Health Matters

Gibraltar Health Authority

Annual Report 2003

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

FOREWORD

By The Hon Dr B Linares, LPh, DD, Minister for Health

It is a pleasure and a privilege for me, once again, to present this Annual Report (2003) which is proof the Government's commitment to transparency and accountability in all matters related to the Health Services.

I want, first of all, to express my sincere appreciation to all those members of staff who day in day out walk into our hospital wards, clinics and places of work with a clear commitment to serve our people. There will be failures, as in all human endeavours, but it is not right that in this blame society in which we live our practitioners should have to work under a permanent fear of criticism, litigation, and often even violence and abuse. I want to say that I do believe in the good will and the tireless efforts of the vast majority of those who work for us in our public services.

The New General Hospital

This Government has had the courage to embark on a multi-million pounds enterprise to provide for our people a state-of-the-art new General Hospital which will be the pride of our community.

Building works at the new Europort Hospital site continue. Works have been progressed on a floor by floor basis, with partitioning, installation of doors and laying of new floors to the lower levels already at an advanced stage. The design has made use of the modular nature of the buildings, with blocks one and three being mostly used for the provision of in-patient services. In patient facilities are made up of a variety of single, double and triple bedded cubicles with a high percentage of accommodation boasting en-suite facilities. The New Hospital will comprise 201 public in-patient beds, a suite with 3 operating theatres, an endoscopy suite, a Day Surgery suite, staff and visitors canteens, a chapel with pews for eighty persons and a mortuary with a room for reflection. New facilities within the complex include a fully integrated rehabilitation facility including hydrotherapy, an orthopaedic and trauma ward, an X-Ray Department which includes a CT Scan, as well as a mammography facility. There will also be a 15 bedded rehabilitation ward. The lower floors of the complex have been planned for outpatient services, with floors six and seven of blocks one and three being used for administration and the School of Health Studies.

The new hospital will boast an air-conditioned environment to all its clinical, administrative and outpatients areas, hence the requirement for increased air handling capacity at rooftop level. Cabling works for communication and information systems are being undertaken by Gibtelecom, while the main electrical sub-contract is being undertaken by Gibelec.

The main contractor Fitzpatrick/Rotary expect construction completion to be in early February 2004. A further 3 months period for commissioning/migration would tentatively see the opening of the new facility around May 2004.

All equipment schedules have been prepared following initial consultation by Ibis Medical with user groups. An in-house GHA team led by Mr Joe Catania, the Director of Operations who is our own client Project Manager assisted by Mr Derek Alman from the GHA Technical Services and Mrs Marisa Desoiza, are working with the consultant project managers and are now preparing room by room listings of items of equipment for transfer to the new hospital. This exercise will reduce the time requirement for the migration process.

But we are determined that this exciting project should serve as a catalyst, in generating heightened expectations and renewed attitudes striving for standards of excellence - a new era in Health Care in Gibraltar.

Clinical Governance Audit

For this purpose we have launched the most radical and in-depth audit of our health services ever to be carried out in Gibraltar.

The Clinical Governance Support Team is made up of four members from the National Clinical Governance Support Team of the NHS Modernisation Agency and four locally appointed practitioners who have been released for this purpose. They are assigned to carry out an audit of the health services together with a health development programme. The Programme was launched on 3rd March 2003.

The programme is made up of three phases. Phase I is the diagnostic phase and has been designed to determine the current state of health care services in Gibraltar.

The findings and recommendations from Phase I will inform the work of Phase II. Phase II is due to commence in September 2003 and will focus upon the environment and development of health care services. This work will be a range of both fast-track improvements and longer term developments.

Phase III will focus upon the implementation of any agreed improvements and redesigned services.

The Facts Speak For Themselves

This Annual Report provides us with an impressive account of progress and developments in all areas of the Health Services during the past year. It is an objective and detailed account of developments in this area of my ministerial responsibility free from value judgments or spin and based on facts and figures. And if we see these latest manifestly positive developments over the last year against the broader context of other developments in the Health Services over the last seven years – the relocation and improved conditions and facilities of Primary Care Centre, the professionalised and greatly expanded Ambulance Service, the School of Health Studies and the School of Nursing, a budgetary provision increased from £22m in 1996 to over £38m this year (over 70% increase well above inflationary growth) the huge increases in the complements of doctors, nurses, other medical professionals, administrative and ancillary staff, the doubling capacity of residential facilities for the elderly and the domiciliary care service, and, above all, the New General Hospital; in this context, only those who are politically blind can speak of our Health Service as a service in crisis and decline. The facts speak for themselves.

INTRODUCTION

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

The report is divided into two main sections.

The first of these is the Public Health Report on the population of Gibraltar. This part of the report deals with the health of the people of Gibraltar. As in last year's report, there is also a contribution from the Environmental Agency on aspects of the local environment relevant to the resident population.

The second section of the report is the Report on the Health Services and is dedicated to the functions of the various departments within the Authority that provide health and sickness care to the public.

Statistical data are set out at the end of the report.

In my introduction last year I mentioned that the promotion of health is as much about individuals as it is about partnerships. The report once again highlights the strategic importance of networking in developing health promotion. The Health Promotion Group is such an organisation.

Some readers may recall having participated in the events that were organised for the Gibraltar Health Week. The main event of the week was undoubtedly the Gibraltar Health Day. Gibraltar's first unified Health Day took place on Saturday 28th September, 2002 at Casemates Square. This was a large scale open-air public event. GBC Radio covered the event through a Roadshow, which helped to build up the atmosphere and make the event a resounding success.

The report also provides an insight into the developments that have taken place in 2002, particularly in the Primary Care Centre, which has seen the introduction of an optometry service, new services for patients with diabetes and the Nurse Practitioner service. I continue to commend the energetic efforts that are being made by all concerned towards the development of the new hospital, which is expected to be in operation by the time the next Report is published.

As always, I would like 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 and their relatives.

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

Ernest Lima, Chief Executive

Section 1

Public Health Report

(Above) Gibraltar Health Day at Casemates (Below) Coronary Heart Disease Awareness Day at the Piazza

PUBLIC HEALTH REPORT

VITAL STATISTICS

Population

At the time of writing, the Government Statistical Office had not published the final results of the national **Census** but has indicated that the resident population of Gibraltar on the last date of the calendar year 2002 should be very close to the published figure of 28,231. The proportion of females is 50.8% and that of males is 49.2%.

Births

The number of babies born in Gibraltar has remained remarkably constant with 361 live births in 2002 as against 363 in 2001. Of these, 177 were females and 184 were males. The proportion of these births attributable to the resident population rose slightly from 90% to 92.5%, while that of the Forces population dropped correspondingly. The birth rate in the resident population fell very marginally to 11.8 further continuing the downward trend in local birth rates since 1992. The birth rate in the Forces population is estimated to be 17.4.

The number of births to teenage mothers rose this year to 23, with again one birth occurring in a mother as young as 15. These figures have hardly changed in recent years and continue to be a matter for concern. There was 1 teenage pregnancy in the Forces population.

At the other extreme, there were again slightly fewer births to mothers aged 40 years or older - only 5†(1.5%) births as against 8 (2.2%) last year. The age of the oldest mother rose to 43.

Deaths

Life expectancy in Gibraltar is again in keeping the normal range for western societies and the mean age of death in the resident population was 72.7 years (males) and 79.1 years (females), similar to previous years.

This year, 111 males and 119 females died, giving a total of 230 deaths in the resident population, a crude death rate of 8.2, again roughly similar to previous years. Five further deaths were registered in Gibraltar, these being of non-residents

There were no stillbirths again this year. One infant died in the neonatal period due to asphyxia, giving an **infant** mortality rate of 3.0. Risks to early life continue to be very low.

Differences in gender patterns for the age of death are quite pronounced. The pattern for women shows very few deaths until the mid 60s after which the death rate rises to a peak in the mid 80's. The pattern for men, on the other hand, shows a rise in deaths as early as in the mid 20s and this rise is maintained throughout, rising to a peak in the late 70s and falling sharply thereafter. Only 8 men reached the 90s, the oldest dying at 96. In contrast 23 women reached 90 and one woman survived to 101. Only 11% of women died before their 65th birthday, whereas 23% of men (nearly a quarter) failed to reach this landmark. Premature mortality is therefore a much bigger problem with men than with women.

Details of the main causes of death and comparisons to previous years can be found in the tables. However, **Heart Disease** continues to remain the most common cause of death, maintaining the familiar pattern of causing one third of all deaths.

The second most common group cause of death is **Cancer**. Once again the actual number of deaths from cancer declined this year relative to previous years, but as before, **Lung cancer** continues to reign at the top, being responsible for over one in seven cancer deaths (6). Once again, the youngest person to die of cancer this year, a man aged 40, died of lung cancer. However, among women, **breast cancer** reigns supreme with 6 out of 22 deaths (27%) of the total.

As in previous years, 15% of the deaths occurred at **home**, but this year only 74% of deaths took place in St. Bernard's Hospital. Sixteen residents of Mount Alvernia died there (nearly 7% of the total) of whom all but two were aged over 80 years. This year, even fewer of those who died at home (one sixth) died from cancer, strengthening the observation made in last year's report that these are striking figures for a western society, where most people with terminal cancers choose to die at home.

The recording of diabetes as a contributory illness in the death certificates was again reviewed and this year about 10% (23 deaths) had **diabetes** noted as a contributory cause. Again, women appeared to outnumber men by 2:1, but there was no difference in the mean age at death between persons with or without diabetes.

"Premature" mortality

As is usual, all deaths under 65 were reviewed as an indication of "premature" mortality, taking a key health goal of society to be for all Gibraltar residents to achieve survival to at least 65 years.

Of the 231 people who died this year, 41 (17.7%) were under 65 years, a proportion remarkably constant in recent years. One third of these (14 persons) died of heart attacks, the youngest being only 24 years of age. This year there were three further deaths in young persons under 25, all males aged 12 (epilepsy), 16 (drowning) and 25 (unexplained sudden death).

INFECTIOUS DISEASES

Laboratory confirmed notifiable infections

There was a sharp fall in the number of cases of laboratory confirmed notifiable infection with reductions in infections reported in all categories. The total number of notifications fell this year to 172 from 265 last year and, 242 (2000) and 233 (1999) in previous years.

Food Poisoning

Virtually the entire fall is attributable to reductions in food poisoning notifications. There were 74 Salmonella cases as opposed to 103 last year, and even Campylobacter infections fell from 98 to 51. However, rotavirus infections in children during the winter months continued at the same level. Whether these reductions represent a real improvement in public food hygiene or a lower level of reporting is difficult to say.

There were two minor outbreaks of salmonella infections. In one, about six members of one family were affected and the cause was believed to be raw egg used in the preparation of tiramisu. In the other, ten children aged between 3 and 6 years developed salmonella enteritidis at around the same time. Despite extensive investigation by the Environmental Agency, no link or common food source could be identified.

In last year's report, it was noted that current food regulations did not cover casual commercial caterers leaving the public at parties served by non-institutional commercial caterers with effectively no protection and it was recommended that a licensing procedure be introduced to cover all forms of commercial catering not covered by existing regulations. This situation remains unchanged.

Meningococcal disease

During 2002, there was one case of meningococcal septicaemia in an adult who recovered fully.

Multi-Resistant Staphylococcus Aureus (MRSA)

During 2002, 18 cases of infection due to MRSA (multi-resistant staphylococcus aureus, an organism resistant to most antibiotics) were reported, the same as the previous year. The sharp fall in the number of cases acquired from St. Mary's Hospital continues, from 10 (2000) to 2 (2001) and 1 in 2002. However, at the same time, the number of cases acquired locally increased from 4 last year to 10 this year. Again, there were 5 infections whose sources were unknown.

All this seems to suggest that while the import of MRSA may have been brought under control, the increase in locally acquired infection is a new cause for worry, although the incidence in St. Bernard's Hospital is still in no way comparable to the endemicity of MRSA infections in most hospitals elsewhere.

Other infections

There were two cases of whooping cough, one in an unvaccinated child and a secondary case in an elderly relative (who was also unvaccinated). Both recovered satisfactorily.

There were no reported cases of chlamydia trachomatis or cryptosporidiosis.

Waste disposal

It was reported last year that in October 2001, the main sewer had collapsed near Red Sands. Immediate measures were taken to prevent sewage backflow into the bay and other areas, followed by the completion of remedial works in 2002. Throughout the episode, water contamination was successfully prevented.

IMMUNISATIONS

Meningitis C programme

One of the most significant new measures in this field, the programme to immunise the entire child population against Meningitis C infection was successfully completed in record time, several months ahead of what was intended as a tight schedule. Over 8000 children were vaccinated in just over a year.

A large measure of the credit undoubtedly goes to the Immunisation nurses who not only had to administer the injections, but keep detailed records, counsel concerned parents and at times, deal firmly with those who were not prepared to wait their turn, all the while continuing with their normal work schedule.

The programme is now being extended to older children and will continue indefinitely to protect future generations through the immunisation of infants.

Other vaccination programmes

Routine immunisation programmes continued to be carried out during 2002 as per schedule. The annual winter Influenza vaccine campaign also continued this year.

Controversies and adverse publicity in the media over the MMR (Measles, Mumps, and Rubella) vaccine continued to impede the programme, although the view of the staff is that this is not on the same scale as in the UK. Nevertheless, efforts to keep the public informed continue, with the summary of the most recent research evidence on the vaccine presented in the 2000 and 2002 annual reports, both of which have been published on the Authority's website.

CANCER REGISTRATION

The Cancer Registry continues to register new cases of cancer. Although the Registry was set up in late 1999, incident cancers for the year 1998 have also been added as it was possible to assure the quality of the data. Further addition of retrospective data will not take place.

The majority of the registrations are received from the pathology laboratory as this is where the diagnosis is often established. Clinicians have also been requested to submit notifications that may not have reached the Registry by the conventional routes. As a result the completeness of the data is steadily improving.

A summary of the cancer notifications from 1998 to 2002 is presented in the tables.

ENVIRONMENTAL HEALTH

The Environmental Agency continues to carry out a series of activities, which have either a direct or indirect effect on health. The comments in this Section detail some of this work. The Agency also works in close liaison with the Director of Public Health on public health matters in general, as well as with other members of the Authority on such issues as infection control, biological and chemical incidents, health promotion etc.

The Agency continues to monitor and assess levels of sulphur dioxide and suspended particulates in the air. Levels continue to comply with World Health Organisation and Ell standards applicable to this type of monitoring.

During the year, the Public Health (Air Quality Limit Values) Rules 2002 were published. These Rules require the assessment of the following pollutants in ambient air - sulphur dioxide, nitrogen dioxide and oxides of nitrogen, particulate matter and lead. A study is being conducted to determine how to best carry out these assessments. It is expected that other pollutants will be added on in the future.

Drinking Water

The quality of the drinking water is controlled by the Public Health (Potable Water) Rules which set out standards and transpose several Ell Directives on this subject.

Drinking water must comply with a series of parameters including:

1. Organoleptic parameters e.g. colour, odour, taste;
2. Physiochemical parameters e.g. pH, conductivity;
3. Parameters concerning substances undesirable in excessive amounts e.g. nitrates, nitrites;
4. Parameters concerning toxic substances e.g. mercury, lead, pesticides;
5. Microbiological parameters e.g. coliforms, faecal streptococci;
6. Minimum required concentration for softened water intended for human consumption e.g. hardness, alkalinity.

Samples are taken throughout the year at different points in the supply chain to ensure standards are maintained. The water quality is very good and during 2002, as in previous years, complied fully with the requirements set in the and EU legislation.

Bathing Waters

The Public Health (Quality of Bathing Water) Rules set down the quality criteria for the bathing waters. Regular samples are taken during the period April to October from pre-determined points at each of the six beaches - Eastern Beach, Catalan Bay, Sandy Bay, Little Bay, Camp Bay and Western Beach. Samples are then analysed for the various microbiological and physiochemical parameters set by the Rules. Results for 2002 followed the now well established trend of beaches on the western side complying with the higher, more rigorous guideline values and those on the eastern side complying with the lower, though still acceptable, mandatory values. All the beaches therefore complied with all mandatory standards.

Food

All premises where food is handled or stored are inspected on a regular basis to ensure adequate standards of cleanliness, precautions against contamination, proper handling and storage conditions and good food hygiene practices.

Similarly all foods imported into Gibraltar are inspected for safety and fitness. Some foods, such as meat, milk, meat products etc, require special documentation on entry certifying their origin, handling, storage and transport conditions.

Infectious Diseases

The Agency works closely with the Health Authority in the investigation and tracing of contacts in cases of infectious diseases. Food poisoning cases are also investigated to try and identify the suspect source and prevent further cases.

HEALTH PROMOTION

As in recent years, the year 2002 has been a very active and busy one for the Health Promotion department. Public presence is very important for its work, but even as press, television, radio and public involvement have made the health promotion section well recognised and supported in the community, demands have increased correspondingly. The delivery of the campaigns, events and initiatives still continues to be shouldered by a single Health Promotion Officer, a situation which is becoming increasingly strained.

The Health Promotion Group which organises and conducts campaigns has continued to meet regularly throughout the year.

Events and Campaigns

The following campaigns have been organised by the Health Promotion Group.

• No Smoking Day, March 2002

The annual No Smoking Day display at the Piazza had to be cancelled due to inclement weather. However, as the thrust of this campaign was shared in many respects by the Coronary Heart Disease prevention campaign due soon, the display was not rescheduled but consolidated with the latter.

• Asthma Awareness Day, May 2002

Gibraltar's second Asthma Awareness Day took place on 11th May 2002 at the Piazza. Members of the department together with staff from Rainbow ward presented visual displays, literature and models on site that helped to explain the concept of asthma as a condition. The locum paediatrician was interviewed on GBC TV and gave an overview on asthma in general. The health promotion officer wrote articles on the topic in the Saturday edition of Gibraltar Chronicle and in the May edition of Insight Magazine, giving a general overview of asthma, offering useful advice and describing the campaign.

The public response on the day was tremendous and the topic appeared to have stimulated a keen interest. Several persons approached the stall with many questions and inquiries. Many of these were from persons who suffer from asthma, which was not unexpected, but the number of children who showed a keen interest in asthma was somewhat of a surprise.

The department wishes to acknowledge with gratitude the transport that was provided by Gibraltar Community Projects, the display boards loaned by the RGP Crime Prevention and Reduction unit and the table kindly loaned by The Piazza Cafe.

• Coronary Heart Disease Awareness Day

Coronary Heart Disease is the biggest killer in Gibraltar and the trend is on the increase. The significant number of deaths particularly in men of middle age in Gibraltar due to heart disease and the existence of opportunities for prevention through public education led to the organisation of an awareness day.

Gibraltar's first Heart Disease Awareness Day took place on 27th May 2002. The health promotion officer and cardiac rehabilitation nurse manned the stall at the piazza, with the senior dietician also available to offer dietary advice. The health promotion officer wrote an article for the Gibraltar Chronicle but was unable to contribute one to Insight magazine owing to incompatible printing schedules.

The public reaction to the campaign was very encouraging and very positive comments were received from persons who had already been affected with heart disease as well as those for whom it could be a potential risk. The Governor of Gibraltar, Mr. David Durie visited the stall and commended the work of the Health Promotion Group. The health promotion officer and cardiac rehabilitation nurse were interviewed on GBC TV about the campaign and the importance of heart disease awareness in Gibraltar. The Gibraltar Chronicle also covered the event. It was generally felt that the campaign had been a success and should continue to appear in future years.

Once again, the department wishes to acknowledge with gratitude the transport that was provided by Gibraltar Community Projects, the display boards loaned by the RGP Crime Prevention and Reduction unit and the table kindly loaned by The Piazza Cafe.

• Sun Awareness Campaign, Summer 2002

Gibraltar's fourth Sun Awareness Campaign beach visits took place on 29th June 2002. This event is always very popular and the campaign team is invariably receive a warm welcome at the beach visits by the general public.

In general the public are aware of the message of sun safety and there is no doubt that the use of sunscreens has become increasingly prevalent. However, it is not clear whether other elements of sun safety such as shade, clothing, etc., receive the same attention. Hence, this year's campaign carried special emphasis that sunscreens alone are not enough. With this in mind, a number of articles were published in the Gibraltar Chronicle and talks presented on the GBC radio Healthfile programme during the two weeks leading up to the campaign. A preview of the event was also screened on GBC Newswatch.

Two new resources were produced to help with the campaign:

- An A5 flyer 'Be Sun wise' featuring the specially designed cartoon character 'Sunny' was distributed in schools to the children before the summer break. The flyer builds on the findings of the Health Promotion Department's "Sun on Skin Study" study last year.
- A re-print of the leaflet "The Sun & You" produced by the Department for distribution to the public at the beaches and elsewhere, with the sub title "Sunscreen Isn't Enough!" There was a minor hitch in that the leaflets arrived from the printers with errors, but this was corrected in a subsequent print run.

During the campaign of beach visits, the team was greatly helped by the participation of the contestants from the Miss Gibraltar pageant, who helped to glamorise sun safe behaviour among young people and offered advice on looking after one's skin. Newall holdings Ltd sponsored tee shirts for the team, displaying the motif 'The Raywatch Team' on the front, which was recognisable to the public as a pun on the famous "Baywatch" TV serial and helped familiarise the message. The shirts also helped the team to present a uniform professional look and promote the team effort, although the tendency of some beauty contestants to utilise the tee shirts more glamorously did not help the message of 'covering up'. Newall Holdings also provided supplies of sunscreens for use during the campaign as well as on-site assistance to demonstrate to people the correct use of sunscreen and safe tanning products.

Regrettably there was no media coverage of the actual events, especially the beach visits. However, photos were taken by the campaign team for future publicity.

The department is grateful to the Miss Gibraltar contestants and Newall Holdings for their contribution. Thanks are also due to the Department of education for distributing the leaflets.

• Gibraltar Health Week

The need has been felt for a long time to organise a public event which would provide a focus for all the numerous health-related activities in Gibraltar and engage the public attention on matters of health throughout the year. A number of combined health events had been organised in 1999 on a modest scale alongside the Essential Services Day and had been an overwhelming success. However, the value of engaging the public mind in important and serious matters of health, but within a relaxed fair-like atmosphere had never before been tested but could potentially be enormous. Such was the thinking that led to the Gibraltar Health Day.

As a number of other health related activities also occurred during this period, the events were extended to form the Gibraltar Health Week. It was decided to organise these events in the last week of September.

A live radio phone-in programme was organised for Gibraltar Health Week with the Health Promotion Officer appearing together with the Clinical Psychologist and responding to questions from the public on mental health issues.

• Gibraltar Health Day

The flagship event of the Week was undoubtedly Gibraltar Health Day. Gibraltar's first ever unified Health Day took place on Saturday, 28th September 2002 at Casemates Square as a large scale open-air public event. Participants and presenters included Gibraltar Health Authority, the Environmental Agency, St. John Ambulance, City Fire Brigade, Education department, Royal Gibraltar Police, Defence services, Diabetes Association, and others There were displays, shows, presentations, distribution of educational materials, interactive displays, demonstrations, opportunities for discussion, etc., building upon on the previously successful models of the Essential Services Day (1999), Child Safety Day (2000), Diabetes Day (2001)

and many others.

A particular and highly popular feature at the event was the Health Check, in which visitors were offered measurement of vital parameters like height, weight, blood pressure, random capillary blood sugar level, assessment of lifestyle risk factors, etc., all of which were recorded on a card, combined into an overall "Risk Score" and given to the visitor with appropriate counselling. Such interaction also provided opportunities for brief but intense health education. General practitioners, nurses, dieticians, members of the health promotion team and school students worked in shifts to meet the public demand. However, as anticipated, the demand for the service outgrew the resources at times with queues developing and the stand remained busy from about 11.30am onwards right up to the close of the event, making it probably the key highlight of the Day.

GBC Radio covered the event through a Roadshow which helped build up the atmosphere to the event tremendously. Talks on GBC Newswatch prior to the event and through the Healthfile slot on GBC radio added to the publicity.

The public response to the campaign was enormously supportive. They also appreciated the opportunities to encounter a wide availability of health information sources.

The complex organisation of the Gibraltar Health Day and Week could not have been possible without a great deal of help and support from staff of the Gibraltar Health Authority who gave freely of their leisure time and the Department remains grateful to them. In addition, thanks must also be given to Ms Jackie Wink (Defence services), student volunteers from the comprehensive schools, Ms Odette Benatar, Mr. Benbrahim Abdelhak and Mr. Stephen Roberts for their services on the day. Last but not least, the contribution of several volunteers, presenters and other enthusiastic members of the public is gratefully acknowledged.

• The GOOD Health Award

Last year's annual report noted that following the demise of the Health Education Authority in the UK and the disestablishment of the Heartbeat Award scheme, the opportunity had been taken in Gibraltar to reinvent the award to suit local circumstances more closely. The new award called the **Good Health Award,** came into being in early 2002 following its launch by the Hon. Minister for Health Dr. B Linares.

The aim of the Award Scheme is to help reduce the incidence of coronary heart disease in Gibraltar by promoting a healthy lifestyle, in which food and environment have a major role to play. Coronary Heart Disease (CHD) is the greatest killer in Gibraltar. It also has the highest death rates for any disease in most of the western world.

The Good Health Award - as the Heartbeat Award before it - is made to catering establishments who offer a positive healthy experience for their customers, judged on the basis of healthy menu choices, healthy dining environments and hygienic food preparation. Aspiring establishments must satisfy three simple criteria:

- They must provide non-smoking areas
- They must offer healthy food choices
- They must practise good standards of food hygiene

The awards are made at three levels, **Gold, Silver and Bronze,** to encourage wider ownership. A certificate is awarded to establishments meeting the required criteria. The awardees receive the right to use the logo for the period of one year in all publicity and to display their certificate during the same period.

The first presentation of the GOOD Health Award took place at the Environmental Health Agency on Friday 5th July 2002 when nine establishments received their certificates from the Director of Public Health and the Minister for Heath. The Awardees were:

GOLD AWARD

The Rock Hotel

Airside Services

SILVER AWARD

Little Rock Cafe

Bunters restaurant

Kowloon chinese restaurant

Carpenters Arms

John Mackintosh Hall Canteen

Paradiso

The Clipper

It is gratifying to see such a high standard and it is hoped that wider publicity will encourage more caterers to join in the initiative.

The department is grateful to GBC TV for covering the event at very short notice.

Health Pack for Nurseries and Playgroups

As anticipated in last year's Report, the Health Pack for Nurseries and Playgroups was formally released in July 2002 at a launch ceremony held at the John Mackintosh Hall in the presence of representatives from several nurseries and playgroups and was distributed to them.

The idea behind this project is to provide a suitable source of health information for Nursery and Day Care personnel that is simple and understandable. It is also a source of information that lends itself to sharing with parents and other carers. The pack provides basic information on various health topics and presents additional detail on the most common. The Pack has been greatly welcomed.

Healthy Eating

Unhealthy fare regularly dispensed to children by school tuck shops still remains an area of concern. The Health Promotion Officer and the Dietician are currently reviewing the eating habits of the local population and this, it is anticipated, will provide the basis for a future Healthy Eating Campaign.

Working with other agencies

Education and Training

The department is a regular contributor to the Nursing School faculty on topics relevant to health promotion. This commitment includes lectures, presentation, facilitation of workshops, etc., at the School of Health Studies.

The Health Promotion Officer also works closely with the Senior Education Advisor in developing resources to support the personal, social and health education curricula in schools. There are ongoing joint efforts to compile a health briefing and resource pack for students leaving for overseas studies, which is expected to be launched this year. The department is also involved in producing resources for use with schoolchildren such as leaflets. The department also contributes to the continuing education of teachers through workshops on health. Finally, it is planned to develop a Healthy School Award scheme.

Networking

The Health Promotion Officer made a significant contribution to the early development of the cardiac rehabilitation programme, which is now running successfully on a regular basis. As part of good networking practice, contributions have also been made to the programmes organised by the Sports Development Unit and special interest groups of the defence services.

Mass media

Broadcast media

The department maintains a regular presence at the "HealthFile" programme on Radio Gibraltar. Health File is a component of Radio Gibraltar's "Focus at lunchtime" magazine programme with pre-recorded interviews on contemporary topics, which is used to raise public awareness on a variety of health related issues and publicise forthcoming campaigns and health promotion Events.

Topical contributions to GBC television programmes have been noted elsewhere.

Health Promotion Group Web site

The Internet is a growing source of information for many people. The Health Promotion Department is currently constructing an Internet website aimed at providing a friendly and enjoyable resource on health issues and health information for the public. Initial planning and outline design has been completed and programming work has commenced. It is expected that the website will be launched sometime in autumn 2003.

Leaflets and other resources

A key work of the department is to provide mass education on important health topics through leaflets, posters and other public education materials. The Health Promotion Officer regularly tours various sections of the health service to determine needs and restock resources used by health professionals in their everyday practice. The department also maintains a resource list of information packs, videos, training materials, etc., which are available on loan to sections of the health services, education

department and youth services.

There is a huge demand in this area, which the department is barely able to address, let alone satisfy. Part of the difficulty is that the department is only resourced for public education which focuses on the primary prevention of disease and promotion of positive health, as applicable to all persons in general. It is not resourced to cover the very substantial area of patient education, which deals with resources and support for individual persons suffering from particular diseases. In practice, the distinction is often subtle and the inability of the department to stretch itself into meeting demand in such areas often causes disappointment and frustration among health professionals.

Future projects

The department continues to maintain a full calendar of events on an annual cyclical basis and these will continue in future months. There are also, as reported earlier, a number of ongoing projects and initiatives which will be completed in the coming year. In addition to these, the department is planning a number of new ventures and campaigns. Some of these are:

- Health Pack for Primary and Secondary Schools
- Health Packs for students studying abroad.
- Healthy Eating campaign.
- Posters for Bus Shelters on health topics.
- Babysitting training for teenagers and young adults.

Part 2

Report of the Health Services

New General Practitioner, Dr. Risso

PRIMARY CARE SERVICES

The year 2002 was a period of relatively rapid development in some areas in Primary Care, though much more radical changes undoubtedly lie ahead of us in the immediate future.

Re-registration of resident patients and associated full computerisation of the Primary Care Services were under active consideration in 2002. The extreme difficulties of finding a proprietary system which will integrate both Primary and Secondary systems has caused much delay. Multiple demonstrations of the various General Practice systems were arranged and a follow up visit to practices in the UK were made to assess one system in particular. However no one system meets all of the GHA requirements and since an integrated architecture is of prime importance, choice of systems remains problematic. A high level GHA IT Strategy Group was set up to deal with these issues in an organised way. Individual general practitioners and nurse practitioners continue to use their own clinical IT systems to good effect. We now have the services of the GHA IT Manager appointed in 2002.

Meetings were set up by the Primary Care management with the Senior Citizens Association and the Moroccan Workers' Association. These meetings will continue and be expanded to take in other representative groups. In this way it is hoped to develop a clearer idea of any defects in the primary care service.

A constant complaint from most groups has been the difficulty in getting through by 'phone to the Primary Care Centre. This has been addressed and the system is somewhat better. At any time there is now one member of the clerical team on telephone duty, sometimes two and occasionally three. However, until a computerised appointment system is in place, appointments will remain a problem area. Other small but important developments are the improved sign posting in the Primary Care Centre and the purchase of large Health promotion Notice Boards for each waiting area.

Primary Care Centre

Development and expansion of primary health care services at the Primary Care Centre continued during the past year.

The **Immunisation & School Health Service** were relocated to new units acquired by the GHA. They now have their own waiting area as well as a child play area that was kindly donated by the RHOB. This new area also houses the new paediatric therapy room, visiting consultants' clinics, dietician's clinic and an extension of the occupational therapy department. The vacated clinic area has now been taken up by the Consultant Paediatrician and by Dr Vassallo.

Access to a full **radiology** service as well as access for general practitioners to refer patients for echocardiography has increased patient satisfaction and reduced patient waiting time.

Following the intake of new **general practitioners** in 2002 to 15, the Authority will further be increasing the number in 2003 to 16. This should reduce waiting times for patients to see a doctor and allow more time for consultations.

The dental department appointed a new Dental Officer who started working in a new surgery that was completed in 2002. This appointment has improved the services provided but unfortunately waiting lists continue to grow and an appointment of a fifth Dental Officer will certainly help cut down waiting time.

The Authority appointed a locum consultant **dermatologist** who comes in monthly and is currently working at the Primary Care Centre. This appointment has cut down waiting time and referrals by doctors get processed faster.

Late in 2002, the Elderly Care Agency piloted a Domiciliary Care scheme to provide basic home care on a regular basis for elderly people, who are identified by General Practitioners (and others) to have inadequate social support and have difficulty with everyday tasks.

General Practitioner Service

The backbone of the primary care service continues to be the general practitioner clinic service. Despite the increasing team element in primary care (including dentistry, nursing, physiotherapy, occupational therapy, psychology, counselling, optometry, orthoptics, prescriptions advice, mental welfare, well woman services, child welfare, immunisation, etc.), the majority of people coming to the Primary Care Centre are still coming to see a general practitioner and the vast majority of contacts between patients and the health service take place between general practitioners and their patients. The general practitioners continue in their generalist role providing a holistic personal service both in the Primary Care Centre and at patients' homes. The trend towards special interest clinics continues with the new Diabetes Review clinics involving 2 or 3 general practitioners and will probably become more important in the future. This year, the General Practitioner complement increased from 13 to 15. The increased resource allowed the setting up of a second "emergency" clinic to deal with casual attenders with illness of recent onset. Prior to this move, the single Duty doctor was invariably overloaded, but now emergency clinic numbers have levelled out.

Note that from October 2001 to January 2002 the Average "Emergency" Clinic Size was 27 patients. In the same period the following winter the average number fell to 24.7 for the First on Call "Emergency" General Practitioner and 22.5 for the second on call. Apart from the reduction in clinic size the flattening out of fluctuations in "emergency clinic size" is evident from the graphs.

The maximum size of each routine general practitioner clinic was reduced by three patients - subject to demand on any particular day allowing. This has given the doctors greater opportunity to practice better quality medicine. The arrival of the sixteenth General Practitioner in 2003 will be accompanied by other changes in service arrangements.

The General Practitioners have had direct access to echocardiography since March 2002. This was carefully initiated and is being monitored, with the outcomes subject to audit. In the first nine months, 80 echocardiograms were arranged. Apart from the other benefits, this has reduced the referral burden on hospital services by the equivalent of nearly 20 clinics.

Various Risk Management steps have been taken, such as notification by Fax of urgent X-ray results, checking by colleagues of laboratory and radiological results when a General Practitioner is away, recording of house call visit details in the Primary Care Centre notes, the organised and rapid filing away of results and letters and the installation of a dedicated phone line for use in Major Public Emergency situations. Some of these developments have been in response to critical incident analysis i.e. responses to adverse events to prevent repetition of those events.

Continuing Medical Education (CME) and Professional Development are becoming more important then ever. Following discussions with secondary care colleagues, and in co-operation with them, a medical education Programme has been set up which now provides a fortnightly Medical Meeting for all medical, senior nursing and allied health professions staff. This meeting is within working hours and so far has been a great success with presentations on a range of medical issues attended by between 30 and 70 members of staff. It is meant to be permanent and is expected to develop considerably. The need for structured Continuing Professional Development (CPD) in Medicine is so important and the field of Medical Knowledge so large and growing so quickly that an entire CPD session i.e. one morning or afternoon per week will be required by each practitioner. This issue will be examined by the Clinical Governance Development Team and is central to the current ideas on organised Appraisal and Revalidation of all Medical Practitioners. Apart from these, general practitioners continued to go to the UK for study sessions . Four attended week long refresher courses. Two general practitioners are engaged in distance learning post graduate courses, one in therapeutics and one on diabetes.

The School of Health Studies Library is now providing a Journal service. General Practitioners are routinely sent a copy of the contents pages of medical journals of interest to them and are able to send for any article that they wish to read. These articles are then printed and sent to the General Practitioner by the Library. This is a tremendously useful service which has been take up with enthusiasm by General Practitioners. The Primary Care Centre also now has an electronic link with the School of Health Studies through which, internet access (including full text access) to a range of medical journals is available to all staff.

A collaboration group of general practitioners and hospital consultants was set up early in 2002 and has met at intervals since. The Hospital Medical Director and the Primary Care Co-ordinator are in regular contact. Professional development sessions described above have been the main outcome of these contacts. Communications and relationships between the two sectors improved in 2002 but are still a little problematic at times. In early 2002 Senior House Officers were given a presentation on the Primary Care Centre and existing services by the Primary Care Co-ordinator as a part of their induction programme. Late in 2002 the Primary Care Centre acquired the services of a Spanish Dermatologist who has a monthly clinic based at the Primary Care Centre.

Nurse Practitioner service

As a new initiative by the GHA, in July 2002 the first Nurse Practitioner specialising in General Practice was appointed. The role encompasses providing nursing services to the practice population, including health promotion, chronic disease management, screening, treatment, establishing audit/quality assurance programmes, possible future research and participation in the development of educational strategies and the implementation of programmes.

In October 2002 the first formal weekly **diabetes annual review clinic** was introduced, a multidisciplinary, one-stop, detailed review and advice session for persons with diabetes, staffed by one of three general practitioners, the Nurse Practitioner, Clinic Nurse, Dietician and the Optometrist. A diabetes register has been initiated and there are ongoing audits both from a clinical perspective and the patient's perspective. The venture has been successful and eventually it is anticipated that most, if not all, diabetic patients will pass through the clinic at least once a year.

A similar clinic for Asthmatics is now being set up, to be staffed by the Consultant Paediatrician, a General Practitioner with a special interest in Asthma

and a Nurse Practitioner and will offer people with asthma intensive and on-going assessment and advice on treatment and general management. It will also offer skin testing for allergy.

Also in October 2002 a twice-weekly **cytology clinic** was introduced. A recall system was introduced so that all ladies are notified of their results and informed when their smear is next due. This ascertains proper follow-up for those who are seen more frequently due to abnormalities. A quality assurance programme of smears has also been initiated and a Cancer Disease Register.

A **cryosurgery** clinic is held every week and Emergency Nurse Practitioner clinics are held daily. A **minor injury/ailment clinic** has been established. Other progress involves preparation of a **handbook** on health for students going abroad, support in the education of Diploma Nursing students, close work with Health Promotion and formulating strategies for working with young people to raise awareness of health issues.

This is just the beginning, but the progress has been very encouraging and in March 2003 a further Nurse Practitioner joined the Primary Care Centre. Both are extremely able, exceptionally well trained and very well motivated individuals with different and complementary range of special interests.

Quite clearly this an area of nursing practice that is here to stay and will develop to the great advantage of the community. The Nurse Practitioners are not just junior General Practitioners. They have a training background and an outlook which is quite different to that of a General Practitioner. This offers a new level of service; not just a General Practitioner support service. The Authority is now planning the training of local nurses as Nurse Practitioners to ensure continuity and consolidation of the current service.

Health Visiting Service

A new initiative last year was the start of health visitor-run developmental clinics for children of eight and fifteen months as well as the existing clinics for children of 3+ years.

The service is run one by qualified health visitor, one registered nurse and one enrolled nurse. It provides advice and support to the parents of all children between the ages of 0-5 years and offers facilities to weigh and measure the children to help assess developmental milestones.

The Health Visiting Service is also involved in audiology clinics and post-natal reviews on all newly delivered women. The health visitor sets up all clinics for the consultant paediatrician within the department, providing an ongoing link between patients and the paediatrician.

The staff enjoy close working liaison with relevant hospital wards and departments as well as with the Social Services Agency. A member of staff is currently in training as a Health Visitor and is expected to commence work in September 2003. Clerical support continues to be in short supply .

Optometry

The Optometric Service is a recent addition to the GHA Ophthalmic Service, commencing in October 2002, with the appointment of a part time Optometrist. The Optometrist's role consists of providing general eye examinations for children and adults. As defined by the WHO "Optometrists are the Primary Healthcare Practitioners of the eye and visual system, who provide comprehensive eye and vision care. This includes refraction (i.e. testing for spectacles), detection diagnosis and management of diseases of the eye and visual system (including referral to the ophthalmologist for treatment), and the rehabilitation of conditions of the visual system. Another important role is to provide screening of common eye diseases and referral to the Ophthalmologist for treatment may prevent future blindness in these groups.

The following optometry clinics have been set up:

1. Children's clinic – for children referred mostly by the orthoptist and sometimes by general practitioners.
2. Two adult clinics – for adults referred by general practitioners for spectacles and eye disease screening.
3. Annual diabetic retinopathy screening clinic – to provide annual eye checks for the detection of sight threatening and preventable changes to the retina that may occur in people with diabetes.

All these clinics are currently held at the Primary Care Centre, and have contributed to a considerable reduction in the patient's waiting time to see the ophthalmologist, as well as alleviating the workload of the hard pressed ophthalmology clinics.

The new service is already under considerable pressure and it is planned to extend the services of the current optometrist on a full-time basis.

Mental Welfare Services

The two Mental Welfare Officers (also called Psychiatric Social Workers) provide a link between the clinical and legal aspects of mental problems within our society. Patients with mental health problems sometimes might not be able to decide for themselves the most appropriate course of action for their illness, which may include professional intervention. This situation can have legal implications and is the province of the Mental Welfare Officers. Unlike in the UK, Mental Welfare Officers are only recruited from the staff nurse grade and this clinical background gives them an added advantage not always found in Approved Social Workers elsewhere. The essential responsibilities of these officers is to see that the Mental Health Ordinance 1968 is complied with during involuntary admissions of patients and to act in a Social Worker capacity in relation to psychiatric patients.

This section continues to provide assessment, treatment and support to clients in several locations including hospital, clinics and the community. There is close liaison with other agencies, teams, organisations and members of the multidisciplinary Mental Health Team. Its main aims are to arrange for services to meet client needs efficiently and to help clients to live independently in their own homes for as long as possible so as to help prevent social problems and reduce distress.

The workload of the Community Services continues to increase and it is hoped that in time, expansion of the service would be feasible. The section wishes to record its gratitude to the Mental Welfare Society and the many charitable friends for their contribution to the service.

Children's Speech and Language Service

Government nurseries are visited each term to discuss programmes and carry out observational assessments. The rolling programme of auditing has covered nursery input this year.

The system of outpatient appointments at the Primary Care Centre has been changed with appointments for new patients, reviews and regular clients given on different days. This provides for more efficient use of time and allows for better forward planning for patients.

Demand for training in the use of the Makaton Vocabulary remains high. The therapist having completed training as a Makaton tutor, it will be possible to offer accredited courses locally and the first two-day course was held in one of the Government Nurseries in November. An induction pack has been prepared to inform staff of the services on offer and how to make referrals.

Secondary Care Services

The Community Mental Health team

SECONDARY CARE SERVICES

Obstetrics

During the year since the last report, the obstetrics department has consolidated the improvements introduced during the year up to June 2002, and discussed in the last annual report. Public opinions and clinical audit have formed a foundation for shaping the service and its future development. In particular, home booking visits have been very popular. The service has now been extended to accommodate more home visits to women who are in the latter part of pregnancy, when it is more difficult to make the trip up to the antenatal clinic.

All new pregnancy data is now being computerised. This will promote access to records and facilitate statistical analysis. Pregnancy record books have also been re-designed in line with modern record keeping. All members of the staff are encouraged to keep detailed notes of clinical events during pregnancy. While the overall approach is to assist natural childbirth, there is a complementary need for more observations and tests to detect and avoid problems at an earlier stage.

The induction of labour protocol introduced 16 months ago is now working well, with fewer women requiring assisted delivery or Caesarean section. However, although the overall the number of assisted vaginal deliveries has fallen, the number of women choosing to have a Caesarean sections has increased. This phenomenon is in line with statistics in the UK and USA, and results from the greater degree of control women now have and wish to have in the management of their pregnancies. As discussed in the previous annual report, the medical staff discuss management options in detail with parents, helping them to make the choice that is correct for them. This has led to more women choosing a Caesarean section rather than proceeding with a potentially difficult delivery, due to physical factors (such as cephalo-pelvic disproportion) or previous experience (such as a traumatic vaginal delivery).

Gynaecology

In the last annual report the new gynaecology services introduced by the GHA were described. Unfortunately, this has led to a flood of patients requiring treatment that was not previously available. Despite efforts to meet this demand, the backlog of cases has proved difficult to accommodate and the waiting time for specialist surgery has increased. However, it is important to note that this delay is still far shorter than seen in most District General Hospitals within the UK. More operating time has been allocated for gynaecological surgery, and this is expected to increase again when the new hospital is commissioned.

The 'one stop' approach to treatment in the gynaecology clinic has proved very popular. Consequently, the service has been extended to include minor surgery under local anaesthetic. At present, on average, about 50 minor procedures are performed each month in the gynaecology outpatients department.

The Urogynaecology service has been well received by both patients and staff. In conjunction with the X-ray department, patients now receive a quality of investigation and assessment that many UK hospitals cannot provide. The range of incontinence surgery offered at St Bernard's is equivalent to that seen in the best UK hospitals and is constantly updated. Recently, equipment has been purchased to perform injection of bulk forming agent (macroplastique) around the bladder neck. This procedure may be used as an adjunct to bladder neck surgery, and also in patients suffering from stress incontinence and urgency who are unfit for surgery.

Child Health

In September 2002, Dr Sam Benady retired as Consultant Paediatrician at St Bernard's Hospital. For 22 years his name has been synonymous with paediatric care to the community. He was responsible for establishing the Paediatrics department and maintaining a high standard of Paediatrics, of which the hospital is proud. Throughout this time he has managed all aspects of paediatrics (wards, new-borns and primary care) single –handed. He takes with him gratitude from the children of Gibraltar spanning two generations.

Dr Steve Higgs, a paediatrician from Cape Town (South Africa) and latterly the Royal Naval Hospital, has been appointed consultant paediatrician from February 2003.

The Department continued to be busy throughout 2002, borne out by the figures in tables.

Once again Rainbow Ward, the Maternity Unit and the Primary Care Centre have been fortunate in having excellent teams of nursing staff whose dedication, hard work and expertise are much appreciated.

In 2003 the Health for all Children 4 programme (which has been adopted in the UK for Primary Health) will be implemented, blending developmental assessments (by the paediatrician, trained health care nursing staff and a general practitioner), hearing screening in the new-born period, and the immunisation schedule.

Also in 2003 a combined asthma clinic will be established in the Primary Care Centre with the paediatrician and a general practitioner to offer a more comprehensive and continuous service to patients.

Anaesthesia

The department has been fairly stable over the last year. There was quite an amount of involvement of the two anaesthetists in the planning and equipping of the theatre suite for the new hospital. Educational seminars were held on the care of ventilated patients, and recently on patient controlled analgesia. The clinical commitment of both anaesthetists makes it difficult to run more educational programs, but with the employment of the third anaesthetist in the early summer of 2003, this may well increase and it may also be possible to run an epidural service for the Labour Ward.

The work done by anaesthetists in **theatre** in relation to operations has not changed much over the last year. In fact while the number of anaesthetic procedures dropped from 2137 (2001) to 2044 (2002), the time spent in theatre appears to have increased, from a review of overtime sheets returned by the theatre staff. No major items of equipment were obtained this year, as anaesthetic and monitoring equipment are of an excellent standard and are well maintained.

The number of patients going through the **Intensive Care (High Dependency) Unit** for anaesthetic / surgical reasons has been very stable in comparison with previous years, being about 60 in all. However, this does not include the numbers admitted for acute medical reasons, which on the whole tend to be in much greater numbers.

The relatively new **Pain Relief** service has had its ups and downs. New offices were finally made available in the summer of 2002, although these offices are shared with the elderology service with the result that the clinic setup does not suit the pain clinic very well. Around 728 patients were seen during this year, shared between the two anaesthetists. The vast majority of these patients were referred by general practitioners, being predominantly cases of spinal disc herniation and a few acute sympathetic dystrophies. Waiting times to see either consultant has been on average about 1 week and urgent cases (requiring epidural injections or X-Rays) have been accommodated in 2 - 5 days.

Operating Theatres

During 2002, a total 2336 operations were performed, representing a slight decrease from last year, the two most notable specialities influencing this being Orthopaedics and dental surgery.

With the appointment of Mr Edgar as visiting spinal surgeon, a number of major complex spinal operations are now carried out locally, but this has the drawback of reducing the theatre time available for orthopaedic operations overall. The main factors affecting dental surgery are cancellation of lists due to visiting consultants and also due to a large number of patients not attending for surgery.

The Patient Transfer Trolley System which was introduced last year, will have a beneficial impact on the control of infection within the Operating Theatre. With the acquired space outside the theatre designated as the transfer area, it is now possible to transfer patients from one trolley to another, avoiding the outside trolley from having to enter the theatre.

Trials of peri-operative visiting by the Theatre nursing team were commenced with a view to implementing this advance in the near future. A redesign of current nursing care plans specific to patients in transit through the operating theatre has also been considered and will be used in conjunction with peri-operative visiting. Both these schemes will allow the theatre nurses to contribute more actively to the delivery of care to surgical patients.

Orthopaedic and Trauma Surgery

The nature of the speciality of Orthopaedics and Trauma surgery is such that it deals with conditions which occur in both sexes and in all age groups right from birth to final years of life. Regular follow up of patients in the special clinics is regarded an important way of monitoring the out-come after major surgery on hip and knee joints, spinal conditions, complex fractures, congenital deformities in children and some other rare conditions.

During the year 2002, over 3350 patients were dealt with in the out-patient clinic. The re-location of the Orthopaedic and Trauma clinic and provision of an extra examination room helped a great deal in coping with the demand on the service. This has helped the staff to devote attention to the patient's problems without the pressure of a colleague waiting to examine another patient, reduced the waiting time, allowed more privacy and eased the stress on the attending doctor.

In order to reduce the waiting time for general orthopaedic out-patient referrals, all the referral letters are classified according to the condition. Necessary investigations are arranged before the appointment date which in turn helps to make the decision at first visit and avoids further visits to clinic prior to surgery. Examination of spinal complaints take more clinical time. It is intended to set up a separate spinal clinic supported by a physiotherapist. This will help in reducing the waiting list for other general orthopaedic problems and generate team effort in care of back pain complaints.

In year 2002 an increase in lower back conditions was noted. After a thorough work up and following failure of preliminary treatment they were presented to the visiting spinal surgeon Mr. M. A. Edgar in the combined clinic. It was decided that the majority (90 %) of these patients would benefit from major spinal

surgery, the majority of which were carried out by the local team and a few in collaboration with the visiting spinal surgeon. Some patients who had been operated upon in Spain or the United kingdom with unsatisfactory outcome underwent repeat surgery here with good result and return to gainful living. This was made possible by the provision of specialised implants, supply of instrumentation, training of theatre staff and addition of skills. In addition to avoiding the inconvenience of travel or longer waits, patients have received more frequent and comprehensive after care by local staff.

Another visiting specialist, a paediatric orthopaedic surgeon from Great Ormond Street has provided a combined clinic every year, Mr. John Fixsen doing so for eleven years and Mr. David Jones in the last two, allowing for some rare paediatric conditions to be operated upon here. This has proved very convenient for children and parents. Such cases need prolonged post-operative care, which has been possible due to the involvement of the local team.

Audit of the 10 to 12 year follow ups of knee and hip joint replacements carried out locally reveals that there is no infection or loosening of the joints. In particular, primary hip replacements using Hydroxy Apatite Coated (HAC) Furlong hip have shown solid incorporation in the bone. There is a high degree of stress on these artificial joints in the local population, because of the number of flights of stairs or slopy terrain most of the patients have to cope with during their day to day activity. There is little published literature to show the outcome of such stress on these joints and therefore the good results of these artificial joints in the local population is encouraging.

Eleven year results of non-cemented HSC coated hip are also very encouraging. Each patient is monitored clinically as well as by specific follow-up X-rays. This procedure has almost eliminated the long term problem of loosening of artificial hip and thus the need for revision surgery. Therefore, the deterioration of joint function, risks of an additional major operation and demand on operating time are also almost eliminated. As a result of this outcome, a number of very young patients who warranted hip replacement have been operated upon during this year.

Major joint replacements continue to be affected by availability of beds which is influenced by prolonged stays of female patients and the unpredictability of trauma. With the co-operation of operating theatre staff, several major planned operations were carried out over a number of week ends, which has helped in reducing the waiting list and enabled more major joint replacements and spinal surgery work during the week days. Provision of extra-operating theatres in the new hospital complex will enable further reduction of the waiting list by the introduction of a separate trauma list.

There was also continued development in techniques for less frequent skeletal conditions. During this year newer procedures such as Polaris IM Nail for non-union of humeral (upper arm) fracture, Neer 11 Joint replacement for shoulder joint fracture, Pedicular screw & rod fixation for spinal stabilisation, and Peek cages & Pedicular system for Posterior Lumbar Inter-vertebral fusion were introduced.

The consultant attends international courses and conferences regularly and junior staff are also provided opportunities to attend courses relevant to provision of service locally. During these visits, interaction with other surgeons, keeping abreast with new developments and observing the work of other colleagues is invaluable in delivering the best care to the patients. Prior to introduction of newer procedures, hands-on workshops are held for the theatre staff, providing insight on the instrumentation and technique to the whole team.

Staff have been following guidelines of care set out for all major joint replacements and other major surgery at the time of introduction of each new operation. All guideline are being revised and a more comprehensive documentation in print is being prepared. A care pathway of each condition is being developed. Regular departmental audit takes place informally case by case and issues that arise are discussed. These audits are expected to become more regular and formal, depending upon available clinical time.

The department is most grateful to the radiology staff who provide an unfailing service for acute trauma surgery, major spinal surgery and follow up of trauma and major joint replacements. The skills, dedication, attention to detail and stringent sterilisation procedures exercised by the theatre staff has been a key in achieving zero infection rate. Their support has also helped in organising visits of super-specialists from United Kingdom to operate on patients locally, an initiative that provides the best care to the patients and at the same time adds to the skills of the staff through in-service training.

Ophthalmology

There was significant progress in the development of the ophthalmic service during this year with the appointment of a part-time **optometrist**, considerably relieving the workload of the consultant ophthalmologist. The out-patient waiting time has come down from 6 months to nearly 6 weeks at present. There are three optometry clinics and a systematic diabetic retinopathy screening programme has been established for the first time. This service is running successfully in conjunction with general practitioners. However, at the same time, the workload of the optometrist has risen steadily and the waiting time for optometry consultation has

increased to three months at present. Further optometry services such as low visual aid clinics, glaucoma screening programmes, etc., are planned for the future when the optometrist is available on a full time basis. The role of the optometrist is described further in the section on Primary Care.

A retinal camera, which had been overdue for several years was purchased recently and will be available for use once assembled. It is planned to use the camera for several applications such as invasive retinal vascular investigation, fundus photography, diabetic retinopathy screening and glaucoma evaluation.

Overall, the workload has been heavy as usual. The ophthalmology department held 147 outpatient clinics in 2002, during which an estimated total of 3675 outpatients and 535 casualties were seen. A total of 145 ophthalmic laser procedures, 135 major ophthalmic procedures and 43 minor procedures were performed. The statistics for tertiary referrals were not available.

The waiting time for cataract surgery is unaltered at about 12 months, but priority is always given to patients with very poor vision. In order to perform more surgery, substantial improvement in the infrastructure and staffing levels is necessary. The new hospital should provide more facilities.

The clinical governance involvement for re-shaping the existing ophthalmic service is welcome.

Orthoptics

The **orthoptist** post was made full time this year providing opportunity for more clinical involvement of the orthoptist in ophthalmic work. Two extra orthoptist sessions are being used to carry out pre-operative assessment and in the future, a glaucoma screening service is planned.

The orthoptist is involved in diagnosing problems of binocular vision and eye movement disorders such as **squint** (which may cause double vision in adults and children), and **'lazy eye'** (which occurs during childhood and must be treated before the age of 7 years whilst the visual pathways are still developing). It is important to pick up these abnormalities early in childhood and one of the ways in which this is done is through the 4 – 5 year vision screening programme in which parents are invited to attend with their child for a vision screening assessment.

The Orthoptist's role is however much more extensive and includes diverse responsibilities. One of these is biometry, which involves measuring the eye before a cataract operation, to enable the ophthalmic surgeon to decide on the strength of the intra-ocular lens each particular patient requires. Another is the follow up of glaucoma patients by performing their visual field analysis and measuring their intra-ocular pressure in the ophthalmology clinics.

Elderology

Over the year, slow progress has been made in developing Elderology Services within the Health Authority. The refurbishment of the Mount Alvernia Home proceeds apace, a Domiciliary Care service has been started and a Meals-on-Wheels service will hopefully start during 2003.

In-patient care for acute admissions to hospital continues, as do regular formal review of all long-stay patients and outpatient clinics, including the Joint Memory Clinic.

Plans for an inpatient Stroke and Rehabilitation Unit, which was to have started on Lady Begg Ward, have been deferred until the new hospital opens. It is hoped that proposals for an Elderology Day Hospital Unit at which elderly people can be assessed by a multidisciplinary team of doctors, nurses, physiotherapists, occupational therapists, dieticians, speech and language therapists and social workers, and then treated on a day attendance basis of once to twice a week without the need for overnight hospitalisation, will be approved and started in 2003.

An audit of those at risk of falling has started among residents at Mount Alvernia and those at high risk will be assessed at a new "Falls Clinic" which is under discussion and will extend its emit to the community when this audit is completed.

Palliative Care

There was a small increase in the number of new referrals for palliative care in the year 2002. This is probably due to a greater awareness of palliative care as a discipline and a subsequent improvement in the communication between health carers in this field. This obviously benefits the patients as more disciplines contribute to their care. A consequence of this success is a heavier workload and the number of hours designated to the palliative care nurse post has increased from 20 to 30 hours a week.

Symptom control, family support and discharge planning remain the main goals of the hospital-based component of the role. Home visits are made at the request of the hospital consultants and some general practitioners. The district nurses are assisted in the community by the Gibraltar Society for Cancer Relief funded hospice-at-home service. Such work is sporadic by nature and it is difficult to recruit and retain staff. An increase in the number of hospice-at-home nurses would help to keep patients who so wish to stay at home in the peace and dignity of their own surroundings.

Two reclining armchairs with integral footstools and two airwave mattresses with airwave cushions were purchased to enhance patient comfort and prevent pressure sore development. This equipment was

funded by the GSCR.

To further enhance palliative care in the hospital a staff nurse was sent to the Royal Marsden for an update on wound care from a palliative care perspective. The palliative care nurse attended a palliative care conference at the Royal Marsden in February. Attendance on both occasions was funded by the GSCR.

Clinical Psychology

The clinical psychology department continues to offer psychological assessment, treatment, consultation, community and in-service education, supervision, and research. Clinics in the Primary Care Centre and at KGV Hospital continue to be well attended. First appointments are usually made within six weeks of receipt of the referral. Referrers and the public appear to have understood that the department cannot offer crisis intervention.

A number of people continue to be referred to the department for counselling. After assessment, they are seen by appropriate volunteer counsellors at the Primary Care Centre under the supervision of the consultant clinical psychologist. The department wishes to express its continuing appreciation to these counsellors for their excellent work.

The department has continued to contribute to in-service training programmes and nurse education programmes at Bleak House.

Support Services

Optometrist at the Primary Care Centre

SUPPORT SERVICES

Laboratory services

The number of tests performed by the laboratory diagnostic services continues to increase significantly. The total number of tests carried out by the Biochemistry section alone rose from 221,953 (2001) to 265,216 (2002), a rise of 20.3%. When compared with the 141,591 tests in 1997, this represents an increase of 87.3% in 6 years! Requests for Thyroid Function Tests rose from 5,075 (2001) to 6,547 (2002) a rise of 29.0%. Again, when compared with 2,586 tests (1997) this is a rise of 153.2%

In July, the Biochemistry section received a Tosoh Autoimmune Analyser, which samples directly from primary tubes and allows full automation for hormone and tumour marker tests. It also made possible the introduction of new assays such as Vitamin B12 and Folate, which had previously to be forwarded to other centres. Testing for Troponin-I, a marker of myocardial damage that is more specific and sensitive than Creatine Kinase, was also commenced.

A new Lithium Analyser was obtained to take over from the ageing Nova 11, but this analyser is also capable of determining sodium and potassium levels and is used to check abnormal results before reporting.

Following the appointment of the Nurse Practitioner in July 2002, the taking of samples for cervical cytology and follow up has been enhanced, records of all cervical smears are now being kept on computer making recall procedures more efficient. Her work has done much to enhance the efficiency of the cervical cytology screening program.

In October, the department was strengthened by an additional MLSO, state registered in Histopathology, the first extra member of staff to be employed in the laboratory since 1981. Also towards the latter part of the year, two supply clerks replaced a staff leaver and have been of great help in reducing the backlog of report filing.

Three senior MLSOs attended courses in the UK covering topics that included Laboratory Modernisation, use of HPLC equipment, Blood Transfusion and Advanced Cytology. In addition, two other MLSOs received training on the use of the AIA-21 Analyser and one attended an Autoimmunity Update course. These last courses were sponsored by the manufacturer.

During 2002, there had been considerable discussion between pathology staff and information technologists on different computerised pathology systems.

Computerisation will also help to start a full-fledged cervical screening programme. At the moment majority of components required for such a cervical screening programme are already in place but without the crucial co-ordination.

The new processing and automated staining machine in the new hospital will greatly benefit Histology. It is important that slides are of required standard because the oncological material generated by the laboratory are invariably reviewed by the histology department of the hospital that treats the patients, most commonly the Royal Marsden Hospital in London.

In the near future it will becoming increasingly necessary to introduce at least basic immunostains. Nowadays histopathology cannot properly function without immunistain confirmation. Cytokeratin (epithelial marker), LCA (Leukocyte Common Antigen), HMB45 (melanoma marker) and BCL-2 (which can differentiate between reactive hyperplasia and follicular lymphoma) have to be considered in first instance.

The terrorist scares brought into focus the lack of PCR (Polymerase chain reaction) assays locally and it is anticipated that equipment will be bought capable of detecting very tiny amounts or viral or bacterial DNA. This will enhance the repertoire of tests available to microbiology and haematology.

The new coagulation analyser due in 2003 should make it possible to carry out thrombophilia screen tests (about 15 different tests) with the exception of three tests that are based on genetic studies. It is envisaged that in the new hospital the laboratory will be able to produce its own fresh plasma.

Radiology

Progress in technology and techniques have made even greater demands on the radiology department this year and it is becoming increasingly difficult to meet the demands on the service. However as always the staff, radiographers, clerks and darkroom technician, are committed and strive to maintain the efficient and effective service the department has given in the past.

It is of note that the obstetric ultrasound service undertaken by the sonographers is more comprehensive. In addition, although there is no formal breast screening programme, it appears that women who visit the well woman service are being routinely offered mammography and bone densitometry scans which are organised through this department. This coupled with the twofold increase, (table) over the last two years, in referrals for CT and MRI scans has had a major impact on the clerical workload.

An opportunity for a training course in the UK was missed due to staff illness but where possible local courses were attended. This included a study day on ethical issues organised by the school of health studies, a diabetic study and an update on manual handling. A lecture was delivered to the student

nurses on radiology preparation and procedures.

In accordance with EU directives, employers' procedures for the protection of patients have been produced, documented and circulated.

Physiotherapy

A clerical post was approved on a contract basis in June 2002 and has proved invaluable given the large turnover of patients seen and more importantly, has demonstrated the vast amount of clerical work that was previously being done by clinicians.

Responsibilities have included:

1. Maintaining patient database on computer
2. Arranging appointments for out-patients
3. Transfer of patients to community and ambulance
4. Preparation of orthotist clinic lists and maintenance of database
5. Ante-natal appointments
6. Daily retrieving and filing of case records , etc.

A locum physiotherapist was recruited to cover annual leave. During this time a total of 65 new patients were assessed including acute patients (backlog), referrals for assessment and patients on chronic waiting list, all of which had a significant bearing on the waiting list. There were also 16 discharges.

The Special needs Physiotherapist is responsible for a wide reaching caseload working across many Ministries. New services in this area include the use of the Primary Care Centre for paediatric assessment and treatment. Review of the physiotherapy input into the Lady Williams Day care Centre is under way, as is a 3 month pilot study of physiotherapy assessment in government day care centres and a review of the psychiatric physiotherapy Service.

In the interests of meeting clinical governance requirements, the department continues to recommend blanket referrals for orthopaedic in-patients, a routine working practice assisted by protocols and known clinical pathways in the UK.

Physiotherapy staff benefited from local multi-disciplinary team courses and their weekly in-service training. The Superintendent Physiotherapist was awarded the Certificate in Management (Level 4) by the Chartered Management Institute. The department achieved Internet and e-mail connectivity, which has facilitated communication with UK Specialist centres and enabled the access to health information systems.

The department aims to provide the following new outpatient services, which require additional staff :

- Primary care physiotherapy – triage and assessment of musculo-skeletal conditions.
- Back pain protocol: multi-disciplinary approach to the management and treatment of back pain.
- Pain management: updated techniques and training to deliver this service according to best multi-disciplinary practice

With the new hospital approaching reality it would seem appropriate to prepare to introduce new services. Consideration is being given to appointing a community physiotherapist to be involved in areas such as:

- Adult Hydrotherapy,
- Prevention of Falls in the Elderly,
- Development of Paediatric/Special Needs services
- Obstetrics Ante-Natal care
- Early Supported Discharge Scheme.

Occupational therapy

The occupational therapy section still continues to have an extended role that affects all members of the service, involving other government departments, such as Housing, Social services, Building & Works and Education. This amounts to a fully-fledged district service run from within the Authority, providing services ranging from professional advice, screening of housing applicants, full assessments and OT service to mainstream schooling.

The addition of an extra post to the St. Bernard's Hospital OT department greatly helped to make it more effective, ensuring that there is more continuity of treatment and a quicker turnover. It is now possible to have an occupational therapist dedicated to each of the two wards, and as time allows to pick up referrals from the long-stay wards. This service is primarily aimed at enabling disabled and frail patients to cope as independently as possible in their own homes upon discharge from hospital. It also plans and provides complete care packages within the limits of its resources to enable carers to look after a sick or disabled relative in their own homes. The service also provides treatment and rehabilitation programmes to hospital inpatients. Another responsibility is the creation of a central pool of wheelchairs and pressure care equipment to enable these to be in a fit state for use when required, to be available when needed and to ensure they are used where they are mostly needed. The continuing problems with community OTs receiving inappropriate requests for showers not only keeps waiting lists up, but forces the hospital OTs to provide community based care to discharged patients.

The community OT service continues to offer a comprehensive service geared towards the maintaining the sick /disabled in their own homes, through assessment, problem identification, solution planning, provision of equipment, design of home alterations, self-care training and general rehabilitation. A key success of this service has been to reduce the waiting list from an average of a just over $1^1/_2$ years to around 6 months, considering that

some regions in the UK with considerably more resources have 2 year mark waiting times.

Sustaining such pace will require the employment of an appropriate number of staff to cater for the extended occupational therapy role in the community, before the new hospital becomes operational. A significant problem arises because some members of the public believed that they are entitled to a shower on request. Only those who are disabled and cannot access a bath safely by any other means are entitled to a shower. Some people may approach the Buildings & Works department directly for a shower, but this bypasses screening procedures that ensure shower safety and other benefits. Other clients refuse to participate in the OT assessment process due to a mistaken belief that this will deny them a shower. Waiting times for equipment cause friction sometime, but this is limited by space and budgets.

The Psychiatric OT service is currently going through exciting changes, moving away from the current hospital based service to one aimed at community patients and primary care led referrals. During the next year, services provided will include individual care plans for KGV hospital in-patients and mental health clients living in the community, weekly group sessions for long-term patients resident at Nazareth house, weekly relaxation skills sessions at the Bruces farm Drug & Alcohol Rehabilitation unit and short-term group sessions for primary – care clients. These developments reflect the wide range of mental health patients. There is a need to establish links with voluntary bodies dealing with mental health to co-ordinate an outreach programme delivering OT services to these users. There is also a joint initiative with the community mental health unit to develop a Clubhouse day centre for mental health, where service users contribute to the running of the centre and are empowered to take the lead on the processes involved in the running of the centre.

A senior OT provided by the Authority runs the paediatric OT service, but most of the work performed takes place within the education department. The Early Birds child development centre provides sensorimotor groups for pre-school children, multi-disciplinary assessment clinics for pre-school children with developmental delay and early intervention groups for pre-nursery children with special needs. Children in mainstream schools and nurseries receive assistance with visual, perceptual and visual motor skills in their mainstream lesson, assessments for IT support when they require an alternative to using a pencil and assessments for environmental alterations/ adaptations to facilitate learning, e.g. special furniture. In addition, the OT facilitates the running of fine motor skills groups within the special units and supports the teachers who work with the child with special needs. Children in St. Martin's school receive individual sessions to increase independence in activities of daily living, to improve visual-motor skills, to enhance visual-perceptual skills and assessments for special seating in liaison with the paediatric physiotherapist.

The department is striving to ensure uniformity of service to all its users and all points at which the service is being delivered. It is necessary to ensure that services are not started or equipment provided which cannot be maintained on a long-term basis, so that patients receive as professional and consistent a service as the resources allow. This does unfortunately involve also saying no to patients/ clients who do not always appreciate the distinction between what would be nice to have and what is essential. The department often feels criticised and to a certain extent blamed because of this.

Efforts continue to be made to ensure that the necessary departmental, organisational, financial and managerial improvements are planned and implemented.

Nutrition and Dietetics

The most significant development last year was the employment of a second dietician in February 2002. This has allowed for an extra outpatient weekly clinic as well as involvement in a cardiac rehabilitation programme and a general increase in the amount of inpatients seen. It has also helped the department to progress in terms of professional development with more opportunities to keep up to date with information as well as holding more seminars for health professionals.

As expected, the number of consultations has increased tremendously. The number of total consultations has almost doubled since the previous year. Over half of the inpatients seen require nutritional support in the form of nutritional supplements, tube feeding, intravenous feeding (551 consultations as compared to 191 in 2001). Almost half of all outpatients seen were given weight-reducing advice (with or without advice for tackling other coexisting factors such as high lipids, diabetes, etc.). This year also saw the controlled use of Reductil (sibutramine) for selected patients requiring further help to lose weight. This has proved successful in the short term.

The Did Not Attend (DNA) rate for outpatient clinics has fallen to 25% from 31% the previous year. It is thought that this is due to the better appointment system in place as well as the increase in clinics held.

The department continues to be involved with health promotion not only in terms of nutrition but also in relation to smoking, heart disease, etc.

Management

The Health Development Team

MANAGEMENT

Human Resources

Three long serving staff retired in 2002. Dr Sam Benady, Consultant Paediatrician retired in September 2002 having joined the Authority in February 1980. Mrs Yvonne Marsh, Clinical Nurse Manager retired in October 2002, having joined the Authority in March 1973. Miss Lillian King, Clinical Nurse Manager retired in April 2002, having joined the Authority in February 1965.

Dr. Stephen Higgs, who had previously worked in South Africa and the Royal Naval Hospital, filled the vacant post of consultant paediatrician, to commence in early 2003. During the course of the year two other consultant posts were advertised with a view to recruiting in 2003, the post of a second consultant obstetrician as well as a third consultant anaesthetist.

In primary care, two general practitioners joined the Authority in 2002 replacing those who left. Dr Ricardo Pinto-Ocana commenced work in March 2002, moving from the Oxford Deanery in Buckinghamshire and Dr Monique Risso commenced work in April 2002, having worked previously at the Springs Medical Centre in Ilkley, near Leeds. The introduction of the Nurse Practitioner service was a key new service in the Primary Care services. It was intended to appoint two officers to the post, but only one Nurse Practitioner, Mrs Irena Melvin, was initially recruited. The post was subsequently readvertised and a second Nurse Practitioner, Ms. Mandy Clare was appointed to commence work in 2003. Another new post was a further Dental Officer for the Primary Care Centre, to which Mrs Emma Caetano was appointed and commenced work in March 2002.

The post of Senior II Dietician was a new creation, to which Miss Cheryll Figueras was appointed and commenced work in February 2002. A newly part-time Optometrist post was advertised and Miss Isabella Perez was appointed, to commence work in September 2002. The Authority appointed its first IT Officer, Mr Heath Watson, who commenced work in July 2002. A further Nurse Tutor was appointed and commenced work with the School of Health Studies.

In 2002 the Ward Clerks complement was increased to 8. The manning levels of Registered and Enrolled Nurses were increased by 5 for the year 2002/2003. Nursing has seen an increase in complement over 2002 with the GHA receiving many applications and interviews particularly for the RGN grade taking place on a regular basis. During the year several other grades including Midwives, Physiotherapists, Occupational Therapists, Cooks, Seamstresses, Supply Cleaners, Engineering Craftsmen and many others were recruited. An increase in the Hospital Attendant complement also took effect.

In February 2002, with the help of MacDonald Consulting, the human resources section established a web presence with the setting up of the GHA Jobs Website. The website carries information about manning levels, vacancies at any given time as well as general information about the section. It has been used in many recent recruitments, including RGN, nurse practitioner, general practitioner, senior house officer, consultant paediatrician, consultant anaethetist, IT officer, MLSO, physiotherapist and many more.

The website project was a very new and challenging experience at first, but has become extremely popular, receiving several hits every day. Section staff have been quite surprised at the feedback received from people from all over the world enquiring about possible Healthcare vacancies and seeking information on possible future positions as well as general information on the Authority. Interest in working for the Authority is on the increase and with the imminent opening of the new hospital this can only be a good thing.

At the end of 2002 the Gibraltar Health Authority had 662 staff members in post.

Appendix

The interior works at the new hospital in Europort

Appendix

1. Civilian Population in 2002

	Populations in 2001		
	Men	Women	Persons
Children	3,027	2,765	5,792
Adults	8,852	8,537	17,389
Elderly	1,737	2,519	4,256
Total	13,616	13,821	27,437

Note: This table contains the same data as last year's report as no separate population estimates were published for December 2002

2. Births in Gibraltar by Location (2002)

	SBH	RNH	Home	Not Stated	Total
Male	168	14	0	2	184
Female	166	10	0	1	177
Total	334	24	0	3	361

3. Births by outcome (St. Bernard's Hospital only, 2002)

	Number	%
Total births	334	
Preterm infants	5	1.5%
Midwife supervised Normal Deliveries	234	70%
Instrumental deliveries	17	5.0%
Caesarean Sections		
Emergency	12	
Elective	64	
Total	76	22.7%
Transfers to Malaga		
In Labour	8	
After birth (Preterm Infants)	4	
Twins (pairs)	8	
Still births	0	
Neonatal deaths	1	
Neonatal mortality rate	2.99	

4. Births in Gibraltar by Month (2002)

Month of Birth	Female	Male	Total
January	24	12	36
February	12	13	25
March	12	14	26
April	14	20	34
May	15	9	24
June	15	16	31
July	21	7	28
August	11	16	27
September	12	26	38
October	11	15	26
November	13	19	32
December	17	17	34
Total	177	184	361

5. Births to Teenage Mothers (2002)

Mothers Age	Female	Male	Total
15	0	1	1
16	0	1	1
17	4	2	6
18	2	6	8
19	3	4	7
Total	9	14	23

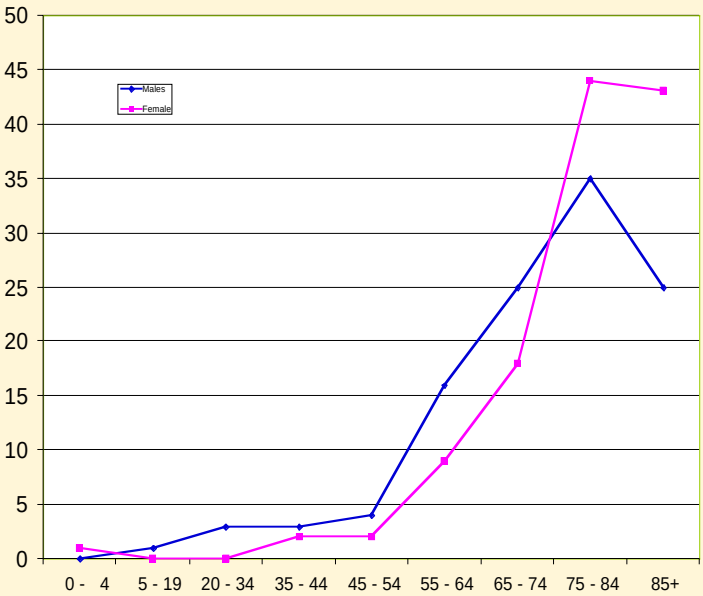
6. Births to Mothers Over the Age of 35 (2002)

Mothers Age	Female	Male	Total
36	4	4	8
37	5	2	7
38	5	4	9
39	0	2	2
40	2	0	2
42	2	0	2
43	0	1	1
Total	18	13	31

7. Deaths in Gibraltar by Age and Sex (2002)

Age of Death	Males	Female	Total
0 - 4	0	1	1
5 - 19	1	0	1
20 - 34	3	0	3
35 - 44	3	2	5
45 - 54	4	2	6
55 - 64	16	9	25
65 - 74	25	18	43
75 - 84	35	44	79
85+	25	43	68
Total	112	119	231

8. Age at death for men and women (2002)



9. Deaths by place of death (2002)

Place of death	Males	Females	Persons
St. Bernard's Hospital	85	86	171
Home	18	16	34
Mount Alvernia	3	13	16
K.G.V. Hospital	2	3	5
Jewish Home	1	1	2
Elsewhere	3		3
Grand Total	112	119	231

10. Deaths in Gibraltar by Cause and Sex (2002)

Cause	Males	Females	Persons
Infant	0	1	1
Cardio-vascular (Heart) disease	41	36	77
Malignant Diseases (Cancer)	26	22	48
Cerebro-vascular disease (Stroke)	13	8	21
Respiratory (Chest) diseases	21	27	48
Infections	1	7	8
Degenerative diseases	3	10	13
Injuries & Poisoning	1	0	1
Other causes	6	8	14
All Causes	112	119	231

11. Deaths in Gibraltar (trends in cause)

Cause	2002 (%)	2001 (%)	2000 (%)
Cardio-vascular (Heart) disease	33%	35%	39%
Malignant Diseases (Cancer)	21%	25%	26%
Cerebro-vascular disease (Stroke)	9%	8%	8%
Respiratory (Chest) diseases	21%	11%	6%
Infections	4%	3%	2%
Degenerative diseases	6%	8%	10%
Injuries & Poisoning	<1%	1%	4%
Other causes	6%	8%	5%
All Causes	100%	100%	100%

12. Cancer Deaths in Gibraltar by site (2002)

Sex	All Persons		Female		Male	
Site of Cancer	Number	(%)	Number	(%)	Number	(%)
Lung	8	16.7%	1	4.5%	7	26.9%
Colon	6	12.5%	3	13.6%	3	11.5%
Breast	6	12.5%	6	27.3%		0.0%
Prostate	5	10.4%		0.0%	5	19.2%
Bladder	3	6.3%		0.0%	3	11.5%
Brain	2	4.2%	1	4.5%	1	3.8%
Kidney	2	4.2%	1	4.5%	1	3.8%
Lymphoma	2	4.2%		0.0%	2	7.7%
Ovary	2	4.2%	2	9.1%		0.0%
Pancreas	2	4.2%	2	9.1%		0.0%
Cervix	2	4.2%	2	9.1%		0.0%
Carcinomatosis	2	4.2%		0.0%	2	7.7%
Others	4	8.4%	2	9.1%	2	7.7%
Unknown	2	4.2%	2	9.1%		0.0%
Grand Total	48	100.0%	22	100.0%	26	100.0%

13. Cancer Registrations (1998 to 2002)

Site of cancer	Malignant	In-situ
Skin	243	8
Breast	59	5
Uterus and Cervix	28	43
Ovary	4	0
Other female reproductive organs	5	0
Colon	19	1
Rectum and Anus	11	0
Stomach	16	2
Oesophagus	4	0
Prostate	18	0
Other male reproductive organs	4	0
Bronchus and Lung	8	0
Larynx	8	2
Bladder	11	22
Blood and lymph	17	0
Mouth and Throat	16	0
Connective tissue	7	0
Brain	1	0
Thyroid	1	0
All other	6	0
Total	486	83

14. Multi Resistant Staphylococcus Aureus infections (2002)

	2002	2001	2000	1999
St Mary's Hospital	1	2	10	5
Cadiz Hospital	2	2	0	0
Leicester Hospitals	0	0	2	1
Guys Hospital	0	0	2	0
Locally acquired	10	4	2	4
Source Unknown	5	5	2	2
Total	18	13	18	12

15. Laboratory confirmed notifiable diseases (2002)

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Campylobacter Jejuni	4	3	0	5	5	6	7	11	2	5	2	1	51
Rotavirus	4	8	1	9	5	0	1	0	0	0	0	0	28
Salmonella	6	4	4	4	4	9	9	13	8	4	6	3	74
Shigella	0	0	0	0	1	0	0	1	1	0	0	0	3
Pathogenic E.Coli	0	1	0	0	0	0	1	0	3	0	0	0	5
M. Tuberculosis	0	1	0	0	0	0	0	0	0	0	0	0	1
Hepatitis A	0	0	0	0	0	0	0	0	0	0	0	0	0
Hepatitis B	0	1	0	0	0	0	0	0	0	0	0	0	1
Meningococcal disease	0	0	0	0	0	0	0	0	0	0	1	0	1
Whooping Cough	0	0	0	0	0	0	0	0	1	1	0	0	2
Giardia Lamblia	0	0	0	0	0	0	0	0	1	0	0	0	1
Cryptosporidiosis	0	0	0	0	0	0	0	0	0	0	0	0	0
Gonorrhoea	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
Other	0	0	0	0	0	2	1	0	1	0	1	0	5
Total	14	18	5	18	15	17	19	25	17	10	10	4	172

16. Trends in Laboratory Confirmed Notifiable Disease (1998 - 2002)

	2002	2001	2000	1999	1998
Campylobacter Jejuni	51	98	92	73	69
Rotavirus	28	37	45	32	17
Salmonella	74	103	58	85	38
Shigella	3	3	2	6	0
Cryptosporidia	0	2	20	0	5
Pathogenic E.Coli	5	4	6	1	5
Tuberculosis	1	1	4	1	5
Gonorrhoea	0	1	0	3	1
Hepatitis A	0	5	6	10	3
Hepatitis B	1	3	1	4	0
Meningitis	1	5	0	1	1
Chlamydia Trachomatis	0	3	0	1	0
Whooping Cough	2	0	1	6	1
Giardia Lamblia	1	0	6	9	0
Toxoplasma Gondii	0	0	0	1	0
Yersinia Enterocolitica	0	0	1	0	0
Other	5	0	0	0	0
Total	172	265	242	233	145

17. Immunisations administered by the Immunisation Clinic (2002)

Vaccine	*Doses*
Polio	1848
Triple Antigen (Diptheria/Tetanus/Whooping Cough)	284
Triple Antigen plus Hib (Haemophilus Influenza type B)	979
Diptheria/Tetanus	609
Meningitis C	3441
Hib (Haemophilus Influenza type B)	17
Measles/Mumps/Rubella	312
Flu	1324
Rubella	11
Pertussis	3
Hepatitis B	10
Hepatitis A	3
Total	8841

18. Immunisation contacts other than in the Clinic (2002)

Children seen at School by Nurses	5880
Children seen by Paediatrician	59

19. Hospital Paediatrics

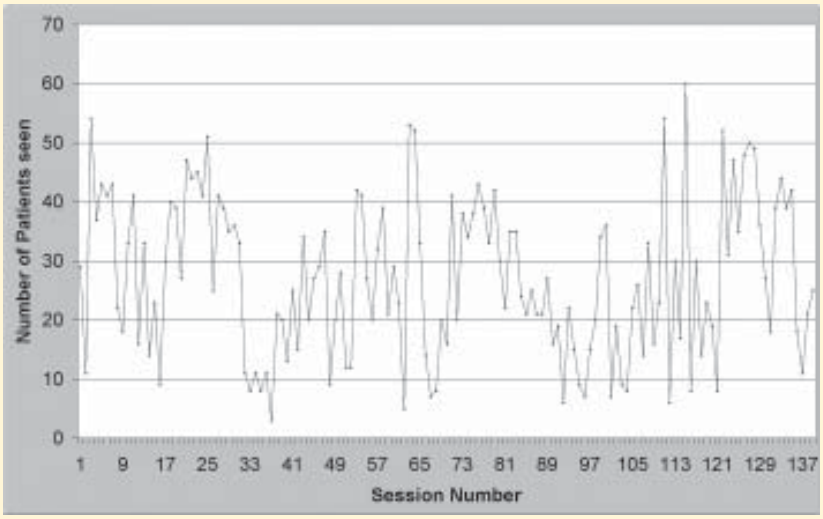
Admissions to Rainbow Ward

Medical	*General Paediatrics*	376
Surgical	*General, ENT, Ophthalmology, Plastic Surgery, Orthopaedics and Dentistry*	493
Outpatients		
Ward follow-ups		765 (approx.)
Clinic visits		341

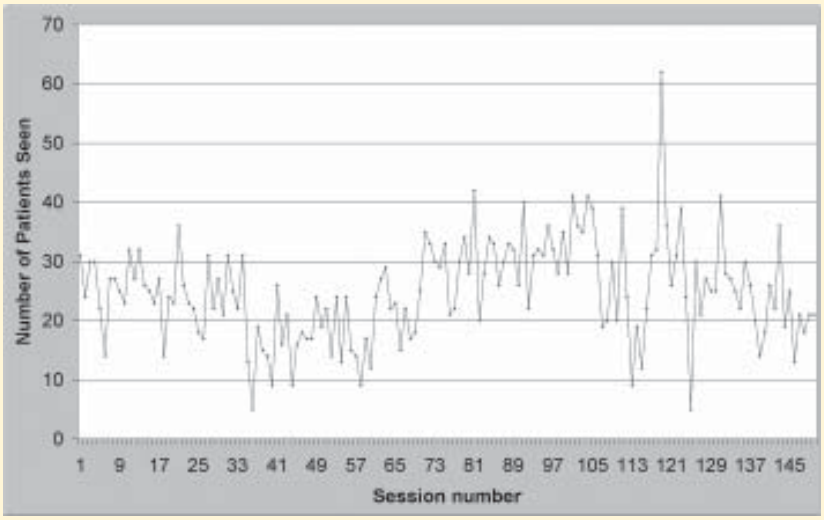
20. Community Paediatrics (Developmental Assessment/School health)

Children	*0-1 year*	*336*
	1-2 years	*498*
	2-3 years	*456*
	3-4 years	*161*
	4-5 years	*28*
	> 5 years	*-*
Visits	*Consultant Clinic*	*1535*
	Health Visitor Clinic(infants and children)	*8000*

21. Emergency Clinic sizes from 1/10/01 to 14/1/02



22.First On Call Emergency Clinic sizes from 7/10/02 to 13/1/03



23. Audit of attendances at the Diabetic Clinic (Oct 2002 to Jan 2003)

Clinical status	*Hb1Ac Range*	*Number*	*%*
Controlled	*<7.0*	*19*	*34%*
Acceptable loss of control	*7.1 to 8.0*	*16*	*29%*
Moderate loss of control	*8.1 to 9.0*	*7*	*13%*
Poorly controlled	*>9.1*	*14*	*25%*
Total		*56*	*100%*

24. Operating Theatre Activity (2002)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
General Surgery	46	60	48	60	56	37	51	55	55	56	67	43	634
Gynaecology	15	15	19	12	32	23	16	28	19	17	16	14	226
Obstetrics	11	8	7	11	3	4	11	4	3	6	9	8	85
Neuro-Surgical	1	1	3	1	0	0	1	0	2	3	3	0	15
Orthopaedics	27	48	40	38	55	37	57	50	47	53	47	31	530
Cardio-Thoracic Surgery	0	1	0	0	7	0	1	0	2	0	1	0	12
E.N.T.	6	21	16	20	15	8	23	18	29	14	17	16	203
Genito-Urinary Surgery	12	8	18	7	13	10	4	12	10	13	13	19	139
Plastic Surgery	11	0	0	10	1	15	0	1	0	12	0	0	50
Dental Surgery	21	29	21	32	23	30	39	29	31	36	18	13	322
Ophthalmology	0	3	0	3	0	2	1	1	0	0	0	0	10
Pain Relief	6	4	3	3	6	1	6	7	4	5	11	10	66
Psychiatry	4	0	0	0	4	0	12	12	5	1	4	2	44
Total	160	198	175	197	215	167	222	217	207	216	206	156	2336

25. Orthopaedics Outpatient Clinics

	2001	2002
Paediatric Orthopaedic	98	96
Adult Orthopaedics	1540	1605
Trauma Clinic	1573	1601
Scoliosis Clinic (Saturdays)	23	
Complex Lumbar spinal conditions	8	
Combined Paediatric Orthopaedics	20	
Total	3262	3302

26. Referrals to the Clinical Psychology Services (2002)

Number of new referrals	156
GPs	110
Psychiatrist	12
St Bernard's	6
KGV	12
Other	11
CPN	5
Persons failing to attend first appointment	20
%age of new referrals	12.8%
Number of ongoing clients	43
Total Caseload	199

27. Source of new referrals to palliative care

Medical	20
Surgical	16
ENT	1
Gynaecology	2
General practitioners	2
Total	41

28. Reason for new referrals to palliative care in 2002

Cancer by site	Male	Female	Total
Lung	5	-	5
Other respiratory	3	-	3
Bowel	5	2	7
Pancreas	-	3	3
Other gastro-intestinal	2	-	2
Urogenital	4	1	5
Breast	-	6	6
Other female reproductive	-	2	2
Blood and marrow	2	1	3
unknown primary	1	2	3
Total	22	17	39

Note: (1) Age range of patients 36-89 years (2) Two referrals were for illnesses other than cancer

29. Sponsored patients (2002)

Hospital	Total
St Mary's Hospital	323
Royal Marsden Hospital	276
Moorfields Eye Hospital	69
Hospital Materno Infantil, Malaga	52
Hospital Universitario Puerta del Mar, Cadiz	161
Charing Cross Hospital	14
Hospital de la Seguridad Social, La Linea	82
Hammersmith Hospital	25
Leicester Royal Infirmary	37
The Middlesex Hospital	27
Spinal Foundation	38
King's Healthcare	20
All other Hospitals	359
Total	1483

30. Trends in Sponsored patients

	U.K	Spain	Total	U.K.	Spain	Total
1992/93	-	-	295	-	-	446
1993/94	329	3	332	517	3	520
1994/95	372	5	377	599	6	605
1995/96	386	5	391	666	5	671
1996/97	432	11	443	653	11	664
1997/98	480	27	507	763	45	808
1998/99	545	32	577	827	50	877
1999/00	566	58	624	889	70	959
2000/01	573	69	642	1034	115	1149
2001/02	599	117	716	966	206	1172
2002/03	631	185	816	1090	393	1483

31. Consultations for Nutrition Therapy (2002)

Classification	Group	2002	2001	2000	1999
By location	Outpatients	1226	832	869	857
	Inpatients	902	360	296	334
By caseload	New contacts	766	547	not available	
	Follow ups	1362	645	not available	
By age group	Children (<18)	219	211	218	222
	Adults (>18)	1909	1053	1029	1191
All consultations		2128	1192	1165	1191

32. Consultations for Nutrition Therapy by purpose (2002) (all ages)

Weight reducing	33%
Non-insulin dependent diabetes	10%
Insulin-dependent diabetes	9%
Lipid lowering	8%
Nutritional support	26%
Others*	14%
Total	100%

* Includes gastrointestinal conditions, allergies, infant nutrition and eating disorders.

33. Laboratory Activity in 2002 (compared with 2001)

Speciality	2002	2001	Test
Clinical Chemistry	265,216	221,953	Investigations
Haematology	24,764	17,186	Samples for full blood count
Blood Group Serology	3,216	3,080	Group and Antibody Screen
	536	560	Groups
Blood Donors	670	678	Bled and Screened
Coagulation	5,402	5,373	Samples
Cytology	1,564	1,536	Cervical Smears
	138	156	Fluids, FNAB, etc
Histology	1,332	1,321	Specimens
Microbiology	4,756	5,202	Urines
	3,103	2,944	Swabs
	1,284	1,502	Stools
	576	510	Blood Cultures
	352	364	Sputum
	64	83	Seminal Fluids
	68	74	TB Cultures
	28	26	Gentamlcin Assays
	71	43	Mycology
	10	12	Cerebrospinal fluids
	85	58	Other fluids
Viral Serology	5,576	5,552	Investigations

34. Special Laboratories used in 2002 (compared with 2001)

Laboratory	2002	2001
Unilabs	841	444
Arrimadas Lab	360	483
Sheffield Childrens Hospital	340	366
PHLS	183	213
Royal Marsden	49	52
Total	1773	1558

35. Public Analysis work in 2002 (compared with 2001)

Sample source	2002	2001
Food and Drink	228	288
Potable water, Civilian	184	719
Potable water, MOD	315	259
Deionised Water	20	27
Sea Water	230	203
Swimming pool water	35	55
Filtrations	12	11
Atmospheric pollution	742	728
Total	1766	2290

36. Radiological Investigations in 2002

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
No. Patients	N.A.	1299	1265	1300	1564	1108	1404	1292	1224	1496	1394	1088
No. Examinations	N.A.	1433	1419	1464	1760	1260	1595	1445	1350	1675	1529	1203
Obstetric Scans	N.A.	48	153	114	98	80	116	92	78	102	125	96
Doppler Scans	N.A.	10	9	5	7	2	4	2	22	6	7	7
General Scans	N.A.	166	-	191	240	170	220	202	175	192	203	158
Salpingograms	N.A.	2	-	5	-	-	-	-	1	-	-	1
Barium Meals/Swallows	N.A.	19	19	14	23	23	18	22	25	23	16	17
Barium Enemas	N.A.	14	14	17	18	13	15	15	23	23	15	13
IV Urograms	N.A.	10	-	2	3	2	3	2	4	3	-	1
Pacemakers	N.A.	-	-	-	3	-	1	-	2	-	-	
Theatre imaging	N.A.	2	12	6	14	6	10	6	14	8	5	4
Portable imaging	N.A.	13	37	32	25	14	13	11	13	23	16	-
Venograms	N.A.	1	-	-	-	-	-	-	1	-	-	-
Mict. Cystograms	N.A.	-	-	-	-	-	-	-	1	2	-	1
Cholecystogram	N.A.	-	2	-	2	3	3	4	2	2	4	-
T-Tube Cholangiogram	-	-	-	-	-	-	-	-	-	-	-	-
Sialograms	N.A.	-	-	-	3	-	-	1	-	-	-	-
CT Scans	N.A.	48	72	44	42	36	64	54	29	100	29	109
MR Scans	N.A.	21	31	26	34	14	27	28	22	65	24	62
Radio Isotope Scans	N.A.	-	4	1	2	2	4	1	2	3	2	7
Mammograms	N.A.	23	20	21	22	24	63	45	26	82	29	59

37. Staffing Complement as on 31 December 2002

Medical	
Director of Public Health	1
Consultants	14
Associate Specialist	1
General Practitioners	13
Senior House Officers	12
Clinical Psychologist	1
Senior Dental Officer	2
Dental Officer	1

(Continued on the next page)

Nursing	
Director of Nursing Services	*1*
Deputy Director of Nursing Services	*1*
Clinical Nurse Managers	*5*
Education Development Officer	*1*
Senior Nurse Tutor	*1*
Nurse Tutor	*1*
Nurse Practitioner	*1*
Charge Nurses	*34*
Staff Nurses	*91*
Staff Nurses (Part-time)	*8*
Staff Midwives	*9*
Senior Enrolled Nurses	*6*
Enrolled Nurses	*72*
Enrolled Nurses (Part-time)	*18*
Nursing Auxiliaries	*12*
Nursing Auxiliaries (Part-time)	*3*
Nursing Assistants	*76*
Nursing Assistants (Part-time)	*20*

Professions Allied to Medicine	
Superintendent Physiotherapist	*1*
Senior Physiotherapists	*6*
Technical Instructors	*2*
Physiotherapist Helper	*1*
Head Occupational Therapist	*1*
Senior Occupational Therapists	*6*
CMLSO/PA	*1*
SMLSO	*5*
MLSO	*2*
JMLSO	*5*
Head Pharmacist	*1*
Pharmacists	*2*
Ward Pharmacist	*1*
Superintendent Radiographer	*1*
Senior Radiographers	*4*
Dark Room Technician	*1*
Head Speech & Language Therapist	*1*
Speech & Language Therapists	*3*
Specialist Dietitian	*1*
Dietitian	*1*
Senior Mental Welfare Officer	*1*
Mental Welfare Officer	*1*
Health Promotion Officer	*1*
Orthoptist	*1*
Optometrist	*1*

Administrative and Support	
Chief Executive	*1*
Director of Operational Services	*1*
Senior Executive Officer	*1*
Higher Executive Officers	*3*
Executive Officers	*8*
Administrative Officers	*31*
Administrative Officers (Part-time)	*5*
Administrative Assistants	*10*
IT User Support Officer	*1*
Medical Secretaries	*4*
Medical Librarian	*1*
Personal Secretary	*1*
Ward Clerks	*4*
Typists	*7*
SPTO	*2*
PTO	*1*
TG1	*2*
Head Porter	*1*
Hospital Attendants	*17*
Messenger/Drivers	*3*
Principal Cook	*1*
Stores Supervisors	*2*

Industrials	
Engineering Craftsman	*2*
Cleaner/Domestics	*48*
Cleaner/Domestics (Part-time)	*13*
Laboratory Operative	*1*
Senior Cooks	*2*
Cooks	*8*
Cooks (Part-time)	*1*
Linen Supervisor	*1*
Asst Linen Supervisor	*1*
Seamstresses	*2*
Industrial Technician	*1*
Craftsman's Mate	*14*

Notes: