illness.

At KGV Hospital, the emphasis is increasingly on a multi-disciplinary approach to diagnosis and treatment. By this means, attention is also paid to social aspects of illness, including accommodation issues, financial benefits and support to the patients' families and carers. One current project is to identify those patients who have been in hospital for some time but who, with adequate support in the community, could live outside KGV, perhaps in supervised accommodation.

The service now has a centralised referral system with all referrals first being prioritised, followed by allocation within the service to the most appropriate professional, and written reports being forwarded to

the referring GP with details of the assessment, diagnosis and treatment plan. In the past six month period there has been an exponential increase in the number of referrals with a peak recently of 24 in one week period. This compares with the department's current ability to carry out about 10 new assessments per week.

Rapid communication is all-important in psychiatry and the Mental Health Service was fortunate to receive approval for a computerised intranet system, linking the hospital wards with the CMHT and through the Mental Welfare Officers, with the Primary Care Centre. The system is currently being installed and will shortly go live.

There is close co-operation with other agencies, including Bruce's Farm for those with alcohol or other drug problems, and the Elderly Care Agency for those with early dementia.

It has been an exciting and challenging time for the mental health service but both the KGV Hospital and the CMHT staff are committed to the changes necessary to ensure that care of the mentally ill remains on a par with UK and European standards.

Clinical Psychology

The Clinical Psychology Department continues to offer psychological assessment, treatment, referrals, community education, in-service education, supervision of trainees (and others), research and teamworking with other members of the multi-disciplinary mental health team.

Clinics in the Primary Care Centre and at KGV Hospital have been well attended. The number of referrals to the Department has increased over the previous years. The waiting period for an appointment has accordingly lengthened, as there is still only one psychologist available. Previous reports highlighted the large number of people who failed to keep their appointments. The department has therefore asked patients to cancel a first appointment if it is not wanted, in order that it can be offered to someone else. Staff have also started to telephone patients prior to their first appointment to ensure that they will attend and hence reduce the number of non-attendances.

All referrals to the Mental Health Service are now being discussed at one allocation meeting attended by staff members from Psychology, Psychiatry, the Community Mental Health Team and the Mental Welfare team. This is being done in order to record all referrals to the service and to improve communication between the disciplines. At this point, referrals to the Psychology Department will still be seen by the Psychologist but the system allows for easy transfer of patients between departments should that be necessary. It is therefore unnecessary for referrers to make separate referrals to the different departments.

A number of people continue to be referred to the Department for counselling and after assessment, they have usually been seen by appropriate volunteer counsellors (under supervision by the Psychologist) using the Primary Care Centre premises. The department wishes to express its appreciation to these counsellors for their excellent work. Funds have been requested to employ a counsellor. Funds have also been requested for an additional Psychologist, to work with children, adolescents and families.

Prior to August, the department made good use of the skills of a part-time Psychology Assistant who, as a trainee, was involved in research, clinical work, and psychometric assessments. It is hoped to be able to make this position a permanent one as a way of training future Gibraltarian psychologists. There are several other problems associated with Clinical Psychology training and, in association with the Gibraltar Health Authority Personnel Department, the Department hopes to address these issues in the future.

The Department remains keen to improve community outreach and is planning to organise public lectures on relevant clinical topics. A public lecture on "Panic Disorder" was well attended in June and as part of World Mental Health Day a public lecture on "Interpersonal Communication" was presented.

The Department has contributed to In-Service Training programmes, including the Nursing Programme at Bleak House, and has formed connections with the Clinical Psychology Department of the British Forces. Hopefully future training might be carried out jointly. If an additional experienced Psychologist is added to the Department, it will then be possible to institute relevant psychotherapy training for the multidisciplinary staff, which may also lead to an ongoing therapy supervision group.

Care of older people

The inexorable rise in the numbers of older people in Western societies has been recognised for several years. The establishment of the Elderly Care Agency in Gibraltar as part of the Ministry for Social Affairs with close links to the Health Authority, has been a positive step forward.

The links have been enhanced with the recent appointment of an Elderologist (Consultant Physician with special training in the care of the Elderly) jointly by the Health Authority and the Elderly Care Agency. A new 'Elderology' Service is being established to gradually move gradually away from the uncomplimentary connotations in many peoples minds of elderly people being "geriatric". "Elders" is a term of respect in the early Christian Church and in many current denominations, and it is intended that this more positive attitude will permeate

dealings with all older people. A seamless service is to be provided, but the specific health aspects that have already started include regularly, weekly, specialist rehabilitation ward rounds in the longer stay wards with multidisciplinary team meetings to plan and effect active care and to improve the physical and mental welfare of these patients. An area has been identified and arrangements are in hand on Lady Begg Ward to improve the rehabilitation facilities. To match improvements in the shower facilities that have already taken place on this ward, approval has been given to have similar upgrading on Lewis Stagnetto Ward.

Regular teaching has been started, concentrating particularly on the care of elderly patients, which is open to all staff and is proving popular. Audit is also being introduced.

As the outpatient service evolves it is planned to start a Specialist 'Falls and Mobility' Clinic, a 'Continence Clinic' and jointly with the Psychiatric Department, a 'Memory Clinic'.

Plans to establish a Day Hospital, as mentioned in previous reports, are being formalised. This will be where patients can be seen by specialists, diagnosed and treated. Patients will be living in their own home, and fewer will need to be admitted to hospital. The rehabilitative services provided by the Day Hospital will also be used to help patients return to their homes from hospital more quickly whilst continuing to receive full and active treatment. Within the new Europort hospital it is hoped to develop a specialised 'stroke unit' since these have been shown to improve survival and reduce residual handicap for this disease, which was the cause of one in every seven deaths in Gibraltar in 1999.

Additionally, regular input has started into the care of older orthopaedic patients to help these patients recover more quickly from their accidents and illnesses.

Finally, discussions are in hand to develop an Elderology Team which will evaluate all elderly people admitted to hospital within one working day of their admission to expedite their recovery and return, to their own home with support from the team if needed for up to six weeks.

Support Services

Refurbished catering facilities

SUPPORT SERVICES

Hospital Administration

Hospital development

Following the announcement of the commissioning of a new hospital in the not too distant future, it would be reasonable that most major works requiring infrastructure investment should be cancelled. However general maintenance has continued throughout the hospital wards and corridors.

Projects, which had already been commenced, were continued and those identified as urgently requiring attention, were authorised. Among these were :

1. The **General surgical** out-patient clinic was completed

2. The **post-mortem** room was re-furbished.

3. The new **orthopaedic** outpatient facilities will be undertaken.

4. An adequate space has been identified for the **Pain Clinic**. It is envisaged that this set-up will be ready for use some time next year.

5. The **ENT** waiting area will also be tackled in an endeavour to provide a more pleasant atmosphere for patients waiting to be seen.

6. The **E.E.G** clinic will be re-sited to provide much needed extra working area for the Occupational Therapy Department.

Structural problems continue to prove too difficult to resolve the eternal problem of the parking area, but efforts to improve the circumstances will continue.

Finally, it is planned to produce informative literature for the public, giving information on hospital facilities.

New Medical Equipment

Over the last year the Gibraltar Health Authority has invested a much larger proportion of its budget on the purchase of new medical equipment. This has enabled the Authority to replace a lot of obsolete and older equipment with state-of-the-art technology. The following are some of the more significant investments made:

The Paediatric Department has always been faced with difficulty when transferring pre-term infants for specialists neo-natal care in Malaga and this has been greatly facilitated by the purchase of a **portable incubator** together with an **oxygen saturation monitor** and **infusion monitors.**

The Intensive Care Unit has benefited greatly this year and to facilitate transfer of adult patients' two **portable ventilators** have been acquired. Most of the **syringe driver** and **infusion pumps** have been replaced by state of the art devices and a **Doppler machine** to measure a peripheral vascular flow has also been supplied.

The Eye Department has acquired 3 **phaco modification sets** which will increase the number of cataract operations performed in any one operating session and hence reduce waiting lists. Additional services have also been provided by the purchase of equipment for the newly appointed **Orthoptist** and Optometrist.

In the theatre new orthopaedic equipment including a **drill** and **automatic tourniquet** will enable joint replacement to take place with increased ease. The theatre has also been supplied with two state of the art **Drager Anaesthetic machines and monitors** which will reduce the cost of anaesthetic gases.

A major benefactor in this year's equipment purchase has been the endoscopy unit which has had all its endoscopes replaced and enhanced. A new **monitor** and **trolleys** for the equipment have also been received together with 3 new **upper GI endoscopes**, 2 **colonoscopes** and a new **bronchoscope**. This will enable a far more detailed examination of the lining of the gut wall to be made and the additional equipment purchased will make it easier for biopsies to be taken, polypectomies to be performed and various upper GI oesophageal work to take place.

Medical staff have been very encouraged by the amount of equipment which has been supplied this year. Further equipment needs to be acquired over the next two years prior to moving into the new hospital in order to provide for all the present services and the enhanced range of services that will be provided in the future.

Medical records and Appointments

One of the pleasant aspects about this year's report is that the Medical Records and Appointments department is able to show the public what progress different projects are making.

The physical state of the hospital records had been steadily deteriorating for many years. Not only were many patient files physically in tatters, but the bad original design of the folders meant that papers could not be grouped or otherwise systematically filed. Although this had long been recognised, and some years ago, a detailed design had been derived from users and submitted for procurement, it had been rejected by the then administration and replaced with the folders that are in use now. Throughout 2000, the Medical Records committee applied itself to the task of redesigning, specifying, consulting, and procuring new folders that (a) resolved the current problems, (b) represented the best of current technology and (c) anticipated future needs, particularly in light of the move to the new hospital. The process has been time-consuming as there are several users and stakeholders to satisfy and the possible variations are almost infinite.

The committee have tried hard to design the new folder to suit everyone's needs. The new folder will:

- contain four separate sections for different types of records
- contain chronological strip-sheets for mounting lab reports
- contain colour-coded dividers to identify and separate all specialties
- will be plastic laminated for durability

A facility for introducing bar codes for easy loan out and retrieval is under consideration.

It has taken a while to consult the "users" of the medical records and to agree about the finished product, but eventually, the design has been accepted by all and new folders for patients' records have finally been ordered. Initially, one thousand folders have been ordered on trial and if everybody is satisfied the rest of the order will be made.

Changing the folders of some 30,000 medical records from the old to the new is going to be a long and arduous process stretching over a few years, but once finished, the outcome should be very rewarding to all. However, the continued success of this exercise will greatly depend upon the commitment and co-operation of all future users and those who handle these folders.

Another project on the way is to try and create a system to trace case notes when not in Records Department. This will need new systems, staff training and general co-operation.

It is also a matter of pleasure to add that the Department had a welcome new addition to its staff this year. This has been greatly appreciated, as the new complement of three has been a great help especially to cover leave.

Laboratory services

Services

There was a further huge increase in requests for **thyroid function tests**, with 4,060 requests in 2000 as against 3,106 in 1999, a rise of 30.7%. It is envisaged that this trend will continue and need to look into a dedicated automated analytical system that will enable the Laboratory to cope more efficiently with this type of work.

The increase in samples received for **coagulation studies** was also notable (30.1%)

Although the numbers of samples received in the **Microbiology** section were similar to previous years, an appreciably greater number of samples grew pathogenic organisms. This meant more time had to be dedicated to identification and antibiotic testing of the positive cultures.

Several new tests for tumour markers were introduced with reports usually available the next day. These are **Carcino Embryonic Antigen** (CEA), which is useful in the follow-up of carcinoma of the colon and rectum, and the **Cancer Antigens** CA125, CA19.9 and CA15.3, which are used in the follow-up of ovarian, pancreas and breast cancer respectively. A serum test for **I Human Chorionic Gonadotrophin** is also available now and is being used in the follow-up of certain testicular tumours and suspected ectopic pregnancy.

A second **analytical module** for the Vidas Enzyme Linked Fluorescent Assay Analyser was made available to the department by bioMerieux at no extra cost to the GHA. The module doubled the capacity of this analyser so that up to 60 tests can be run simultaneously. The Vidas analyser is shared by the Microbiology, Haematology and Biochemistry sections on a daily basis.

Staff changes.

Dr Robert Kay, consultant pathologist, retired at the end of August. He had joined the Authority in May 1990 and in the previous 30 years had held similar posts in various hospitals in the United Kingdom and abroad. Locum cover was provided till the end of the year by a number of pathologists specialising in histopathology. Dr Kay (like his predecessors, Dr Wijesinge and Dr Imossi), was a general pathologist, virtually impossible to replace in the present day of specialised medicine. Senior laboratory staff tend to be approached from time to time by clinicians for advice on certain tests and interpretation of results, as the specialist histopathologists have not felt able to provide this advice.

The Junior Medical Scientific Officer who had worked in the Laboratory since 1996 left on transfer and was replaced on 31st July. The one month overlap between the appointments was appreciated as it provided extra time for training.

Education and Training

Two courses were undertaken in 2000. One scientific officer was seconded to Unilabs for two weeks to study various aspects of tumour markers, autoantibodies, toxicology and genetics; and another officer attended a conference on transfusion medicine, spending several days at the North London Blood Transfusion Centre. Valuable contacts were established with personnel at both centres.

Radiology services

Table (43-44) presents the work of the Radiology department in 2000. Although numbers are not always a true reflection of intensity of workload, it is seen that the throughput of patients and examinations has increased considerably. The number of referrals to Spain for further investigations has also increased which means that it takes one full-time administrative officer to run this service.

Like other parts of the service, this department has also been involved in the planning of the new hospital, in particular the Imaging service. This is an exciting time for all, working to ensure better working conditions and a more patient friendly environment.

Two radiographers attended the UK 2001 Annual Conference and Exhibition in Radiology as part of their Continuous Professional Development and also to evaluate the new technologies in view of the possible requirements of imaging equipment for the new hospital. One sonographer attended the May Day Hospital in London to update her skills in Obstetric Scanning.

Health and Safety is a major preoccupation for radiology departments as they have to deal with dangerous ionising radiation as well as heavy equipment. The department has prepared a draft of the different procedures required to meet the EEC Ionising Medical Exposures Regulations in anticipation of these being transposed into Gibraltar's local legislation.

Physiotherapy

Staff

There was no increase in the Physiotherapy staff complement but a commitment for recruiting further physiotherapists was made. Regrading for one staff member was granted, upgrading a Physiotherapy Assistant to Technical Instructor 3. This has provided greater versatility with the staff member having increased input into patient mobility treatments. Regrading for a further 2 staff members is being considered.

Future recruitment is an important matter. There is currently only 1 local physiotherapy student in training, with a physiotherapy graduate undergoing her post-graduation 2 year rotation in UK. Unfortunately another local physiotherapist did not take up her post in June as expected. There is on-going liaison with both Comprehensive Schools to recruit students for physiotherapy.

Training

The Superintendent Physiotherapist attended the Physiotherapy Congress 2000, which included lectures, case studies and a Trade Fair. Physiotherapists also attended other courses, including one on neurology, advanced life support, cancer care, Working Safely and the Diabetes Study Day.

A Senior Physiotherapist also gave teaching support to the nurse training curriculum by presenting a comprehensive insight into physiotherapy over a 2 week period, attended by 12 nurses.

Orthopaedics

A major part of physiotherapy workload is in orthopaedics. The department has been in consultation with Management for a while to improve the overall orthopaedic care package, emphasising the role of the multi disciplinary team. Ways of raising standards by addressing issues such as orthopaedic / trauma protocols, pre-admission policy for joint replacements, pre-op joint clinics, improved communication, in-service training, etc., have been identified.

New hospital

The department is pleased to note that following wide consultation with physiotherapy staff and other therapists with regard to the new hospital and the vision of a future Therapy & Rehabilitation Department, the evolved plans have been widely accepted.

Speech & Language Therapy

The Department's most significant development over the last year has been the setting up of a comprehensive service to provide speech and language therapy to all adults with communication and swallowing difficulties.

The service is provided to:

St Bernard's Hospital

St Bernardette's Centre

KGV Hospital

Primary Care Centre

The community

Particular developments include:

- Dysphagia Service (for people with swallowing difficulties)

(i) The development of joint Barium Swallow Clinics with the radiologist to further explore swallowing difficulties.

(ii) The development of close working relationships with the dietician and the Head Caterer at St Bernard's Hospital to provide appropriate textures and nutrition for those with swallowing difficulties.

- **Adult Learning Difficulties (ALD)**

  Full training has been given to all the staff at St Bernardette's Centre by the speech & language therapist, in the areas of:

- Communication skills and ALD
- Makaton
- Dysphagia

- **Voice**

  A close working relationship has been developed with the ENT Consultant in order to provide a comprehensive service to those with voice difficulties. Joint clinics (Speech / Language therapy and ENT) are carried out where appropriate.

- **The Elderly**

  Weekly ward-based multi-disciplinary team meetings have been developed involving the consultant elderologist, Speech & Language therapist, Physiotherapists, Occupational Therapists, Nurses, Social Worker and Dietician.

- **Education**

  Training sessions regarding Speech & Language therapist have been provided to both the diploma and enrolled nursing students as an inherent part of their course.

Nutrition

The department is awaiting approval of another dietician post, which would hopefully be funded from September 2001. This would certainly allow for development in a wide number of clinical areas and allow for the application of evidence based clinical guidelines.

Statistics on dietician consultations (see table) are comparable in numbers to 1999. Outpatient consultations include clinics at the Primary Care Centre, consultant referral clinic, home visits, paediatric diabetic and cystic fibrosis clinics, consultations for children outside school hours and visits to St Martin's School.

Obesity is on the increase, bringing associated morbidity and mortality. About 42% of all consultations are for advice for weight reduction. New treatments for obesity include use of the drug Orlistat (Xenical®) which can have long-term benefits if prescribed correctly and taken with a low fat diet. A policy was implemented in 2000 by the Gibraltar Health Authority, which required that every prescription for Orlistat must be authorised by the dietitian. An audit is being carried out looking at the effectiveness of Orlistat in weight reduction.

The findings of the research on Childhood Obesity in Gibraltar were presented by the dietitian at the International Dietetics Conference in Edinburgh (April 2000) and at the Inter-Island Public Health Forum in Gibraltar (May 2000). The same results were also presented by the Director of Public Health at the Public Health Medicine Conference in Scarborough (July 2000).

The department continues to be involved in many other non-clinical areas. The dietitian is an active member of the health promotion team and is involved in health awareness campaigns and the introduction of the Heartbeat Award. The dietician is also involved in many areas of education and training, such as the teaching of student nurses, regular evening lectures to parent-craft and cardiac rehabilitation groups, and education within schools

The budget this year was largely invested in a computer package. This now allows computerised statistics to be kept.

The department is looking forward to the move into the new hospital and is confident that this will assist to promote the multidisciplinary team approach to patient care.

The need to expand the inpatient service is recognised. Following the appointment of a second dietician, this service would include greater patient contact, regular ward rounds, the use of nutrition screening tools to identify patients at risk of malnutrition and regular education sessions for ward staff.

Education and Training

School of Health Studies

EDUCATION AND TRAINING

The School of Health Studies

The School of Health Studies has over the last twelve months continued to develop its commitment to continuing education and the professional development of all its staff, based on the principle of lifelong and shared learning. This has been largely possible thanks to the progressive and proactive approach of the Authority in creating the right environment to facilitate the growth of this young department. The staff have also been very supportive of the initiative and have constructively contributed to the policy development. The School however does face challenges ahead but there is confidence that these will be overcome with continued support.

Library facilities

The creation and full utilisation of a Library is central to the development and effectiveness of such a rapidly changing field as healthcare. The establishment of a centralised Health Studies Library resource clearly affirms the need to establish close links between the different education establishments in Gibraltar. It also is a testimony to the commitment given to education and training by the Authority.

The School of Heath Studies has been working closely with the College of Further Education in the development of an integrated library system for Gibraltar. The partnership has been very productive, with the Director of Education, Mr. Leslie Lester actively encouraging and promoting the collaboration between the sister organisations. Mr. Melvyn Rose has been greatly instrumental in setting up the library facilities.

The Authority has made a substantial commitment in both financial and human resources. Over the last twelve months, the School has employed a clerical officer to act as a library assistant, has subscribed to over 70 journals, has purchased well over 1,000 texts covering all aspects of healthcare and installed a computerized library management system.

The SHS is working closely with the members of staff of KGV Psychiatric hospital and the Primary Care Centre in the development of their satellite resource units. The needs of each of the units have been identified and the equipping of these is at an advanced stage. There is already a similar unit functional at St. Bernard's Hospital (seminar room) which will have access to the latest in teaching aids including data projectors. This will greatly assist all types of training from the pre-registration student nurses to the senior medical and nursing staff. It is hoped that there will also be Internet access in all the units by the end of 2001.

Continuing medical education

The continued professional development of all medical staff will present the School of Health Studies with its most exciting and demanding challenge. This will include trained grades (consultants, general medical practitioners) and training grades (senior house officers).

Consultants and General Medical Practitioners.

The programme for continued professional development in the United Kingdom is well advanced and therefore urgent efforts are necessary for local practice to catch up. It is essential that the School work in partnership with the Public Health Director, Medical Director and the Primary Care Coordinator to develop a policy that reflects high standards and meets public expectation on matters such as appraisal and revalidation of doctors. Some of the courses attended by medical staff were:

Clinical Governance and Clinical Effectiveness in Elderly Care - Royal College of Physicians

Course in Medicine for General Practitioners- Guy's Hospital

Advanced Medicine Conference - Royal College of Physicians

Keynote Conference - Millennium Festival of Medicine

Senior House Officers

The School of Health Studies will ensure that a major effort is made in order to improve the educational needs of this group. The School will work closely with senior medical staff in order to achieve the environment and conditions for the senior house officers that the Royal Colleges recommend. The School has for the first time provided funding for senior house officers to attend examinations and courses and secured study leave in collaboration with the Hospital Medical Director. A program of lunchtime seminars led by the Orthopaedic Surgeon has commenced. The School welcomes this initiative and will use all resources at its disposal to ensure the continued success of these sessions.

Nursing education

This has truly been the flagship programme for the School over the last year. The nursing staff and the staff of the Department of Nursing Studies have excelled themselves over the last twelve months and been instrumental in fostering the excellent progress that has been made by the diploma students. The staff have shown enthusiasm for the courses they have organised and visibly embraced a higher education culture. The Director of Nursing Services and his senior nursing managers have also led from the front and have done everything in their power to facilitate

this revolution in nurse education. In the next twelve months the two departments will continue to work together. It is proposed that in the future, an Education Liaison Officer and the Education Development Officer will assist both departments to develop a 5 year strategic plan for post-registration/ post basic training.

Education of Professions Allied to Medicine

The School of Health Studies has given a commitment that it will fund each professional within this group to attend a conference abroad once every three years. This will help them keep their knowledge and skills up to date and so meet their continued professional requirements as stipulated by their colleges. The courses should obviously meet with service requirements and the department's development strategy.

Some of the courses attended last year include:

- Placement North London Blood Centre
- D-Dimer as a Diagnostic tool
- BSHAA Annual Conference
- U.K. Radiological Congress
- Moving and Handling people-Annual Conference
- Assessment of motor and process skills training course.
- Placental scanning-Placement at Mayday University Hospital.

Education of Support staff

The School of Health Studies is working closely with the Technical Services and Works Department. The latter have begun to identify their training needs and are currently developing with a School a 3-year training program that not only identifies current needs but also the future needs of the new hospital. Two members of this department have already completed a course in the United Kingdom on sterilisation. Future courses include Medical Gas Pipeline Systems and X-ray Diagnostics.

Local Courses

The delivery of courses locally is an efficient means of maximising the delivery of training in a cost-efficient manner and is also central to the professional development of staff. These courses are usually multidisciplinary in nature with the aim of encouraging a team approach to the delivery of healthcare and the softening of traditional professional boundaries. The speakers are either local or professionals from abroad. Some of the Local Courses delivered were:

- Cancer Care Course
- Diabetes Care Course
- Lymphoedema Course
- Health and Safety courses
- IOSH Working Safely
- Control of Substances Hazardous to Health
- Customer care course
- Suturing Workshop

In conclusion

The School of Health Studies would like to take this opportunity to thank all the staff who have given of their time and effort in making the last year a success. Despite the challenges that lie ahead it is felt strongly that the rewards are far too great to miss the opportunity. The total involvement of staff in the development of policy and the equitable allocation of human and financial resources are the principled paradigms on which the School's strategy is based.

Management

New hospital design team

MANAGEMENT

New hospital development

Quite without doubt, the most exciting preoccupation that most of the health service staff have faced in the year 2000 is the planning of the new hospital. The task was a mammoth one, especially given the staff's unfamiliarity with the steps towards building up a specification and the tight time-scale set by Government.

Despite these formidable obstacles, the programme for the development/construction of the new General District Hospital at Europort remains on schedule. The Design Team have conducted a structured programme of user consultation through to the room data sheet stage. This process was a demanding and time-consuming affair, as it involved user discussion on specification requirements for each and every individual room within the new hospital complex. The hardest task is to reconcile the differing concepts that each user has and bring several visions into one reality-room by room. The last stage of this process involved the incorporation into the drawings of all engineering requirements. It is a tribute to the competence and professionalism of the Design Team that the users have virtually unanimously endorsed the final designs, praising the openness and rigorousness of the process.

Devereux Architects from United Kingdom are the project's lead consultants, and have been involved with the project since the initial feasibility study stage. Nic Allen and Rosemary Jenssen are the project's lead architects. David Bird from Hornagold of Hills is the Project Director. Troup Bywaters & Anders provide engineering support to the team on the mechanical and electrical side, while Ross & Partners oversee the structural aspects. E C Harris & Partners are the project's Quantity Surveyors. John Macdonald of Churchburn Estates represents the Government of Gibraltar and the Gibraltar Health Authority for the project. He is also the link with the Authority's project co-ordinating officers.

The process is managed locally through monthly client review meetings, which includes several senior managers from the GHA as well as representatives from all specialities within the UK Design Team. The Group reports directly to the Steering Group, which is chaired jointly by the Hon Keith Azopardi, Minister for Trade & Industry & Telecommunications and the Hon Bernard Linares, Minister for Education, Training, Culture & Health.

Contractors are to be recruited by February 2002. Construction works are expected to commence early in March 2002 with completion expected by September 2003.

The new facility presents a gross internal area of 30,245 sq. metres of which approx. 20,000 sq. metres are available as design areas. The new hospital will provide a spacious and welcoming environment, which will do much to lift the morale of patients and staff alike. The design takes on board the improvement in the facilities for existing services, and also the incorporation of several new services, which are not available at present. For example the inclusion within the new facility of new services, such as Day Surgery, Orthopaedic & Trauma Ward is currently being discussed.

Health Authority Finances

The Finance Section planned to take over the income/revenue transactions of the hospital and other accounts which had been previously undertaken by the Accounts section at St Bernard's Hospital. An administration Officer was deployed from the Accounts Section to the Finance Section to assist with the increase in workload. Although there is a noted expansion of work, it is easier to collate, as the information is readily available.

The section is also eager to introduce on-line budgetary information. This facility will enable budget-holders to have up to date information on all financial statistics which will assist them to constructively plan ahead on all financial matters. We are hopeful that this service will be available within the next couple of months.

The expenditure of the Gibraltar Health Authority for the year ending March 2001 is shown Table (50)

Prescription monitoring

The Prescription Monitoring Unit was set up in 1999. The department monitors prescriptions with reference to the following factors:

(1) Number of prescriptions

(2) Number of items

(3) Cost of prescriptions

(4) Cost of items

(5) Cost and number of prescriptions by individual doctors

(6) Specific drugs to be prescribed only by consultants

(7) Specific drugs that may only be prescribed to specific patients

(8) Specific patients that are presumed to be abusing the system in a variety of ways

(9) Prescriptions above a certain cost where patients could be guilty of abuse and corruptive practices

(10) Medicines that could be abused at any one time

(11) Medicines that are prescribed in incorrect doses or in incorrect time schedules

Statistics on some of the above practices are available but full detailed statistical information will have to await further developments such as:

(1) Full re-registration of all patients with strict allocation named general practitioners.

(2) Computerised prescribing.

(3) An efficient computerised repeat prescription procedure

Personnel

Retirements

A significant event in 2000 was the retirement of Mrs Mari-Carmen Durante, Clinical Nurse Teacher. Mrs Durante joined the GHA in 1957 and retired in December 2000.

Mrs Paula Galliano, Clinical Nurse Manager-Maternity Services retired in April 2000. Mrs Galliano joined the GHA in 1963.

Dr Robert Kay, Consultant Pathologist who joined the GHA in 1990 also retired in August 2000.

The Authority wishes all the above a long and happy retirement.

Appointments

Dr John Coogan was appointed to the post of Consultant Psychiatrist following the retirement of Dr Cecil Montegriffo in 1999. Dr Coogan joined the GHA in October 2000 from South London & Maudsley NHS Trust.

Mrs Jennifer Stentiford was appointed Clinical Nurse Manager-Maternity in May 2000 for three years.

Dr Tadeuz Biedryzcki was appointed to the post of Consultant Pathologist.

During the year

The year 2000 was a very busy one. The Authority was actively involved in the recruitment of Cooks, Cleaners, Radiographer, Hospital Attendant, Ward Clerks, Clerks, Nursing Assistants and a Speech & Language Therapist from the UK. This was also the first time that Registered General Nurses were recruited from the UK. It was very gratifying to have received so many applications when the NHS itself is experiencing so many difficulties in recruitment of nurses that they are employing nurses from overseas. As has been the practice for the past few years Registered Mental Nurses, Registered Sick Children's Nurses and Midwives were also recruited from the UK.

The post of Consultant in Elderly Care was advertised and the GHA offered the post to Dr Stephen Barber. A candidate was also appointed to the second Consultant post in Obstetrics & Gynaecology, but due to personal circumstances the candidate declined the offer.

Appointments of personnel from the UK invariably involve a great deal of work for the department as passages have to be booked, personal effects have to be shipped and suitable accommodation has to be sought.

The department has also been actively involved in liaising, and corresponding with some of the Gibraltarian students who are studying for the health professions in the UK. This initiative will help in the manpower planning of posts for the future.

Another key event was the setting up of the Manpower Committee as recommended in the Nursing Review of 1997. This committee, which is made up of the Director of Operational Services, Director of Nursing Services, Principal of School of Health Studies, Personnel Officer and Staff Side representatives, is currently looking into nurse manning levels with a view to deploying adequate manpower when the new hospital is commissioned in 2003.

In the future

A further two Occupational Therapists and Physiotherapists from the UK will be joining the GHA very shortly. The GHA will also see the second Consultant Obstetrician & Gynaecologist take up his post soon and interviews for a Ward Pharmacist, Nursing Assistants as well as Charge Nurse/Nursing Sister are imminent.

At present the Gibraltar Health Authority has 625 staff (as on 31/12/2000) and this figure is increasing gradually during the present year. It is clear that another very busy and challenging year lies ahead as the Authority gears itself to recruit staff for the new hospital.

Complaints

The Complaints Procedure.

The complaints procedure was set up with certain key goals:

1. To resolve genuine grievances.
2. To provide opportunity and time for patients and staff to improve mutual understanding following a conflict.
3. To provide a constructive mechanism to improve the health services where possible.

It is true to say that both the Hospital and the Primary Care Centre encountered a number of problems at the very start. Due to the substantially greater number of complaints on the Hospital services, the difficulties of managing them in this sector also multiplied.

From the outset, it soon became apparent that the infrastructure needed for the complaints procedure

to function effectively did not exist. Some were resolved as a matter of urgency, for example, a standardised format for the handling of the procedure did not exist and had to be quickly drawn up. However other factors have been more difficult to resolve. The complaints procedure provides for an early stage (Stage 1) at which problems can be resolved between complainant and staff member without third party involvement. This was seen as the sensible first step and one which would result in the bulk of the complaints being dealt with and closed quickly, without much paperwork. But in practice, there appears to be a widespread reluctance on both sides to settle complaints in this way, and therefore, most complaints bypass this stage and come directly to the designated officers, adding substantially to the workload that was envisaged for them when the procedure was drafted.

There are several essential administrative steps that designated officers are required to follow and these are often time consuming :

1) The complaint has to be appropriately recorded. Each of these statements can run to several pages of (partly legible) handwriting.
2) The complaint must be filed properly as it needs to be readily accessible until it is resolved, which could take several months.
3) Letters have to be written to acknowledge the receipt of each complainant.
4) Complaints have to be forwarded to the staff member.
5) Staff are busy people and frequently (especially in the hospital) reminders have to be sent.
6) Staff have to be mindful that a complaint could become a lawsuit at a later stage and compose their written replies only after detailed study and circumspection, which takes time and effort.
7) On receipt of a report from the staff member, written replies have to be composed by the designated officer, reviewing both sides of the complaint.
8) Files often have to be kept open for several months even after apparent resolution, because the complainant does not have to declare an end point at any time.

In summary, the complaints procedure proved overwhelmingly popular with the public as a means of engaging in constructive communication as well as of securing redressal. However, it easily swamped the resources that were available to deal with it and created stresses for busy staff.

Improvements

The Authority has committed itself to resolving many of the problems discussed above.

1) Adequate premises are now available for both designated officers. Rooms have been redesigned, refurbished, and equipped to allow privacy when meeting complainants.
2) An administrative officer has been appointed to assist the Hospital Manager.
3) A computer has been installed to provide technical support and a software program has been set up dedicated solely to recording and administering complaints.
4) An administrative structure has been produced for the handling of the Complaints Procedure
5) Systematic dissemination of public information on the Complaints Procedure has been begun.
6) The setting up of the Complaints Board has further helped to consolidate an effective framework for the Complaints Procedure.
7) Staff experiencing a burden of complaints have been granted protected time from clinical commitments to resolve them.

Tables

TABLES

List Of Tables

1. Civilian Population of Gibraltar (as on 31 December 2000)

		Gibraltarians	Other British	NON British	TOTAL
ADULTS	Male	7,850	950	1,454	10,254
	Female	8,454	1,642	581	10,677
	TOTAL	16,304	2,592	2,035	20,931
CHILDREN	Male	2,510	552	90	3,146
	Female	2,307	552	91	2,950
	TOTAL	4,817	1,104	181	6,102
TOTAL	Male	10,360	1,502	1,544	13,406
	Female	10,761	2,194	672	13,627
	TOTAL	21,121	3,696	2,216	27,033

2. Births in Gibraltar (2000)

	St Bernard's Hospital	Royal Naval Hospital	Home	Not stated	Total
Male	191	14	1	7	213
Female	169	19	0	8	196
Total	360	33	1	15	409

3. Births by month of birth (2000)

Month of birth	Female	Male	Total
January	10	16	26
February	11	13	24
March	16	15	31
April	11	17	28
May	21	29	50
June	15	22	37
July	14	16	30
August	17	22	39
September	16	19	35
October	23	14	37
November	14	16	30
December	23	19	42
Total	191	218	409

4. Births to teenage mothers (2000)

Mother's Age	Female	Male	Persons
15	1	1	2
16	1	2	3
17	1	2	3
18	4	5	9
19	5	6	11
Total Teenage mothers	12	16	28

This table excludes 7 mothers (2% of the births) for whom data was not available

5. Births to mothers over the age of 35 (2000)

Mother's Age	Female	Male	Persons
36	4	13	17
37	3	4	7
38	2	3	5
39	1	1	2
40	3	2	5
41	2	3	5
42	3	1	4
Total Mothers over 35	18	27	45

This table excludes 7 mothers (2% of the births) for whom data was not available

6. Deaths in Gibraltar by Age and Sex (2000)

Age at death	Males	Females	Total
0 - 4	-	1	1
5 - 19			
20 - 34	5	-	5
35 - 44	-	1	1
45 - 54	7	3	10
55 - 64	17	8	25
65 - 74	19	14	33
75 - 84	49	44	93
85 +	19	46	65
Total	116	117	233

7. Mean ages at death

	2000		1999		1998	
	Males	Females	Males	Females	Males	Females
Mean age at death	73.0	79.3	69.5	78.9	69.3	77.6
Standard Deviation	15.3	13.3	15.3	11.3	18.5	13.4

8. Principal causes of death in Gibraltar at all ages (1999 and 1998)

	2000		1999		1998	
CAUSE	No	%	No	%	No	%
Cardio-vascular (Heart) disease	90	39%	87	34%	73	30%
Malignant Diseases (Cancer)	60	26%	52	19%	59	25%
Cerebro-vascular disease (Stroke)	18	8%	40	15%	31	13%
Respiratory (Chest) diseases	15	6%	39	15%	29	12%
Infections	6	2%	8	3%	11	5%
Injuries & Poisoning	9	4%	11	4%	5	2%
Degenerative diseases	23	10%	9	3%	10	4%
All other causes	12	5%	21	7%	23	9%
Total	233	100%	267	100%	241	100%

9. Principal causes of death in Gibraltar in persons under 65 (1999)

	Numbers		Proportion	
	All Ages	<65s	All Ages	<65s
Cardio Vascular Disease (Heart diseases)	90	16	39%	38%
Malignant Diseases (Cancers)	60	13	26%	30%
Cerebro Vascular Disease (Strokes)	18	2	8%	5%
Respiratory Diseases (Chest diseases)	15	-	6%	-
Infections	6	1	2%	2%
Degenerative diseases	23	1	10%	2%
Injuries	9	7	4%	16%
All other causes	12	3	5%	7%
Total	233	43	100%	100%

10. Distribution of cancers causing death (by anatomical site)

Site of cancer	2000	1999
Breast	6	5
Uterus	1	3
Cervix	0	1
Ovary	1	1
Vulva	1	0
Prostate	3	4
Bladder	5	3
Kidney	2	0
Oesophagus	3	3
Stomach	4	4
Pancreas	3	1
Liver	0	1
Gall bladder	1	1
Colon	6	4
Rectum	2	0
Lung	9	11
Pharynx	3	0
Lymph	2	4
Brain	0	2
Carcinomatosis	8	3
Unspecified	0	1
Total	60	52

11. Distribution of causes of death in diabetics and non-diabetics (2000)

	Diabetics		Non-diabetics	
Heart disease	12	50%	78	37%
Stroke	2	8%	16	8%
Cancer	2	8%	58	28%
Chest conditions	0	-	15	7%
Kidney failure	1	4%	3	1%
Other	7	29%	39	19%
Total	24	100%	209	100%

12. New cancers recorded by the Cancer Registry over 2 years (1999 and 2000)

Site	Malignant	In situ, Borderline & Unspecified
Skin	86	*
Breast	22	*
Uterus	8	*
Cervix	*	34
Other female reproductive	6	*
Prostate	5	*
Bladder	7	9
Stomach	6	*
Colon, Rectum & Anus	13	*
Mouth	6	*
Lung & Pleura	*	*
Larynx	*	*
Blood & bone marrow	6	*
Other sites	8	*
All cancers	182	54
All cancers, except Skin	96	*

Note: In accordance with international conventions on confidentiality, all cells where the value is less than 5 or where the value can be deduced, will show only an asterisk (*).

13. Laboratory confirmed notifiable diseases (2000)

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Campylobacter jejuni	3	4	10	7	12	6	14	10	11	3	5	7	92
Rotavirus	1	17	8	7	5	0	0	1	0	5	1	0	45
Salmonella	6	0	1	3	1	4	9	9	10	7	5	3	58
Shigella	0	0	0	0	0	1	0	0	0	0	0	1	2
Cryptosporidia	0	0	0	0	0	0	0	5	14	1	0	0	20
pathogenic E. Coli	2	2	0	0	0	0	1	1	0	0	0	0	6
Tuberculosis	0	2	0	1	0	0	0	1	0	0	0	0	4
Gonorrhoea	0	0	0	0	0	0	0	0	0	0	0	0	0
Hepatitis A	1	0	0	0	2	0	1	1	0	0	1	0	6
Hepatitis B	0	0	0	0	0	1	0	0	0	0	0	0	1
Meningitis	0	0	0	0	0	0	0	0	0	0	0	0	0
Chlamydia trachomatis	0	0	0	0	0	0	0	0	0	0	0	0	0
Whooping cough	0	0	0	0	0	0	1	0	0	0	0	0	1
Giardia lamblia	0	0	0	0	0	1	2	0	2	1	0	0	6
Toxoplasma gondii	0	0	0	0	0	0	0	0	0	0	0	0	0
Yersinia enterocolitica	1	0	0	0	0	0	0	0	0	0	0	0	1
TOTAL	14	25	19	18	20	13	28	28	37	17	12	11	242

14. Trends in laboratory confirmed notifiable diseases

Month	2000	1999	1998
Campylobacter jejuni	92	73	69
Rotavirus	45	32	17
Salmonella	58	85	38
Shigella	2	6	0
Cryptosporidia	20	0	5
pathogenic E. Coli	6	1	5
Tuberculosis	4	1	5
Gonorrhoea	0	3	1
Hepatitis A	6	10	3
Hepatitis B	1	4	0
Meningitis	0	1	1
Chlamydia trachomatis	0	1	0
Whooping cough	1	6	1
Giardia lamblia	6	9	0
Toxoplasma gondii	0	1	0
Yersinia enterocolitica	1	0	0
TOTAL	242	233	145

15. Immunisations administered in 2000

	1st	2nd	3rd	Booster	Total
Polio	393	357	363	781	1894
Triple Antigen	387	336	329		1052
Diphtheria & Tetanus	18	28	39	452	537
MMR	358				
Tetanus	343				
Influenza	1468				
HIB	12	14	12		38
Rubella	4				
Meningitis A & C	201				
Hepatitis B	8				
TOTAL	3192	735	743	1233	3521

16. Primary care clinic services

Type of work	Frequency
Routine General Practitioner Clinic	Daily with 40 patients per GP
Emergency GP clinic by on call GP	Twice Daily (40-80 patients)
Weekend GP Clinics (Saturday and Sunday)	Twice Daily (60-80 patients)
Public Holiday Clinics (All public holidays including Christmas Day and Boxing Day)	Twice Daily 60-80 per day
Well Woman Clinic (Dr Vassallo)	Three times weekly
Diabetic Clinic (Dr Beguelin)	Monthly
Asthma Clinic (Dr Mañetto)	Monthly
Verruca and Cryosurgery Clinic Drs Fitzpatrick and Nerney	Weekly
Minor Surgery Clinic (Dr Fitzpatrick)	Weekly
Post Natal Clinics (Dr Vassallo)	Weekly
Developmental Clinic (Dr Vassallo)	Weekly
Ear Syringing (Nurse Led)	As required
ECG (Nurse Led)	As required
Venesection (Nurse Led)	Daily
Audiometry and Speech Clinic (Mr A Loddo)	Daily
Diet Clinic (Ms M McLeod)	Twice Weekly
Prison Clinics (Dr Mañetto)	Weekly
Mount Alvernia Geriatric Clinic (Dr Penrice) Locum	Once Weekly
Jewish Home Geriatric Clinic (Dr Caetano)	As required
Dr Giraldi Home for Handicapped Children Clinic	As required
Consultant Psychiatrist OPD clinic - Dr Coogan	Once weekly
Clinical Psychologist - Dr G McColl	Twice weekly

17. General Practitioner activity 1998 - 2000

	Clinic Consultations	House Calls	Complaints		
			clinical	non-clinical	Total
1998	84,090	5,153	4	11	15
1999	84,273	6,107	5	12	17
2000	85,050	5,782	4	10	14

18. Average weekly consultations by GP in 2000

Dr. Galloway	*230*
Dr. Soler	*205*
Dr. Beguelin	*190*
Dr. Kumari	*190*
Dr. Nerney	*190*
Dr. Fitzpatrick	*185*
Dr. Jones	*185*
Dr. Thompson	*185*
Dr. Caetano	*180*
Dr. Miles	*175*
Dr. Morris-Davies	*170*
Dr. Saltissi	*170*
Dr. Mañetto	*160*
Dr. Vassallo (part time)	*90*

19. Referrals to Out-patient clinics by all general practitioners (May - Nov 2000)

Specialty	*Consultant*	*During 6 months*	*Average per month*	*Average per week*
Medicine	*Dr. Maskill*	*138*	*23.0*	*5.3*
Medicine	*Dr. Borge*	*76*	*12.7*	*2.9*
Paediatrics	*Dr. Benady*	*13*	*2.2*	*0.5*
General surgery	*Mr. Sene*	*320**	*53.3*	*12.3*
Orthopaedics	*Mr. Malik*	*199*	*33.2*	*7.7*
Obs / Gyne	*Mr. Armon*	*120*	*20.0*	*4.6*
ENT	*Dr. Farrell*	*184*	*30.7*	*7.1*
Ophthalmology	*Mr. Haroon*	*316+*	*52.7*	*12.2*
Oral surgery	*Mr. Morillo*	*9*	*1.5*	*0.3*
Psychiatry	*Dr. Coogan*	*14*	*2.3*	*0.5*
Psychology	*Dr. Mccoll*	*5*	*0.8*	*0.2*
Pain Relief	*Drs. Correa / Moeser*	*29*	*4.8*	*1.1*
Dermatology	*Dr. Hutchinson*	*39*	*6.5*	*1.5*
Plastic Surgery	*Mr. Henderson*	*12*	*2.0*	*0.5*
Total		*1474*	*245.7*	*56.7*

** Includes 274 referrals for minor surgery*

+ Includes 220 referrals for Refraction (eye tests and glasses)

20. Referrals ratios of general practitioners (May - Nov 2000)

	Referrals in 6 mths	*Consultations*	*Proportion*
Dr. Beguelin	*195*	*3,416*	*5.7%*
Dr. Vassallo	*65*	*1,135*	*5.7%*
Dr. Soler	*178*	*4,121*	*4.3%*
Dr. Nerney	*147*	*3,644*	*4.0%*
Dr. Miles	*110*	*2,862*	*3.8%*
Dr. Galloway	*147*	*4,219*	*3.5%*
Dr. Thompson	*114*	*3,432*	*3.3%*
Dr. Kumari/Locum	*112*	*3,465*	*3.2%*
Dr. Jones	*97*	*3,081*	*3.1%*
Dr. Saltissi	*90*	*3,135*	*2.9%*
Dr. Caetano	*75*	*2,861*	*2.6%*
Dr. Fitzpatrick	*75*	*2,913*	*2.6%*
Dr. Morris Davies	*39*	*3,155*	*1.2%*
Dr. Manetto	*30*	*2,888*	*1.0%*
Total	*1,474*	*44,327*	*3.3%*

21. School Nurses

Children Seen in School by nurse	*7810*
Eye Appointments arranged	*120*
Dental Appointments arranged	*20*
Paediatric Appointments arranged	*18*

22. Child welfare clinics

	Babies seen	*Total attendance*
January	*328*	*636*
February	*430*	*682*
March	*420*	*790*
April	*370*	*630*
May	*392*	*778*
June	*372*	*740*
July	*360*	*690*
August	*407*	*720*
September	*400*	*663*
October	*422*	*810*
November	*410*	*785*
December	*464*	*620*
Total	*4775*	*8544*

23. Community Nursing in 2000

	MacMillan visits			*Nursing Visits*			*Patients visited*		
	S	*T*	*G*	*S*	*T*	*G*	*S*	*T*	*G*
January	*0*	*3*	*4*	*118*	*804*	*299*	*25*	*83*	*38*
February	*1*	*6*	*4*	*187*	*910*	*269*	*32*	*78*	*52*
March	*1*	*6*	*3*	*245*	*1012*	*275*	*40*	*75*	*42*
April	*1*	*5*	*5*	*256*	*905*	*294*	*34*	*72*	*39*
May	*2*	*8*	*3*	*313*	*934*	*345*	*39*	*76*	*39*
June	*2*	*6*	*2*	*291*	*803*	*257*	*40*	*81*	*39*
July	*3*	*8*	*0*	*300*	*816*	*298*	*36*	*81*	*38*
August	*5*	*10*	*0*	*297*	*757*	*249*	*38*	*85*	*36*
September	*3*	*10*	*1*	*302*	*839*	*253*	*38*	*83*	*33*
October	*0*	*11*	*4*	*333*	*798*	*339*	*40*	*87*	*39*
November	*4*	*10*	*6*	*527*	*881*	*532*	*56*	*86*	*47*
December	*0*	*10*	*0*	*455*	*787*	*247*	*56*	*86*	*33*
Total	*22*	*93*	*32*	*3624*	*10246*	*3657*	*474*	*973*	*475*
		147			*17527*			*1922*	

Key: S= South sector; T=Town sector; G=Glacis sector

24. Clinic Nursing

	Phlebotomy	*X Rays*	*Treatment Room*	*Ear Syringing*	*Minor Operations*	*Diabetes*	*ECGs*
Jan	*329*	*192*	*167*	*5*	*29*		*109*
Feb	*339*	*290*	*48*	*10*	*30*		*84*
Mar	*337*	*250*	*55*	*20*	*40*		*73*
Apr	*307*	*224*	*67*	*9*	*65*		*65*
May	*375*	*252*	*55*	*13*	*42*		*100*
June	*329*	*278*	*34*	*20*	*34*		*83*
July	*358*	*220*	*55*	*21*	*42*		*67*
Aug	*371*	*258*	*71*	*19*	*0*		*48*
Sept	*359*	*226*	*81*	*12*	*0*	*9*	*67*
Oct	*406*	*320*	*76*	*19*	*24*	*16*	*93*
Nov	*389*	*290*	*73*	*22*	*42*	*59*	*118*
Dec	*230*	*189*	*53*	*15*	*23*	*56*	*67*
Total	*4129*	*2989*	*835*	*185*	*371*	*140*	*974*

25. Sponsored referrals to UK Hospitals in 2000

	Females	Males	Total	%
St Mary's Hospital	124	185	310	39%
Royal Marsden Hospital	122	69	191	24%
Moorfields Eye Hospital	32	20	52	7%
Other hospitals	137	108	245	31%
All UK Sponsorships	415	382	798	100%

26. Sponsored referrals to Spanish Hospitals in 2000

	Females	Males	Total	%
Hospital Materno Infantil	14	19	33	40%
Hospital Universitario Puerta Del Mar	16	12	28	34%
Hospital Regional Carlos Haya	7	8	15	18%
Hospital Municipal	4	2	6	7%
All Spanish Sponsorships	41	41	82	100%

27. Operations performed in 2000 in main Operating Theatre

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
General Surgery	51	48	40	48	56	54	55	72	38	56	56	48	622
Gynaecology	19	20	24	22	21	21	25	17	9	16	29	18	241
Obstetrics	5	8	8	2	8	5	9	16	11	13	3	6	94
Neuro-Surgery	1	1	0	0	0	0	0	0	1	0	0	4	7
Orthopaedics	43	48	58	49	30	46	36	53	18	38	48	32	499
Cardio-Thoracic	0	0	0	0	1	0	5	1	0	1	2	1	11
E.N.T	13	14	15	23	13	14	18	18	18	28	13	11	198
Urology	15	24	28	16	23	19	10	14	15	22	17	8	211
Plastic Surgery	6	4	11	0	0	0	13	0	0	0	14	0	48
Dental Surgery	30	38	35	22	26	37	37	32	36	26	14	28	361
Ophthalmology	1	0	0	4	0	3	1	0	0	3	1	1	14
Pain Relief	4	15	7	9	0	6	6	7	12	15	15	4	100
Total	188	220	226	195	178	205	215	230	158	218	212	161	2406

28. Emergency Operations accommodated in 2000 outside scheduled hours (listed by procedure)

Operation	*Number*
Caesarean Section	*31*
Appendicectomy	*24*
Laparotomy	*5*
Caudal Epidural	*4 each*
Salpino-Oophorectomy	
D.H.S	
Insertion Cardiac Pacemaker	*3 each*
Retained Placenta	
Above Knee Amputations	
Bartholins Cyst	
Hysteroscopy	*2 each*
Manipulation Colles fracture	
Ruptured Ectopic pregnancy	
Tendon Repair	
Abdominal Hysterectomy	
Cautery anal bleeding	
Duodenal Perforation	
Evacuation of Eye	
Gallstone Ileus	
Hartmans procedure	
Herniorrhaphy	
Hydrocele	*1 each*
Injection into Shoulder	
Insertion Denham Pin	
Laparoscopic Sterilization	
Normal Delivery	
Orchidectomy	
Plating of fractured Jaw	
Sigmoidoscopy	
Tonsillectomy	
Total	*105*

29. Emergency Operations accommodated in 2000 outside scheduled hours (grouped by Specialty)

Obstetrics	*38*
Surgery	*37*
Orthopaedics	*11*
Gynaecology	*9*
Anaesthetics	*4*
Medicine	*3*
ENT	*1*
Maxillofacial - dental	*1*
Ophthalmology	*1*
Total	*105*

30. Emergency Operations accommodated in 2000 by interrupting the scheduled list of another Specialty (listed by procedure)

Operation	*Number*
Caesarean Section	*6 each*
Dental Extraction	
Manipulation Colles fracture	
Appendicectomy	*3 each*
Epidural Injection	
Herniorrhaphy	*2*
Testicular Torsion	
Incision & Drainage Testes	
Gastrectomy	*1 each*
Hysteroscopy	
Evacuation of products	
Insertion Cardiac Pacemaker	
Total	*29*

31. Emergency Operations accommodated in 2000 by interrupting the scheduled list of another Specialty (grouped by Specialty)

Specialty	*Number*
Surgery	*8*
Obstetrics	*7*
Maxillofacial - Dental	*6*
Anaeathetics	*3*
Orthopaedics	*3*
Medicine	*1*
Gynaecology	*1*
Total	*29*

32. Emergency Operations accommodated in 2000 within Specialty's own scheduled list (listed by procedure)

Operation	*Number*
Incision & Drainage	*9*
Appendicectomy	*6*
D.H.S	*2 each*
Sigmoidoscopy	
Repair Ulna Nerve1 each	
Above knee Amputation	
Trimming Index Finger	
Tendon Repair	
Manipulation of fractured Radius & Ulna	*1 each*
Ramstedts Operation	
Laparoscopy	
Laparotomy	
Excision of Necrotic patch Breast	
Herniorrhaphy	
Thoracotomy	

33. Emergency Operations accommodated in 2000 within Specialty's own scheduled list (grouped by Specialty)

Specialty	Number
Surgery	23
Orthopaedics	7
Total	30

34. Reasons for Cancellation of operations in 2000

REASON - Specialty	Gyn / Obs	Surg/ Uro	Ortho-	Plas Surg	E.N.T	Dent/ Fac Max	All Specs	
PATIENT CHOICE								
Patient did not attend	4	11	3	1	1	18	38	37.5%
Cancelled by patient	1	3	2	1	3	10		
PATIENT FITNESS								
Patient ate before operation	1	1				2		12.5%
Patient unfit for surgery	3	4	2		3	2	14	
CLINICAL FACTORS								
Postponed by surgeon	8	2	1				11	11.0%
Re-scanned no op needed	1					2	3	
RESOURCE LACK								
No beds available	13	2	13		3	3	34	37.5%
No theatre time available	4	1	4			5	14	
ADMINISTRATIVE								
Patient not informed of date		2					2	1.5%
ALL REASONS								
All Reasons	36	24	26	2	7	33	128	100%

35. General Surgical operations carried out between 1993 and 2000

	1993	1994	1995	1996	1997	1998	1999	2000	Average
Major	155	151	138	171	174	144	152	170	157
Intermediate	280	271	268	269	240	288	269	289	272
Minor	193	175	177	195	175	174	195	194	185
Total	628	577	583	635	589	606	616	653	611

The classification of operations into major intermediate and minor is based on the system used by the old Office of Population, Censuses and Surveys (OPCS Classification).

36. Urological Operations carried out between 1993 and 2000:-

	1993	1994	1995	1996	1997	1998	1999	2000
MAJOR								
Nephrectomy	0	2	0	1	1	0	0	1
Transurethral resection of prostate	39	35	13	24	34	23	29	34
Retropubic or open prostatectomy	0	1	1	2	0	0	0	0
Transurethral resection of bladder tumour	18	17	15	7	10	10	9	12
Supra pubic cystotomy	0	0	0	2	1	0	0	3
Repair ureteric injury / re-implantation	0	0	1	0	0	0	0	2
Other Major operations	0	0	1	0	0	2	1	2
INTERMEDIATE								
Cystoscopy plus retrograde or JJ Stent	5	4	9	10	5	9	5	6
Optical internal urethrotomy	18	19	17	23	11	10	12	14
Circumcision - (mainly in children)*	20	28	31	27	22	30	31	39
Scrotal adult operations – includeshydroceles, cysts, orchidectomies, epididymectomies	15	21	12	14	13	23	11	23
Other Intermediate operations	4	2	0	5	0	0	0	1
MINOR								
Cysto-urethroscopy (with or without dilatation, biopsy, stone retrieval or diathermy)	80	92	71	85	85	88	98	81
Urethral dilatation only	4	2	2	3	12	4	8	6

The classification of operations into major intermediate and minor is based on the system used by the old Office of Population, Censuses and Surveys (OPCS Classification).

**Includes some separations of adhesions/frenuloplasties.*

37. Psychology Referrals by Source

Number of new referrals	*140*
GPs	*104*
Psychiatrist	*14*
St Bernard's	*8*
KGV	*7*
Other	*4*
CPN	*3*

38. Psychology Referrals by Gender

Total	*140 (100%)*
Female	*84 (60%)*
Male	*56 (40%)*

39. Patients who Did-Not-Attend (DNAs) Psychology clinics by Gender

Total	*18 (100%)*
Female	*12 (67%)*
Male	*6 (33%)*

40. Psychology Caseload

Number of new referrals	*140*
Number of ongoing clients	*29*
Less Number of DNAs	*18*
Total Caseload	*151*
%age of new referrals	*12.8%*

41. Total Psychology Caseload by Gender

Total	*151 (100%)*
Female	*86 (57%)*
Male	*65 (43%)*

42. Total Psychology Caseload by Problem

Panic Disorder	*38*
Depressive Disorder	*24*
Generalised Anxiety Disorder and stress problems, PTSD	*13*
Personality Disorder and personality problems	*12*
Physical Disorder : associated problems	*9*
Psychotic Disorder: associated problems	*9*
Obsessive Compulsive Disorder and obsessive personality	*9*
Bereavement: unresolved	*7*
Marital : associated problems	*5*
Organic: cognitive impairment, dementia	*5*
Sexual and CSA	*5*
Addiction	*4*
Self Harm	*4*
Anger Management	*3*
Other	*4*

43. Imaging (X-ray) examinations during 2000

Number of patients referred	*13847*
NHS	*13394*
Private	*453*
Number of investigations	*14664*

Special Investigations	*Number*
General ultrasounds	*1513*
Obstetric ultrasounds	*538*
Salpingograms	*3*
Barium Meals	*139*
Barium Enemas	*190*
Radiculograms	*11*
IVU	*65*
Theatre	*82*
Portables	*195*
Venograms	*8*
Sialograms	*4*
Micturating Cystograms	*2*
T-Tube Cholangiograms	*1*
Pacemaker Insertions	*9*
Small Bower Enemas	*4*

44. Imaging (Xray) Referrals to Spain during 2000

CT Scans	*349*
MRI Scans	*217*
Mammograms	*180*
Radio-isotope scans	*59*
Densitometry	*10*

45. Consultations For Nutritional Therapy (2000) by condition.

Conditions	*Paediatrics 0-18yrs*	*Adults > 18 yrs*
Weight reduction	*50*	*471*
Non- insulin dependent diabetes	*0*	*139*
Insulin dependant diabetes	*73*	*102*
Lipid lowering	*0*	*76*
Nutritional Support	*47*	*136*
Infant feeding (including Allergies)	*16*	-
Eating Disorders	*11*	*14*
Other disorders requiring Nutritional intervention	*21*	*91*
Totals (includes some overlap)	*218*	*1029*
Totals 1999	*222*	*1191*

46. Consultations for Nutritional Therapy by location

Location	*2000*	*1999*
Outpatient (Attendance %)	*869 (71%)*	*857 (74%)*
Inpatient	*296*	*334*
Total	*1165*	*1191*

47. New referrals to Palliative Care in 2000

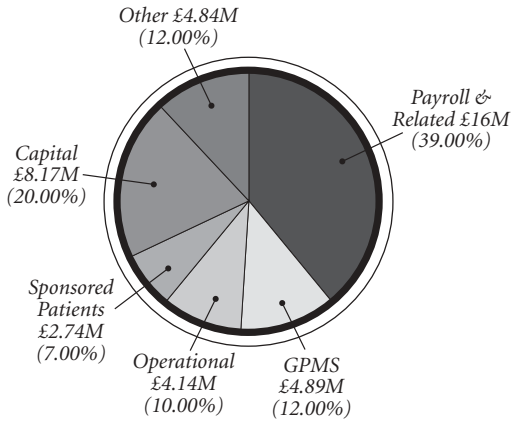
Sex		Age range	
Males	Females	Youngest	Oldest
26	22	37	96

48. Source of referrals to Palliative Care

Medical	18
Surgical	21
Gynaecology	1
ENT	1
General practitioners	1
Lady Williams Centre	4
Royal Marsden Hosp.	1
Self referral	1

49. Range of diagnoses in Palliative care

Malignancies of:	Patients	Females	Males
Bladder	5	1	4
Bowel	7	3	4
Breast	7	7	
Carcinomatosis	1		1
Cervix	1		
Head and neck	1		1
Gall bladder	1	1	
Kidney	1		1
Leukaemia	1		1
Liver	1	1	
Lung	3		1
Mesithelioma	1		1
Non-Hodgkins Lymphoma	1		1
Oesophagus	4	3	1
Oral	2	1	1
Ovary	1	1	
Pancreas	2	1	1
Prostate	4		4
Stomach	2	1	1
Non Cancer Palliative Care	2	1	1



50. Gibraltar Health Authority Expenditure by categories (2000-2001)

Category	Expenditure	Includes
Payroll and related	£16.02 million	Salaries, wages and social insurance.
GPMS	£4.89 million	Payments made to retail pharmacies and costs of Prescriptions Pricing List.
Operational	£4.33 million	Operational costs, (pharmaceuticals, drugs, appliances, bandages, provisions, linen, etc) and the School of Health Studies.
Sponsored Patients	£2.74 million	Expenses in connection with sponsoring patients for diagnosis/treatment away from Gibraltar.
Capital	£0.817 million	Equipment and works (including costs related to the new Primary Care Centre).
Other	£0.613 million	Other aspects of expenditure such as payments to St John's Ambulance, funeral expenses, registration boards, studies in relation to the new hospital, ex gratia payments and claims.
Total	£29.41 million	

51. Personnel

MEDICAL	
Director Of Public Health	*1*
Consultants	*12*
Associate Specialist	*1*
General Practitioners	*14*
Senior House Officers	*10*

NURSING	
Director of Nursing Services	*1*
Deputy Director of Nursing Services	*1*
Clinical Nurse Manager	*6*
Education Development Officer	*1*
Senior Nurse Tutor	*1*
Charge Nurses	*31*
Staff Nurses	*84*
Staff Nurses (part-time)	*8*
Staff Midwives	*8*
Senior Enrolled Nurses	*10*
Enrolled Nurses	*70*
Enrolled Nurses (part-time)	*24*
Nursing Auxiliaries	*12*
Nursing Auxiliaries (part-time)	*4*
Nursing Assistants	*63*
Nursing Assistants (part-time)	*24*
Student Nurses	*9*

ADMINISTRATIVE & CLERICAL	
Chief Executive	*1*
Director of Operational Services	*1*
Senior Executive Officer	*1*
Higher Executive Officers	*3*
Executive Officers	*7*
Administrative Officers	*33*
Administrative Officers (part-time)	*6*
Medical Secretaries	*4*
Typists	*6*

PROFESSIONS ALLIED TO MEDICINE	
Superintendent Physiotherapist	*1*
Senior Physiotherapists	*5*
Physiotherapist Helpers	*2*
Head Occupational Therapist	*1*
Occupational Therapist	*4*
Senior II Occupational Therapist	*1*
Senior Dental Officers	*3*
Head Pharmacist	*1*
Pharmacists	*2*
Superintendent Radiographer	*1*
Radiographers	*4*
Chief Speech & Language Therapist	*1*
Speech & Language Therapists	*3*
CMLSO/PA	*1*
SMLSO	*5*
MLSO	*1*
JMLSO	*4*
Dietician	*1*
Senior Mental Welfare Officer	*1*
Mental Welfare Officer	*1*
Health Promotion Officer	*1*

INDUSTRIAL & SUPPORT GRADES	
SPTO	*1*
HPTO	*1*
PTO	*1*
TG1	*2*
Engineering Craftsman	*1*
Head Porter	*1*
Hospital Attendants	*15*
Stores Supervisor	*2*
Messenger/Drivers	*3*
Cleaners/Domestics	*46*
Cleaners/Domestics (Part-Time)	*19*
Laboratory Operative	*1*
Principal Cook	*1*
Senior Cooks	*2*
Cooks	*9*
Cook (Part-Time)	*1*
Linen Supervisor	*1*
Assistant Linen Supervisor	*1*
Seamstresses	*3*
Plant Operator	*1*
Industrial Technician	*1*
Craftsman Mate	*10*
Labourer	*1*