Health Matters

Gibraltar Health Authority

Annual Report 2004

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Acknowledgements

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Minister's Foreword

The Hon. Ernest Britto, Minister for Helath

"The GHA is determined to implement the massive programme of change that has been initiated and ensure that health services are of the standard Gibraltar deserves and is entitled to expect"

In November last year, I was entrusted with a new portfolio as Minister for Health. These last nine months have proved to be extremely challenging but even more rewarding at a time when the Government is committed to commissioning a new hospital as well as to a complete overhaul of Gibraltar's Health Services which, once it has taken place, will provide Gibraltar with the Health Service that it deserves and expects.

My colleague, The Hon Bernard Linares the then Minister for Health, had the vision and courage to commission this complete and indepth examination by the Clinical Governance Unit of the Modernisation Agency of the UK NHS. This major Review, which is being conducted locally by the Healthcare Development Team, still continues under my Ministerial responsibility and leadership. I would like to take this opportunity to pay tribute to the dedicated work of my predecessor during his term as Minister for Health.

Clinical Governance Review

The Clinical Governance Review started in April 2003 and examines all aspects of healthcare in Gibraltar. It seeks to identify strengths and weaknesses and to focus on changing the ways our Health Services function in order to improve them and strengthen them.

Phase I of this Review was made public on the 17th September 2003 and received wide circulation which included publication on the GHA Website. In preparing this Diagnostic Report, data and information was sought from local residents and, as a result, almost 10% of the population of Gibraltar contributed to this Review.

Since September last year, work has continued non stop on Phase II of this extensive Review and we are now at the more visible and exciting stage at which tangible changes are starting to be made. The recommendations of the Healthcare Development Team are being presented to the Government as and when their work is completed on a particular aspect of the Health Service. If and when such recommendations are accepted by the Government, they are then implemented over the following weeks and months.

This second phase of the Healthcare Development Programme involves a total of 19 different Workstreams which cover all aspects of the services provided by the Gibraltar Health Authority. It also includes reviews by independent Clinicians of each of the Specialty Services provided by our Consultants, with recommendations to the Government on how to achieve improvements in service delivery.

GHA will implement all the recommendations of the Review which are accepted by Government in our determination to correct the criticisms of the Health Service. Once all these changes have taken place, Gibraltar's Health Services will have been transformed beyond all recognition.

Implementation of these recommendations has already started and the Government has recruited a new Chief Executive who has international experience of Healthcare Management. The Government is also actively engaged in the process of recruiting a Director of Nursing Services and Patient Management and a Director of Human Resources.

Government is moving ahead to introduce these Management changes and interviews have already taken place for all these posts. In the meantime, two experienced Healthcare Directors have been appointed on an interim basis to strengthen and support the present Executive Management Team.

Mr. John Langan has been engaged to work as Joint Chief Executive with Mr. Ernest Lima, which has enabled Mr. Ernest Lima to focus on the role of Finance Director for the Health Authority. Mr Frank McGurrin has been engaged as Co Director of Operations with Mr. Joe Catania. This appointment has enabled Mr Catania to concentrate most of his time on the important issue of commissioning and opening the New Hospital later this year.

The New General Hospital

To fulfil our vision of how health care should be provided we also need new facilities in which to deliver our services and a

workforce equipped and managed to provide the best possible care. St. Bernard's has served us well for nearly 150 years with its varied facilities. However, changes are now needed and when our magnificent new hospital opens it will provide excellent new facilities for patients and for staff and representing the largest capital investment in health care that Gibraltar has ever seen.

The two most notable and important innovations to be provided at the New Hospital will be CT Scan services and a Renal Dialysis Unit. There has been a long term expectation for these services to be provided in Gibraltar to all the many patients who at the moment have to travel to Spain to obtain them and I am delighted to confirm the availability of these services in the New Hospital to meet these expectations.

The hospital will have a capacity of 211 beds, and will incorporate new facilities not currently available at St. Bernard's Hospital. These include CT Scan and Mammography services within the Radiography Department and a Renal Dialysis Unit. These services are currently not available in Gibraltar and patients need to travel to Spain to obtain them. Other new services include a day surgery unit, an integrated rehabilitation department incorporating a hydrotherapy pool, a palliative care unit, specially designed infection control units within both medical wards and assisted bathing and inpatient treatment cubicles within all wards. Outpatient consultation facilities are considerably improved and include comfortable and spacious waiting and reception areas.

On the technical side, a number of services have been included which have not previously been available at every bedside in every ward. These include air-conditioning throughout, piped medical gases at the bedside, nurse call and emergency alarm systems as well as a fully computerised building management system.

Primary Care

At the Primary Care Centre, a new computerised appointment system for all GPs and Nurse Practitioner Clinics was introduced in the summer of 2003. This has been successfully in operation since then and has improved the process of making appointments. It has also served to update basic patient details.

An increase in telephone lines has also made it easier to make appointments by telephone.

Following the increase this year of GPs to 16, there has been a considerable reduction in the waiting times for patients to see a doctor of their choice. This, and other changes arising from the Healthcare Review, will help patients to receive better access for follow-up for referral appointments, less queuing up, friendlier approach and continuous care by the same team members.

The group of workstreams under the heading of Primary Care looks specifically at the way the primary care services are carried out. They include: a review of General Practitioner Services, Patient re-registration which will ensure that we have a comprehensive and up-to-date database of the entire population as well as lay the foundations for the future introduction of computerisation of clinical data. The GHA is also preparing to introduce a revised Healthcare Entitlement Card in the format of the familiar plastic credit cards and which will replace the cardboard ones currently used. It will be issued in tandem with the revised interim E111 to be issued in a similar format and Primary Care appointments which will build upon the work that had already been initiated within phase I of the Primary Care Centre and present a number of different appointment options all of which are designed to speed up the process to be seen by the appropriate member of the Healthcare Team.

Our Staff

The health care that GHA can offer is only as good as those who deliver it. We have in the GHA an excellent workforce who are more than capable of delivering a first rate service.

It is essential for the provision of healthcare services that there is good communications and liaison between staff and management. This is essential to bring form and structure to the efforts expended by our staff and to allow for constructive dialogue and feedback so that staff efforts are focussed on the needs of patients at all times.

Staff must also have a voice in the affairs of the GHA. They are the health service of Gibraltar and without their full and active involvement little can be achieved.

I take this opportunity to pay tribute to the GHA staff at all levels and in all disciplines for the dedicated, efficient and productive way the majority of them carry out the day-to-day execution of their duties. I would also record the Government's and GHA's appreciation for the enthusiastic and co-operative way in which the staff is participating in the various stages of the Healthcare Review, in the implementation of changes that this brings and in the concurrent preparation and planning for the commissioning of the New Hospital.

Conclusion

GHA is determined to implement the massive programme of change that has been initiated and ensure that health services are of the standard Gibraltar deserves and is entitled to expect. The programme of change will bear fruit in the shape of a vastly improved service over the next twelve to eighteen months.

Our forward planning envisages that all of our inpatient specialties will have at least two Clinicians at Consultant level to allow for some 'sub-specialisation' between them, provide for more rapid treatment of patients and better cover arrangements for doctors.

But we cannot provide unlimited services nor do we have unlimited funds and there is a constant balance to be met between what can safely be provided within Gibraltar and what can only be provided in the larger health care settings of the UK or Spain. Medical and surgical services in all western countries have, over the past decade, become more and more specialised. In contrast, we need to realise and accept that Gibraltar's medical services, with their limited human resources, have to remain more generalist in nature with reliance

Public Health 2003

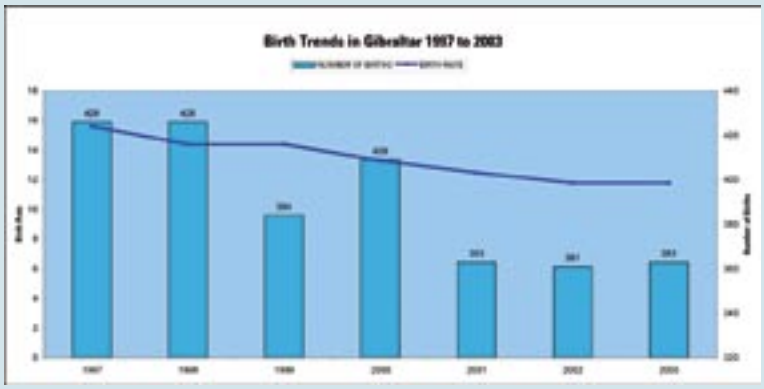
Vital Statistics

Births

The number of babies born in Gibraltar has once again remained remarkably constant for the third year running. There were 363 live births in 2003, following on from 361 (2002) and 363 (2001). The sex ratio also remains constant at 1.06, with 187 males and 176 females. The proportion of these births attributable to the resident (not Forces) was 90% , similar to previous years. 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 fell sharply this year to 9, with the youngest mother being 16. This is a welcome development, as health risks to both mother and child are significant when the mother is this young. The number of births to teenagers has been regularly more than 20 each year in the recent past.

At the other extreme, there were significantly more births to mothers aged 40 years or older - 11 (3%) births, as against 5 (1.5%) last year and 8 (2.2%) in 2002. The age of the oldest mother rose further to 46.



Interesting statistic

363 babies were born in 2003. Births to mothers aged 40+ doubled, from 1.5% to 3%

The school immunisation programme is a key element in assuring the health of the next generation

Immunisations

Routine immunisation programmes continued to be carried out during 2003 as per schedule. The Meningitis C programme which was begun in 2002 was completed, immunising the entire under 18 population in record time, a tremendous achievement. The annual winter Influenza vaccine campaign also continued this year.

As world-wide stocks of BCG vaccine began to improve, a decision was taken to introduce neonatal BCG vaccination in 2004.

Longetivity continues to rise in Gibraltar and now exceeds 83 years in the case of women

Life expectancy and mortality

Life expectancy in Gibraltar is again in keeping the normal range for western societies, although the gap between men and women continues to grow. The mean age of death in the entire resident population remained about the same as in previous years, but that for males fell slightly to 71.9 years, whereas that for females rose to 81.1 years.

This year, 112 males and 119 females died, giving a total of 231 deaths in the resident population, a crude death rate of 8.2, which is again similar to previous years. In addition, three deaths of non-residents were registered in Gibraltar.

There were no stillbirths or infant deaths this year. One three year old child died of childhood cancer.

The pronounced differences in gender patterns for the age of death which were reported last year continue to be seen. Very few women die until the mid 60s after which the death rate gently rises to a peak in the mid 80s. Men, on the other hand, experience many deaths as early as in the mid 20s and continue to die in greater numbers than women throughout the middle years, reaching a peak in the late 70s and falling sharply thereafter. Only 7 men reached the 90s, the oldest dying at 96. In contrast 23 women reached 90 and two women passed the 100. Only 8% 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.

The main causes of death are as in previous years. However, the number of deaths due to **Cancer** exceeded that of **Heart Disease** for the first time, these two causes together accounting for 55% of all deaths.

Once again, **Lung** cancer (for which the main risk factor is smoking) continues to reign at the top, being responsible for over one in six cancer deaths (10). However, this year there has been an unusual rise in deaths from cancer (for which the main risk factor is alcohol consumption) with seven deaths being reported.

As in previous years, 15% of the deaths occurred at **home**.

This year 37 persons died before the age of 65. As in previous years, certain causes are particularly over-represented in this age group - such as injuries and bowel cancer.

This year the number of deaths which had diabetes recorded as a contributory illness in the death certificates rose sharply to 41 (18% of all deaths) as against around 10% in previous years. Again, women appeared to outnumber men by 2:1 and there was no difference in the mean age at death between persons with or without diabetes. It is not possible to say whether this represented a rise in incidence or a reflection of better recording practices.

Health Promotion

Significant events and campaigns

Gibraltar's second **Bug Busting** campaign took place on Saturday 1st February 2003. Letters were distributed to parents enclosing a copy of the Health Promotion Group's leaflet on Head Lice reminding parents of the two annual bug busting days on 1st February and 1st October. In August 2003 a guidance pack was produced for staff of all the educational institutions, to complement the above work with specific advice, incorporating recent thinking/development in this area and intended to clear misconceptions on the management of head lice in schools.

The annual **No Smoking Day** campaign took place on Wednesday 12th March at Casemates Square, but the reaction to the campaign was felt to be subdued, partly because of poor weather. People continue to approach the department for information on how to quit smoking and the demand for a Smoking Cessation service remains high.

Gibraltar's fifth **Sun Awareness** Campaign beach visits took place on 21st June 2003. The assistance from the Miss Gibraltar contestants was again invaluable in helping to promote the issue of sun safe behaviour with the younger generation. A new campaign logo **'Sunny'** was launched with 100 A3 posters being distributed around Gibraltar, to overwhelming public appreciation.

A plan to repeat the successful Gibraltar Health Day was called off due to poor support and high cost.

Bus stop posters

The department has begun a new campaign to make better use of bus shelters and has produced a number of posters which help to promote health education themes. Three areas have initially been targeted, Sun Safety, Smoking and the GOOD Health Award Scheme.

The GOOD Health Award

The GOOD Health Award scheme has been in operation now for a year, a scheme intended to promote the concept of healthy catering.

The current Awardees are:

Gold Award

The Rock Hotel
Airside Services
Bunters
Rooke Officers Mess (MoD)
WO + Sgt's Mess (MoD)
Devils Tower Camp (MoD)
Carpenters Arms

Silver Award

Little Rock Café
Kowloon Chinese Restaurant
The Clipper
Paradiso
Chez Nous
Just Desserts

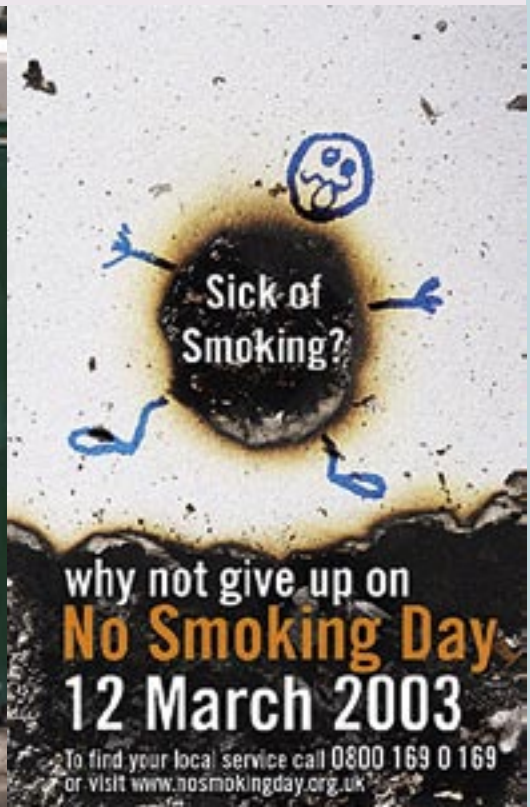
Bronze Award

Café Boheme

Visit the Health Promotion Group web site today on www.health.gov.gi

Health Promotion Group Web Site

Work on the creation of the Health Promotion Group Website continued through the year, with a plan for launch in the spring of 2004. This is work that could not be rushed as there are many examples of good websites on the internet and a sound professional design with attention to detail is essential to establish credibility, particularly with younger visitors.



Education

The education of children in healthy lifestyles is paramount and the public health department has a number of collaborative projects with the Education department. This includes:

- producing resources for the schools such as leaflets and posters.
- workshop for teachers 'Training for Health'
- designing a Healthy School Award;
- developing School Policies on health matters

GBC Health File

The Health Promotion Officer regularly contributed to the 'HealthFile' slot (which is part of Radio Gibraltar's 'Focus at lunchtime'), although the commitment had to be reduced from fortnightly to monthly interviews this year due to pressures of work.
The aim of these talks is to raise public awareness on a variety of health related issues and to encourage healthier lifestyles.

Resource distribution

The essential but intensive task of keeping GHA staff and premises constantly stocked with health educational literature and resources continued to be time-consuming.
The department continues to operate a resource library and is looking to improve and update it.

Future Plans

The department is currently involved in planning for future projects such as:

- Health Pack for Primary and Secondary Schools
- Focusing on Alcohol in teenagers
- The 'Smokefree Class' European competition aimed at schools
- Health Promotion Strategy for Gibraltar

Infectious Diseases

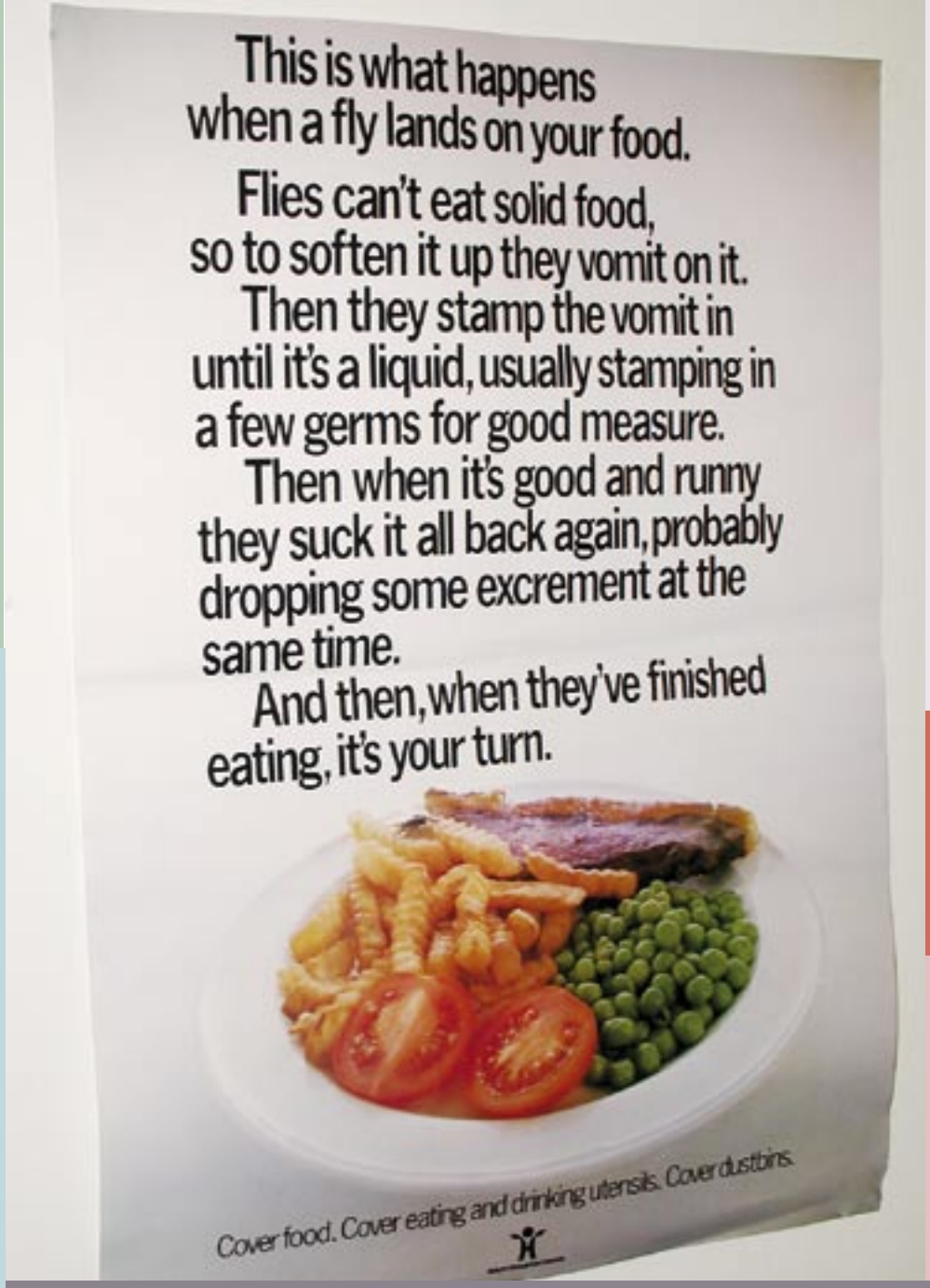
Laboratory confirmed notifiable infections

The downward trend in the number of cases of laboratory confirmed notifiable infection reported in recent years persists. Although the total number of notifications at 184 is slightly higher when compared with 172 last year, this is still much lower than previous years, being 265 (2001), 242 (2000) and 233 (1999).

Food Poisoning

Significantly this year, Salmonella notifications sharply rose to 129 cases. Although a sizeable proportion of this (22 cases) arose from a single outbreak, the remaining number is still the highest recorded in the last six years. Paradoxically, Campylobacter infections continued to fall sharply from 51 last year to 24. Whether this continuing reduction represents a real improvement in public food hygiene is difficult to say.

There was one moderately sized outbreak of Salmonella infection in one of the local hotels in early spring. At least 32 persons reported symptoms, of whom 22 cases were confirmed to be infected with salmonella and there was strong associative evidence to implicate scrambled eggs that were served for breakfast and had been "runny". Three persons were admitted to hospital. The hotel reacted promptly, switching their immediate supplies to British eggs and planned to move to pasteurised eggs in due course. Staff affected were excluded as a precautionary measure and hygienic practices were tightened up. Overall, the hotel's response to the incident was found to be thorough and very professional.



Food poisoning due to Salmonella and other germs can be a result of poor hygiene, particularly when eating outdoors.

Viral gastro-enteritis

A second outbreak occurred in the autumn in a local restaurant, in which 26 cases of brief gastro-enteritis were reported. Despite investigation, no specific item could be implicated or organism isolated. No staff were affected. The standards of hygiene were generally found to be good and the staff trained.

In the autumn, there was considerable public anxiety over the imminent arrival of the cruise liner Aurora of the P&O line following news of an outbreak of over 500 cases of norovirus gastro-enteritis on board. Fortunately, the liner's efficient outbreak containment protocol helped to control the outbreak rapidly and by the time the liner reached Gibraltar, new cases were in single figures. Thus, barring a few persons deemed to carry a risk, most passengers were allowed to disembark without risk to the public health. Despite public fears, no impact on local infections was reported.

Meningococcal disease

During 2003, no cases of meningococcal disease were reported. Late in the year, two closely occurring cases of meningitis in teenage schoolchildren in Algeciras caused the authorities to implement mass prophylaxis of contacts. Although there was no direct implication for Gibraltar, parents required reassurance.

Laboratory confirmed notifiable diseases (2003)

Month	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Total*
Salmonella	10	2	4	26	5	8	18	10	17	10	13	6	**129**
Campylobacter	4	0	4	3	3	2	1	0	2	3	0	2	**24**
Rotavirus	2	7	6	0	0	0	0	0	0	0	0	0	**15**
Shigella	0	0	1	0	0	0	1	0	0	0	0	0	**2**
Cryptosporidia	0	0	0	0	0	0	0	2	3	1	0	0	**6**
Pathogenic E.Coli	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Tuberculosis	0	1	0	0	0	1	0	0	0	0	0	0	**2**
Gonorrhoea	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Meningitis	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Chlamydia	0	0	1	0	0	0	0	0	1	0	0	0	**2**
Other	1	0	0	0	0	0	0	0	0	0	0	1	**2**
Total	**18**	**10**	**16**	**30**	**8**	**11**	**20**	**12**	**23**	**14**	**13**	**9**	**184**

In the last 2 years, the import of MRSA infections into Gibraltar has been greatly reduced through strict practices

Multi-Resistant Staphylococcus Aureus (MRSA)

During 2003, 19 cases of infection due to MRSA (multi-resistant staphylococcus aureus, an organism resistant to most antibiotics) were reported, a figure virtually identical to that of previous years. Four cases were imported (3 from St. Mary's Hospital and 1 from Cadiz), while 6 were locally acquired. The rest were infections whose sources could not be determined.

These findings seem to confirm that the import of MRSA may have been brought under control. The increase in locally acquired infection is a cause for worry, but the incidence in St. Bernard's Hospital still remains relatively low.

Other infections

There were six cases of cryptosporidiosis, which did not appear to be linked. During the summer, the discovery of a case of open tuberculosis in a canteen worker was followed by health screening of 420 contacts, but no secondary infection or primary source was found. In late spring, the emergence of SARS in the Far East caused local concerns. Local policies were formulated to prevent the entry of infection locally.

Eating at least 5 portions of fresh fruit and vegetables every day wards off cancer and other diseases.

Trends in Laboratory Confirmed Notifiable Disease (2003)

	2003	2002	2001	2000	1999	1998
All forms of food poisoning	156	133	208	158	165	112
Campylobacter Jejuni	24	51	98	92	73	69
Rotavirus	15	28	37	45	32	17
Salmonella	129	74	103	58	85	38
Shigella	2	3	3	2	6	0
Cryptosporidia	6	0	2	20	0	5
Pathogenic E.Coli	1	5	4	6	1	5
Tuberculosis	2	1	1	4	1	5
Gonorrhoea	1	0	1	0	3	1
Hepatitis A	0	0	5	6	10	3
Hepatitis B	0	1	3	1	4	0
Meningitis	0	1	5	0	1	1
Chlamydia Trachomatis	2	0	3	0	1	0
Whooping Cough	0	2	0	1	6	1
Giardia Lamblia	0	1	0	6	9	0
Toxoplasma Gondii	0	0	0	0	1	0
Yersinia Enterocolitica	0	0	0	1	0	0
Other	2	5	0	0	0	0
Total	**184**	**172**	**265**	**242**	**233**	**145**

What is Bioterrorism?

As terrorism continues to capture the headlines, bioterrorism requires special consideration. Bioterrorism is the use of biological agents (live germs and toxic products) for terrorist purposes.

For the terrorist, the use of biological agents has the advantage that the incident can not only damage the forces of law and order, but bring down hospitals and health facilities, thus creating a high impact. On the other hand, biological agents are complicated to manufacture, often quick to perish, unpredictable in behaviour, difficult to control and carry huge personal risks to the producers. It is therefore unlikely that biological agents will be the instruments of choice for terrorists looking for a high profile, sudden impact public incident. They are more likely to be used by persons seeking to inflict permanent damage on societies or nations.

Certain agents are better suited to bioterrorism than others.

- Smallpox is a good example because it can cause serious illness and deaths, as most people will have no immunity against it. However, it is not generally available, is difficult to transport, dries out rapidly and needs crowded conditions to spread well.
- Anthrax is a disease of cattle that can cause serious illness in humans. It is widely available, easy to manufacture, simple to spread and difficult to diagnose However, its impact is slow and effective treatments are available.
- Ricin is a toxin from the castor bean, which can kill in minute doses. It is easy to produce and transport, but requires to be injected in order to work, making it a poor choice for mass terrorism.

The main principles of counter-terrorism in the case of biological agents are preparedness, vigilance, diagnostic alertness, containment, treatment and mass prevention. Access to specialist knowledge when needed and remediation after the event are other important factors.

Response to Bioterrorism

Following on from the terrorist events of 2001, it was decided that smallpox presented a credible threat to western nations and the UK Government published detailed guidelines on mounting a proper response in December 2002. Through most of the year 2003, the Gibraltar Smallpox Diagnosis and Response Group has worked at producing a response plan for Gibraltar.

The response against smallpox is based on surveillance, containment and immunisation. There are also some treatments available. A frequently asked question is whether a vaccine exists and can be used in advance on all people. At present the only vaccine available is 30-year-old stock, which unfortunately has some serious side effects. As it could cause serious harm to normal people, it should only be used if the threat of smallpox has become real.

Although there were no further hoaxes concerning anthrax this year, the operational policy continues to be in place.

All the emergency services in Gibraltar came together in an exercise against terrorism which lasted three days and involved the simulated invasion by a small group of armed terrorists. Such exercises provide learning opportunities and the chance to mount more effective responses to a real life incident.

SARS

In early 2003, a new term entered the medical lexicon - SARS, acronym for "Severe Acute Respiratory Syndrome". This was a disease that the world had never seen before, had the ability to spread rapidly, killed people of all ages and did so with terrifying swiftness.

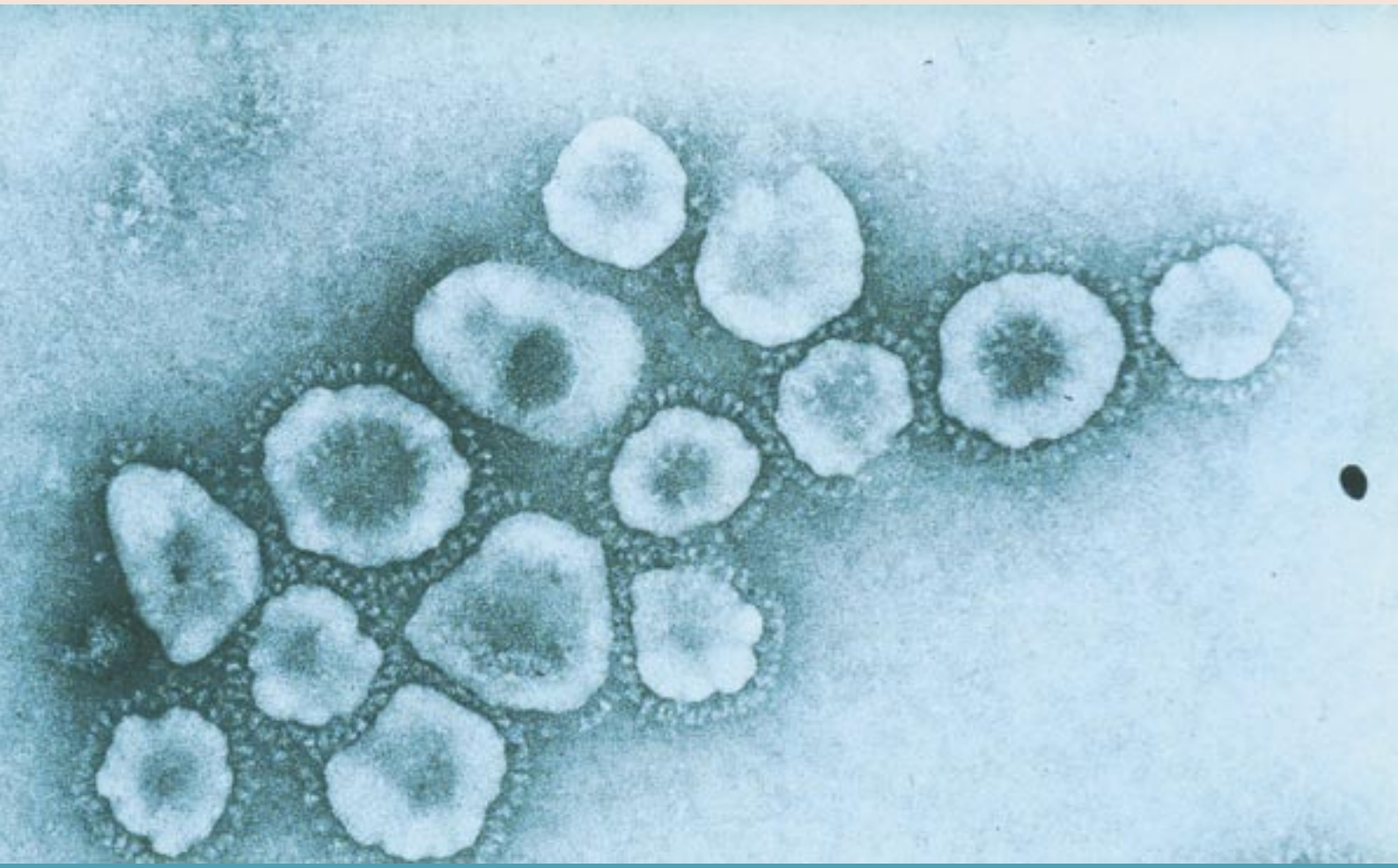
By February 2003, the World Health Organization (WHO) had received several sporadic reports of patients with an unknown severe flu-like illness from a number of countries in South East Asia. Hong Kong, China, Taiwan, Vietnam and Singapore were affected, but the surprising inclusion of Toronto, Canada made it clear that this was no local Asian problem. The outbreak progressed to become, not merely an epidemic (affecting large numbers) but a pandemic, as it went on to affect countries in every continent.

The cause of the mystery illness was unknown and believed to be caused by a flu-like virus, which was subsequently confirmed by laboratory studies. Affected patients had symptoms of a flu-like illness but far more severe, with breathing difficulties. There was no known treatment and several health care workers were affected, leading to breakdown in health services. Control of the disease was organised purely on the empirical basis of isolating persons who had either travelled from one of the affected countries within 7 days (the incubation period) or had had close contact with someone suffering from SARS. This was probably the first time that air travel had played such a key role in spreading disease. Images of seriously ill children and of persons cycling to work wearing face masks, splashed on television screens across the world made SARS a global nightmare.

Gibraltar did not encounter any cases of SARS, but as often happens, there were a few false alarms. However, behind the scenes, several policies were rapidly put in place at all entry points (the airport, the seaport and the land frontier) and guidelines issued to emergency personnel (doctors, ambulance staff, etc.) to be prepared should a case arrive. The public were kept informed and advised of precautions through press releases and television broadcasts.

Despite its brief tenure, SARS left a large legacy. When the epidemic eventually dwindled by the summer of 2003, it had infected 8096 persons in 29 countries and killed 774 persons. In a largely complacent post-antibiotic world, it dramatically raised the profile and importance of rigorous infection control procedures across the world. Not surprisingly, many debates examined the role of SARS in bioterrorism. However, on a more positive note, this was also perhaps the first time that a potentially rampant disease had been identified, analysed and contained over a remarkably short time, entirely as a result of energetic global co-operation in which countries across the world pooled staff, resources and expertise towards the common goal.

SARS has now been contained, but this brief pandemic can claim to have changed the global face of infection control forever.



Electron micrograph of the Coronavirus. The cause of SARS is now understood to be an previously unknown variant of these viruses that cause common colds.

Health Care 2003

Some members of the Gibraltar Health Authority's Executive Team (from left to right) John Langan, Ernest Lima, Joe Catania and Dr. Vijay Kumar

Gibraltar Healthcare Development Programme

The Gibraltar Healthcare Development Team has had a busy year, carrying out a detailed review of the health service.

The team conducted the first large scale, systematic study of what the Gibraltar population thought about their health system, using a telephone survey on a sample of 1,000 people and nine focus groups. In addition, three clinical services - Primary care, Trauma & Orthopaedics and Accident & Emergency were subject to a review by professionals from their respective disciplines.

The team found that residents enjoyed good primary care services, though they could be more accessible. Waiting times for new outpatient appointments to see a consultant could be reduced if not eliminated in most specialties. They were critical of the fact that the GHA makes little use of information for patient and resource management and that there has been little use of information technology. On external relationships, the team concluded that Gibraltar Health Authority had the power, authority and responsibility (through the Ordinance) to deliver health care, but that this could be better developed if the Gibraltar Health Authority were not part of the civil service and subject to its General Orders.

Overall, they felt that Gibraltar compared well to the rest of Europe on health care expenditure, though escalating costs needed to be arrested.

In September 2003, the Government launched Phase II of the Programme, made up of eighteen separate work streams grouped into Human Resources, Processes, Primary Care, Clinical Improvement and Clinical Service Reviews. It is expected that this phase will complete its substantial work by late summer of 2004.

Ms. J. Smith, Gibraltar Healthcare Development Team

Obstetrics and Gynaecology

The department is delighted to welcome the second consultant, Mr. David White from early 2004. On a sadder note, the department saw the retirement of Sister Flor Figueras, whose kindness and popularity with staff and patients was a role model for others. A new midwifery sister post has been created.

The Obstetric Department has been working towards the implementation of Clinical Governance. Work practices are being audited, new updated protocols for obstetric management implemented of and patient information sheets produced. These new initiatives will help maintain a high standard of modern obstetric practice. Pregnant women now book through the practice nurse at the health centre, thus streamlining the obstetric management of common problems and improving records administration.

Efforts are been directed to reduce the gynaecology waiting lists and by April 2004, routine appointments will be given within 4 weeks, if not sooner. Operating time, still a major limiting factor will be improved in the new hospital. A new initiative offering surgery on Tuesday evenings has proved popular with patients. With the help of the anaesthetic department, more major surgery is being done under regional and local blocks, rather than a general anaesthetic. Other improvements include an increasing number of Tension Free Vaginal tape procedures for stress incontinence.

Mr Alan Brooks, Obstetrician & Gynaecologist

Children's nurse Mary Sene with a child ventilator in the Rainbow Ward

General Medicine and Specialties

General medicine and specialty consultants are making slightly greater use of the consortium arrangements in London. Waiting lists for tertiary referrals to Spain are starting to increase because of the increased demand on the Spanish hospitals from the Spanish population.

The waiting list for general medicine specialties is extremely low being about 6 weeks for out patient appointments. All procedures including endoscopy are generally done within a week of being requested.

Interesting statistic

240 babies were born in 2003

Paediatrics

Several improvements have been introduced in child health services during the last year.

A new twice-weekly Rapid Access Clinic was established on the ward to attend to urgent referrals and ward follow-ups. This has reduced waiting for urgent appointments to 3 days.

An Allergy clinic is conducted twice a month, led by the paediatrician and two nurses with a special interest in asthma, which provides skin tests together with counselling for parents and teachers.

A Learning Disabilities Clinic has been started in close co-operation with Mr. Freddie Trinidad, where the medical aspects of children with learning problems are investigated. Mr. Trinidad refers children after his assessment at school.

The paediatric diabetes service now offers an adolescent clinic to aid the transition to the adult diabetic clinic and to encourage independence in self-management.

A Paediatric Endocrinologist, Dr Massoud, visits twice yearly to review all the diabetic children. After an absence of over six years a paediatric neurologist Dr Philip Jardine, will start a twice-yearly visiting service.

Rainbow Ward acquired a state of the art Child Ventilator (Oxylog 3000) used for the safe transfer of children to specialised centres, courtesy of Jyske Bank, Newcastle Building Society and Research into Childhood Cancer.

Seven midwives from Maternity completed a course in newborn care, which will enhance understanding of sick new-borns.

Dr Steve Higgs, Consultant Paediatrician

St. Bernard's Hospital's historic old entrance

Anaesthesia and Intensive Care

The sad and untimely death of Dr Andrew Correa has overshadowed all events this year.

Dr. Richard Roberts from Cardiff who has a special interest in Intensive Care, Dr. Paul Buckley from Cayman Islands with expertise in Pain Relief and a third consultant to be appointed make up the team of consultant anaesthetists.

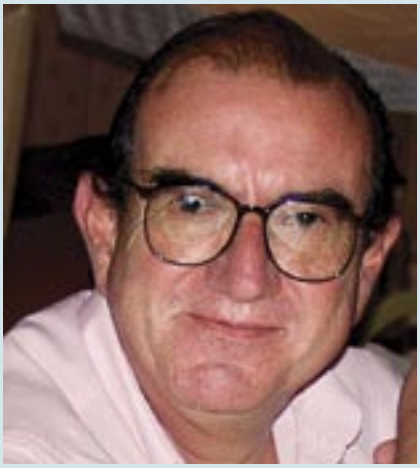
The department has done a lot of work in planning and equipping the new hospital for the care of critically ill patients, including transport and resuscitation, as well as care before, during and after surgery. The department will also have a more proactive role within the Intensive Care Unit.

The chronic pain clinic is being completely reorganised with more time to spend with patients during consultations. Prescribing techniques are being modernised with help from the pharmacists, multidisciplinary team approach is promoted and only evidence based medical techniques with proven effects are used.

Several guidelines and protocols have been produced, using international standards and codes of practice and with a large multidisciplinary input, the main purpose being to improve the safety and quality of the service. The department has begun a programme of education and training of all staff, in partnership with the St John ambulance team.

With its new staff and its expanding role the department looks forward to a bright dynamic future and the tremendous opportunities the new General Hospital will bring.

Dr. Richard Roberts, Consultant Anaesthetist



The late Dr. Andrew Correa -

Consultant Anaesthetist at St. Bernard's Hospital from 1986 to 2003

Born and brought up in Gibraltar, Andrew dedicated his life to anaesthesia in Gibraltar. The backbone of the anaesthetic service in Gibraltar for more than 17 years, he never reduced his commitment to the service, single-handedly running it for several months at a time, two lists a day and on call 24 hours a day seven days a week. His workload, in arguably the most stressful specialisation in medicine, never allowed him either to lower his standards of care or reduce his commitment to the service in Gibraltar.

Andrew was educated locally at the Gibraltar Grammar School, and on completion of his schooling proceeded to the United Kingdom to fulfil his lifelong ambition of studying medicine. In June 1976 he gained his MB ChB at the University of Edinburgh, and after completing his house officer jobs returned to Gibraltar in 1977. Following a stint at St Bernard's Hospital, Gibraltar, he temporarily took up a general practitioner appointment at the Health Centre. However, his vocation in life always seemed to be anaesthesia, a subject growing in importance and complexity, and he returned to the UK to train in his preferred speciality.

On his return to Gibraltar in 1986 he was appointed associate specialist in anaesthesia and in 1990 to consultant anaesthetist, a post he held up to his unexpected and sudden death.

The introduction and development of new techniques in anaesthesia in Gibraltar were primarily the result of Andrew's enthusiasm and sheer ability, for though other skilled anaesthetists have served the community in Gibraltar from time to time it was Andrew Correa who for more than 17 years has been the constant inspiration and mainstay of the service in Gibraltar.

Andrew was a quiet, reserved man, never seeking the glamour or publicity the media often bestows on medical men, yet by his manner and kindness he endeared himself to his patients. Mothers attested to his proverbial patience with young children, the elderly to his understanding of their fears and concerns, but in spite of the daily stresses of his work nobody can ever remember him having ever lost his temper. He will be sadly missed but never forgotten.

Dr. Andrew Correa suddenly and tragically died from a massive cerebral haemorrhage on 25 August 2003. He leaves his wife, Laura, and three daughters, Mandy, Sally, and Claire.

Tribute by Dr. Richard Roberts and Dr. Cecil Montegriffo

Laboratory services

The number of tests performed by our Department continues to increase significantly.

The introduction of a cost-free but feature-limited IT system in July has allowed the Department to have the Biochemistry analysers and the Hematology counter online. Although bar-coding of samples now takes up a substantial amount of staff time, clerical errors are minimised, time spent in filing reports has been greatly reduced, and results are far more easily accessed.

Some equipment for the new hospital such as the tissue processor and automated coagulation analyser, have already been put to use.

A new system of donor blood packs was introduced with a new preservative that extends shelf life from 35 to 42 days and incorporates filters that allows Leucodepletion. Computerisation of Blood Transfusion is now an EU requirement and this is being reviewed.

A. J. Montero, Laboratory Manager

New blood donor packs have been introduced which will make blood safer and last longer

Speech assessment and therapy

The Speech and Language Therapy service for adults now in its fourth year. Referrals to the service have seen an increase of nearly 20% over the last year (105 - 125) with significant increases in both St Bernard's Hospital and the community.

Since February 2003 a newly qualified speech and language therapist has been offering between 7-10 hours a week to the service on a voluntary basis. Two study days on Adult Acquired Neurological Dysphagia, presented by a visiting specialist from the National Hospital for Neurology, were organised for the benefit of all health professionals at Bleak House in May.

Demand for speech and hearing assessments in children increased in 2003, resulting in a waiting list for the first time in many years. School and nursery visits have been rationalised and a new computer helps to improve efficiency.

Public Analysis work in 2004 (compared with 2003)

Sample source	*2004*	*2003*
Food and Drink	205	228
Potable water, Civilian	209	184
Potable water, MOD	306	315
Deionised Water	34	20
Sea Water	156	230
Swimming pool water	33	35
Filtrations	13	12
Atmospheric pollution, SO2	728	742
Total	**1, 684**	**1, 766**

Joe catania (Management Lead) and Derek Alman (Estates Manager) in front of the new hospital

The New Hospital

It is heartening to realise that the new hospital is almost here. After the intense and sometimes frantic specification process of 2002, the year 2003 has largely been of construction and design implementation.

Europort Hospital will now incorporate several new facilities, including a Day Surgery Unit, an integrated rehabilitation department, a hydrotherapy pool, a renal dialysis unit, a palliative care unit and specially designed infection control units. All wards will have assisted bathing and in-patient treatment cubicles.
The out-patient consultation facilities will be greatly improved, with adequate waiting and reception areas. On the technical side, there will be air-conditioning throughout the building as well as a fully computerised building management system.
At the bedside, piped medical gases, nurse call facilities and emergency alarm systems will bring the hospital up to date.

Mr. J. Catania, Management lead for the new hospital

Operating Theatre

The Peri-operative Group, a new forum of Operating Theatre and Surgical Ward nurses, was introduced, to address surgical care issues in a supportive and constructive manner through consensus and collaboration.

In line with the commitment of raising standards of care and professional development, the operating theatre nurses undertook two departmental specific courses- Operating Theatre practice and Anaesthetic care. All courses were delivered by the University of Sheffield and held locally at Bleak house.

The department has acquired new equipment for sterilisation of endoscopes, whose active ingredient is effective and less toxic than the old glutaradehyhe solution.

It is also unique in providing quality assurance and uses parametric monitoring to achieve standardisation.

John J. Alvez, Theatre Manager

New consultants have either joined or will be joining soon in the following specialties:

Psychiatry, Anaesthesia, Obstetrics & Gynaecology

Plans for additional consultants are under consideration in the following specialties:

Orthopaedics, General Surgery, Paediatrics

'The A&E (Casualty) department sees on average 60 patients every week-day and 40 patients every weekend - but three-quarters of these are not true accidents or emergencies'

Eye Care

Considerable advances have been made to eye care during the past year due to enhanced Orthoptist, Optometrist and Ophthalmologist services.

The Orthoptist service is now provided full time and offers assessment and treatment for a number of eye disorders such as binocular vision disorders, squint, 'lazy eye', double vision and other visual impairments. The conditions are treated by a trained orthoptist using ocular exercises and appliances. A screening service is now offered for all 4-5 year olds to detect disorders of ocular motility, binocular vision and visual impairment, which might otherwise be ignored. The orthoptist also carries out visual field and intra-ocular pressure assessments.

The Optometrist's role consists of providing comprehensive eye and visual health in the community, by correcting refractive errors through spectacles, screening for serious eye conditions such as glaucoma and diabetic retinopathy and taking part in the rehabilitation of conditions of the visual system. Since its part-time introduction in October 2002, the demand on the new optometric service has been considerable and despite extension to full time, continues to increase. On moving to the new hospital, additional services such as digital fundus imaging (for use in diabetic retinopathy screening and other retinal conditions), a fortnightly glaucoma screening clinic and a monthly Low Vision Clinic for blind and partially sighted persons are expected.

A major initiative in December was the ophthalmology waiting list initiative, which, with the help of a visiting Scandinavian ophthalmic team, systematically cleared the bulk of the waiting list. Several elderly people with visual impairment due to cataract, who would otherwise have waited several months were important beneficiaries. This pioneering initiative, coupled with the increased facilities in the new hospital will enable the ophthalmologist to keep waiting times under control in the future.

The GHA continues to invest substantially in Information Technology

Information Technology

The Health care Development Team has several criticisms about the poor progress in information technology in the Authority despite the potential being recognised for some time. They noted that the use of information for decision making is not common practice and that information systems to support patient care and resource management were poorly developed. They suggested that a system of registration and scheduling to support patient management should be an early priority.

A core committee has been set up to develop the Authority's information strategy. A report 'Informatics in the Gibraltar health Authority: a strategy to modernise the use of information to improve patient care' has been written to guide the work of this committee. A plan has been drawn up to introduce registration of health care users. The Authority's current network of over 130 computers, 5 servers and other components is set to expand in the new hospital, as further development of information systems will need to be a key priority if efficiency is to be sustained. The maintenance of this stock is itself a matter that requires attention.

ENT Services

The ENT Department continues to function despite the restrictions inherent in the old hospital. The work carried out by the service has been much as it has been in the previous years, except in the last 12 months.

A visiting specialist rhinologist service was introduced in 2003, enabling the technique of endoscopic Dacryocystorhinostomy (internal drainage of obstructed lacrimal duct) to be carried out in Gibraltar.

The move to the new hospital will provide 21st century ENT diagnostic services for outpatients, double the operative capacity for ENT, and will make inroads into the unacceptable long waiting list, to bring it down toward a planned service.

Dr. K. Farrell, Associate Specialist in ENT

Palliative Care

The Palliative care service is intended for people with serious and incurable illness. Its aim is to maximise independence, to rehabilitate and to help such people live with their disease. At the end of life, when death is inevitable, the emphasis shifts to helping people to die peacefully without physical or mental distress either in their own home, or in hospital. This can be a challenging time for all concerned, requiring the best medical and nursing practice.

There was a 20% increase in new referrals to palliative care this year. As in previous years, this is most likely due to an increased awareness of the service and an appreciation of the many opportunities for improving quality of life for the chronically sick, rather than an increase in the incidence of disease.

This appointment in January of a hospice at home nurse by the Gibraltar Society for Cancer Relief to work alongside the district nurses on a regular basis has been a great success. This nurse provides much needed support to the community team, helping to keep those patients who wish to remain at home, and extending the scope of home treatments such as intravenous infusions. In addition, four more nurses have been recruited to work if needed in patients' homes enabling the care of seriously ill patients at home if they wish it.

A large number of new pressure relieving mattresses has been purchased by the Society for use in the hospital and the community. The Rotary Club of Gibraltar also donated a double pressure-relieving mattress for patients at home, an expensive and much appreciated resource. Teaching sessions have been carried out at the Elderly Care Agency and at the Health Centre. Informal teaching takes place regularly on the wards. Assistance has been given in the development of pain protocols for the hospital. These protocols have yet to be finalised. The Palliative care nurse attended a week's intensive course in London for experienced professionals. The medical input into palliative care is under review.

Palliative Care Nurse Susan Rhoda with pressure relieving mattress

Clinical Psychology

First appointments in clinical psychology are usually made within six weeks of receipt of the referral. Users now appear to be clear that the department cannot offer crisis intervention or counselling, but use the free service provided by volunteer counsellors at the Health Centre.

Dr Graham F McColl, Consultant Clinical Psychologist

Mental Welfare Services

The two Mental Welfare Officers provide the link between the clinical and legal aspects of mental illness care. These officers ensure that involuntary admissions of patients are carried out in proper compliance with Mental Health Ordinance and also act as social workers for mentally ill patients. Their main aims are to arrange for services to meet client needs efficiently and to help clients to live independently in their own homes. During the year Joseph Winwood retired as Senior Mental Welfare Officer and Paul Llambias took his place.

A key task in the coming year will be to review and modernise the current Mental Health Ordinance and special consideration needs to be given to ensure that Gibraltar's unique needs are met.

Physiotherapy

The year has been a busy one. Joint Spinal Clinics with the orthopaedic surgeon commenced in November. Appointments times for patients were increased in line with UK norms, giving the physiotherapist more direct time for patient contact and documentation. However, the numbers of patients not turning up for booked appointments continues to cause concern, despite audits being in place. Two extra sessions in Special needs Paediatrics have resulted in increased patient contact and will support the overall aim to equip all staff with paediatric skills.

Several quality improvements were introduced. The Patients Appliance policy was formalised. Formalised documentation for obstetric antenatal relaxation classes was introduced. A package for Falls Prevention Care is being developed in the community. Physiotherapy services are regularly being audited for improvements both in clinical and managerial practice. Staff appraisals were carried out and Personal Development Plans introduced. Improved inter-professional links resulted in a new batch of general practitioners visiting the department for an induction into physiotherapy services.

It is heartening to hear that five new students are undertaking physiotherapy degrees in the UK. The departments is proud that Eddie Linares obtained his Masters in Health Practice Management with Distinction and was appointed to Deputy Grade from July 03.

C. Vinent, Superintendent Physiotherapist

Occupational Therapy

The department is continuously developing and seeking to improve services to the public. Initiatives taken during the year included the development of :

- an intermediate care service to allow patients being discharged from hospital, bringing rehabilitation into their homes.

- a community mental health OT service for clients who are not ill enough to warrant admission but need support.

- a paediatric team in the Health centre, with good practice guidelines and enhanced facilities.

- explicit policy incorporating criteria for equipment-provisioning

The department is actively working with other agencies to resolve continuing problems, such as the identification of older citizens who require specialised OT assessment. A much welcomed initiative is the creation of a team by the Department of Building & Works dedicated to the adaptation of clients' homes to OT specification, a development that has considerably improved the service on offer to elderly people.

However these improvements have necessarily focussed on well-established need and greatest priorities, due to limits in resources. The New Hospital will, for the first time, provide a purpose built OT treatment facility, giving excellent new opportunities to improve the service, but will undoubtedly bring with it new service demands and increased turnover of patients.

A. Wink, Head Occupational Therapist

Nutrition and Dietetics

The department's main caseload is based around weight reducing and nutrition support. The activity this year was generally comparable to that of the previous year. The department has have now started offering a wider paediatric service, in recognition of the growing problem of paediatric obesity.

During 2003 (July to December) a temporary dietician was employed to cover maternity leave. During the year, 24% of patients failed to keep their appointment. Although this is an improvement over the previous years, it is still a substantial waste of resources and the method of booking clinic appointments at the Primary Care Centre has been changed in an effort to improve this situation. The department continues to promote nutrition in non-clinical areas through the health promotion team.

C. Figueras, Dietician

'More than 2 out of 3 residents used the health service in the last 12 months'

For more of such statistics visit the GHCDT Website on: www.gha.gov.gi/GHDT/GHDTHome.htm

Statistics 2003

1. Public Health Statistics

1.1 Births in Gibraltar by location (2003)

	SBH	RNH	Home	Not Stated	Total
Male	173	14	0	0	**187**
Female	157	18	0	1	**176**
Total	**330**	**32**	**0**	**1**	**363**

1.2 Births By Month (2003)

Month of Birth	Female	Male	Total
January	11	15	**26**
February	10	10	**20**
March	15	17	**32**
April	13	19	**32**
May	14	18	**32**
June	13	15	**28**
July	20	11	**31**
August	21	17	**38**
September	9	24	**33**
October	17	13	**30**
November	18	12	**30**
December	15	16	**31**
Total	**176**	**187**	**363**

1.3 Births to Teenage Mothers (2003)

Month of Birth	Female	Male	Total
15	0	0	**0**
16	1	1	**2**
17	1	0	**1**
18	1	4	**5**
19	1	0	**1**
Total	**4**	**5**	**9**

1.4 Births to Mothers Over the Age of 35 (2003)

Mother's Age	Female	Male	Total
36	10	7	**17**
37	6	8	**14**
38	4	5	**9**
39	1	1	**2**
40	5	1	**6**
41	1	0	**1**
42	1	0	**1**
43	1	0	**1**
44	1	0	**1**
46	1	0	**1**
Total	**31**	**22**	**53**

1.5 Deaths in Gibraltar by Age and Sex (2003)

Age of Death	Males	Female	Total
0 - 4	1	0	**1**
5 – 19	0	0	**0**
20 - 34	4	0	**4**
35 - 44	2	2	**4**
45 - 54	8	3	**11**
55 - 64	12	4	**17**
65 - 74	36	12	**51**
75 - 84	32	44	**75**
85+	24	47	**69**
Total	**119**	**112**	**231**

1.6 Deaths by place of death (2003)

	Males	Female	Total
St. Bernard's Hospital	102	80	**182**
Home	12	18	**30**
Mount Alvernia	0	4	**4**
K.G.V Hospital	1	2	**3**
Jewish Home	0	5	**5**
Elsewhere	4	3	**7**
Total	**119**	**112**	**231**

1.7 Deaths in Gibraltar by Cause and Sex (2003)

	Males	Female	Total
Cardio-vascular	36	26	**62**
Malignant Disease	34	32	**66**
Cerebro-vascular disease (Stroke)	12	25	**37**
Respiratory (Chest) diseases	19	4	**23**
Infections	5	8	**13**
Degenerative diseases	6	11	**17**
Injuries & Poisoning	3	3	**6**
Other Causes	4	3	**7**
Total	**119**	**112**	**231**

1.8 Cancer Deaths in Gibraltar by site (2003)

	Males	Female	Total
Lung	9	1	**10**
Oesophagus	4	3	**7**
Carcinomatosis	3	4	**7**
Colon	5	1	**6**
Blood	0	5	**5**
Oral	2	2	**4**
Brain	2	2	**4**
Pancreas	1	2	**3**
Breast	0	3	**3**
Bladder	1	2	**3**
Stomach	2	-	**2**
Biliary	1	1	**2**
Larynx	2	-	**2**
Cervix	-	2	**2**
Vulva	-	1	**1**
Ovary	-	1	**1**
Uterus	-	1	**1**
Kidney	0	1	**1**
Liver	1	-	**1**
Unknown	1	-	**1**
Total	**34**	**32**	**66**

1.9 Cancer registrations by site (1998 to 2003)

Site	Borderline	Malignant	Unspecified	Grand Total
Skin	10	344	2	**356**
Breast	7	84	1	**92**
Colon Rectum Anus	3	47		**50**
Cervix	71	37	2	**110**
Blood & Lymph		34		**34**
Uterus	3	29	1	**33**
Stomach	3	23		**26**
Mouth		21		**21**
Prostate		21		**21**
Bladder	41	17		**58**
ENT	3	11		**14**
Soft tissue		9		**9**
Lung	1	8		**9**
Ovary	1	8		**9**
Oesophagus		7		**7**
Bone		2		**2**
Liver		2		**2**
Other sites		33		**33**
Unspecified			11	**11**
All sites except skin	133	393	15	**541**
All sites	143	737	17	**897**

Note: These continue to be interim figures. Due to the Registry being constantly updated with new data on past years, the above figures will not be directly comparable with those published in previous reports.

1.10 Laboratory confirmed notifiable diseases (2003)

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Salmonella	10	2	4	26	5	8	18	10	17	10	13	6	**129**
Campylobacter	4	0	4	3	3	2	1	0	2	3	0	2	**24**
Rotavirus	2	7	6	0	0	0	0	0	0	0	0	0	**15**
Shigella	0	0	1	0	0	0	1	0	0	0	0	0	**2**
Cryptosporidia	0	0	0	0	0	0	0	2	3	1	0	0	**6**
Pathogenic E.Coli	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Tuberculosis	0	1	0	0	0	1	0	0	0	0	0	0	**2**
Gonorrhoea	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Meningitis	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Chlamydia	0	0	1	0	0	0	0	0	1	0	0	0	**2**
Other	1	0	0	0	0	0	0	0	0	0	0	1	**2**
Total	**18**	**10**	**16**	**30**	**8**	**11**	**20**	**12**	**23**	**14**	**13**	**9**	**184**

1.11 Trends in Laboratory Confirmed Notifiable Disease (2003)

	2003	2002	2001	2000	1999	1998
All forms of food poisoning	156	133	208	158	165	112
Campylobacter Jejuni	24	51	98	92	73	69
Rotavirus	15	28	37	45	32	17
Salmonella	129	74	103	58	85	38
Shigella	2	3	3	2	6	0
Cryptosporidia	6	0	2	20	0	5
Pathogenic E.Coli	1	5	4	6	1	5
Tuberculosis	2	1	1	4	1	5
Gonorrhoea	1	0	1	0	3	1
Hepatitis A	0	0	5	6	10	3
Hepatitis B	0	1	3	1	4	0
Meningitis	0	1	5	0	1	1
Chlamydia Trachomatis	2	0	3	0	1	0
Whooping Cough	0	2	0	1	6	1
Giardia Lamblia	0	1	0	6	9	0
Toxoplasma Gondii	0	0	0	0	1	0
Yersinia Enterocolitica	0	0	0	1	0	0
Other	2	5	0	0	0	0
Total	**184**	**172**	**265**	**242**	**233**	**145**

2. Health Care Statistics

2.1 Number of operations by specialities (2003)

	Jan	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Total*
General surgery	55	52	38	36	47	49	53	39	44	44	45	55	**557**
Gynaecology	22	16	19	21	16	21	18	10	20	19	15	10	**207**
Obstetrics	5	6	5	9	3	7	9	7	10	8	5	4	**78**
Neuro-surgical	1	1	2	0	0	0	0	0	0	0	0	0	**4**
Orthopaedics	41	35	30	64	55	38	52	46	34	40	41	31	**507**
Crdio-thoracic	5	0	0	0	0	0	0	4	0	0	0	0	**9**
ENT	19	16	18	15	13	19	16	14	18	15	17	14	**194**
Genito-urinary	6	13	17	5	11	6	16	17	10	7	15	15	**138**
Plastic surgery	0	0	16	0	0	11	0	0	12	0	12	0	**51**
Maxillo-facial	0	0	0	0	0	3	2	1	3	0	0	0	**9**
Dental	21	31	21	29	39	32	11	24	20	24	25	15	**292**
Opthalmic	0	1	0	1	0	1	0	0	0	3	0	1	**7**
Pain clinic	5	9	5	6	4	4	2	8	6	3	4	1	**57**
Psychiatry	0	0	0	0	0	6	9	5	1	2	3	1	**27**
Total	**180**	**180**	**171**	**186**	**188**	**197**	**188**	**175**	**178**	**165**	**182**	**147**	**2,137**

2.2 Operations Cancelled in 2003

Reason	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Total*
Patient reasons													
Patient did not attend	6	2	4	2	2	3	4	4	4	4	4	1	**40**
Cancelled by Patient	1	-	2	1	2	-	-	1	-	1	-	3	**11**
Unfit for surgery	1	3	-	-	-	1	-	2	1	-	1	-	**9**
Staff reasons													
Cancelled by Surgeon	3	2	-	1	3	-	1	9	1	1	1	1	**23**
Cancelled by Anaesthetist	-	1	-	1	-	-	1	3	-	3	-	3	**12**
Shortage of theatre staff	-	-	-	-	-	-	2	-	-	-	4	-	**6**
Resource Reasons													
Non availability of beds	-	9	6	-	-	-	-	2	5	2	3	-	**27**
Emergency Surgery	-	3	2	3	1	1	-	-	-	-	-	-	**10**
No theatre time available	-	3	4	4	1	1	-	-	-	5	-	2	**20**
Awaiting implants	-	-	-	-	-	-	-	-	-	1	-	-	**1**
Postponed	2	-	-	-	-	-	-	-	-	-	-	-	**2**
Cancelled due to faulty diathermy	-	1	-	-	-	-	-	-	-	-	-	-	**1**
Cancelled Air Conditioning not working	-	-	-	-	-	-	-	-	-	-	8	-	**8**
Total	**13**	**24**	**18**	**12**	**9**	**6**	**8**	**21**	**11**	**17**	**21**	**10**	**170**

2.3 Consultations for Paediatrics (2003)

Group	*Number*
Outpatients	426
Inpatients	896
Community Routine assessments	7,568
Community Specialist assessments	1,057

2.4 Consultations for nutrition therapy by location (2003)

Location	*2003*	*2002*	*2001*	*2000*	*1999*
Outpatients	1,214	1,226	832	869	857
Inpatients	910	902	360	296	334
Total	**2,124**	**2,128**	**1,192**	**1,165**	**1,191**

2.5 Consultations for nutrition therapy (2003) By Client Group

Classification	*Group*	*Number*
By Location	Outpatients	1,214
	Inpatients	910
By Caseload	New Contacts	806
	Follow ups	1,318
By age group	Children (Under 18)	190
	Adults (Over 18)	1,934
All Consultations		**2,124**

2.6 Consultations for nutritional therapy by purpose – all ages (2003)

Dietary advice	*No.*	*%*
Weight reducing	1,054	47%
Non-insulin dependent diabetes	212	10%
Insulin-dependent diabetes	101	5%
Hyperlipidaemia	180	8%
Nutritional support (nutritional supplements; tube feedings; intravenous feeding)	452	20%
Gastro*	45	2%
Other**	176	8%
Total (includes some overlap)	**2,220**	**100%**

**Gastro includes (Crohns; colitis; diverticulitis; coeliac, etc.) excluding those requiring nutritional support*

***Others include (healthy eating; pregnancy; renal; liver, etc.) excluding those requiring nutritional support*

2.7 Referrals to the Clinical Psychology Services (2003)

Number of new referrals	149
GPs	109
Psychiatrist	16
St Bernard's	4
KGV	6
Other	8
CPN	6
Number of ongoing clients	42
Number of DNAs first appointment	16
Percentage of new referrals	10.73%
Total Caseload	**191**

2.8 Source of new referrals to palliative care (2003)

Medical	21
Surgical	6
ENT	1
Dental	1
GP's	8
Elderologist	1
Gynaecology	3
Sponsorship Office	2
Royal Marsden Hospital	3
Self Referral	2
Total	**48**

2.9 New referrals to palliative care in 2003

Age range of patients 36-89 years

Malignancy by site	*Male*	*Female*	*Total*
AML	1	-	**1**
Bladder	-	1	**1**
Bone	1	-	**1**
Bowel	1	1	**2**
Brain	1	1	**2**
Breast	-	4	**4**
Cervix	-	2	**2**
Gall Bladder	1	1	**2**
Head and Neck	3	1	**4**
Hodgkims Lymphoma	-	1	**1**
Lung	4	1	**5**
Mult Myeloma	-	2	**2**
Oesophagus	2	2	**4**
Pancreas	3	1	**4**
Prostate	2	-	**2**
Renal	-	1	**1**
Stomach	1	1	**2**
Uterus	-	1	**1**
Vulva	-	2	**2**
Unknown Primary	1	1	**2**
Non-Cancer	2	1	**3**
Total	**23**	**25**	**48**

2.10 Speech and Language Therapy (Children's Services) Annual Statistics 2003

Referral to Service	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*June*	*July*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Total*
School	6	3	1	3	5	0	1	0	4	0	1	0	**24**
Pre- school	1	2	1	6	4	4	0	4	4	6	2	3	**37**
Discharged from service													
School	9	11	1	5	2	7	1	1	5	7	1	10	**60**
Pre- school	2	0	1	4	1	2	1	5	0	0	0	2	**18**
Reason for discharge													
Treatment complete	5	8	0	6	1	6	0	1	4	1	1	8	**41**
NAD	2	1	2	3	0	2	1	2	1	4	0	0	**18**
Did not attend	2	2	0	0	2	1	0	2	0	1	0	4	**14**
Transfer to another part of SLT service	2	0	0	0	0	0	1	1	0	1	0	0	**5**
Attendance's													
Primary Care Centre contacts	62	47	50	31	44	31	4	43	28	37	31	12	**420**
School visit contact	72	90	70	46	87	63	3	0	89	108	96	43	**767**
DNA appointment	11	8	8	9	14	8	1	18	17	14	19	19	**146**

2.11 Speech and Language Therapy (Adult Therapy) Contacts 2003

St Bernard's	611
PCC	180
Home Visits	250
St Bernadette's	316
Dr Giraldi & Respite	9
Total	**1,366**

2.12 Speech and Language Therapy (Adult Therapy) New Referrals 2003

Location	Community	59
	St Bernadette's	0
	St Bernard's	66
	Total	**125**
Source of Referrals	GP's	7
	Medical Consultants/ SHO	63
	ENT Consultant	31
	Physio	7
	Others	17
Client Group Referred	CVA/ TIA	37
	Voice	31
	Paed & Other Dysphagia	19
	Dementia	11
	Other	27
Reason for Referral	Communications	47
	Dysphagia	54
	Communication	24

2.13 Radiological Investigations (2003)

	Jan	*Feb*	*Mar*	*Apr*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*
No. Patients	1498	1314	1606	1440	1416	1323	1476	1273	1361	1574	1159	1195
No. Exams	1744	1496	1800	1584	1596	1554	1596	1406	1606	1700	1258	1480
Ob. Scans	126	106	92	91	103	82	106	60	86	108	80	77
Dopplers	11	8	8	6	14	5	4	0	12	11	3	15
Gen.Scans	212	184	227	170	201	204	196	191	221	221	150	160
Salps	2	1	0	1	0	0	0	0	0	1	0	0
Ba.M/S	12	16	23	21	19	20	3	23	12	26	10	6
Ba. Enemas	17	17	14	12	15	16	4	18	20	25	17	24
IVU's	3	3	7	1	7	4	7	4	0	1	6	1
Theatre	12	12	14	8	9	4	8	8	12	5	8	9
Pacemakers	0	0	0	0	0	0	0	4	0	0	0	0
Portables	27	25	30	27	16	19	19	17	21	24	43	16
Mict. Cyst	2	0	0	0	1	0	0	1	0	0	0	0
C. Cyst	1	1	30	2	1	4	4	2	21	2	1	6
Sialograms	0	0	0	1	0	0	0	0	0	0	0	0
CT.	114	64	72	50	56	76	57	55	86	99	28	105
MRI	40	51	44	28	50	58	46	34	85	67	27	76
Isotopes	6	4	4	1	3	10	5	5	2	10	1	28
Mammo	56	51	59	44	47	65	35	26	47	55	23	75
Densitometry	29	12	15	20	24	22	15	12	25	20	20	1
PET scans	1	0	0	1	0	0	0	1	0	0	0	0

2.14 Laboratory Activity in 2003 (compared with 2002)

Speciality	*2003*	*2002*	*Test*
Clinical Chemistry	323, 477	265,216	Investigations
Haematology	25, 223	24, 764	Samples for full blood count
Blood Group Serology	2, 454	3, 216	Group and Antibody Screen
	602	536	Groups
Blood Donors	830	670	Bled and Screened
Coagulation	6, 106	5, 402	Samples
Cytology	1, 468	1, 564	Cervical Smears
	180	138	Fluids, FNAB, etc
Histology	1, 255	1, 332	Specimens
Microbiology	4, 801	4, 756	Urine's
	3, 089	3, 103	Swabs
	1,430	1, 284	Stools
	610	576	Blood Cultures
	388	352	Sputum
	58	64	Seminal Fluids
	81	68	TB Cultures
	92	71	Mycology
	3	10	Cerebrospinal fluids
Viral Serology	6, 647	5, 576	Investigations

2.15 Special Laboratories used in 2004 (compared with 2003)

Laboratory	*2003*	*2004*
Unilabs	756	841
Arrimadas Lab	179	360
Sheffield Children's Hospital	378	340
PHLS	234	183
Royal Marsden	45	49
Total	1, 592	1, 773

2.15 Public Analysis work in 2004 (compared with 2003)

Sample source	*2004*	*2003*
Food and Drink	205	228
Potable water, Civilian	209	184
Potable water, MOD	306	315
Deionised Water	34	20
Sea Water	156	230
Swimming pool water	33	35
Filtrations	13	12
Atmospheric pollution, SO2	728	742
Total	**1, 684**	**1, 766**