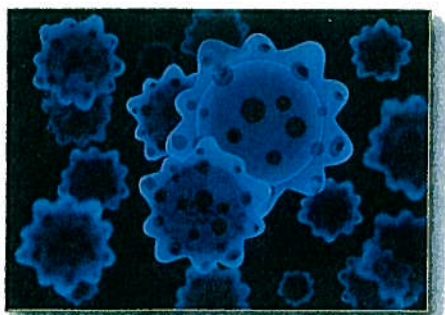
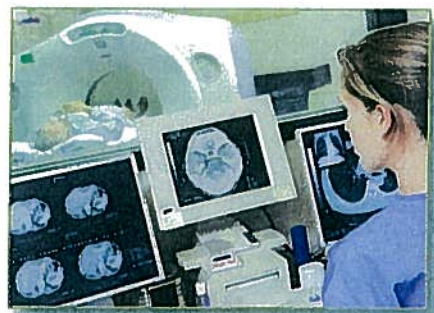


HEALTH AND SOCIAL SERVICES

A STATES OF GUERNSEY GOVERNMENT DEPARTMENT

110th ANNUAL MOH/DPH/CMO REPORT Bailiwick of Guernsey



Special theme:
First Impressions



Report for Year 2008/09





Photograph supplied by Mark Leightley

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First impressions on the State of the Public Health

I am delighted to present my first Public Health Annual Report as the tenth Medical Officer of Health (MOH) (Jeffs 1999), and the second Director of Public Health (DPH) and Chief Medical Officer (CMO) for the States of Guernsey. I took up post in January 2009, on the retirement of Dr David Jeffs.

Compared to many jurisdictions, Guernsey is clearly a relatively healthy place by many measures. Great credit can be taken for this by the people of Guernsey themselves, its businesses, States Departments including Health and Social Services, and previous Medical Officers of Health (MOH) and their Directorate staff. However, there remain many challenges to both maintain and improve the state of public health in Guernsey.

I report on work carried out in departments of the Directorate in chapter two.

In the first part of this report I reflect on some of the achievements in public health improvement in Guernsey, but also consider some of the major health challenges that will face Guernsey over the next few years with some early recommendations to maintain improvement. For convenience, I consider issues within three often used domains of public health; health protection, health promotion, and health and social care services, although, of course there is considerable overlap between them.

Health protection

This is the aspect of public health practice that protects people from communicable disease, chemical and other hazards.

Fundamental to health is clean water, clean air, shelter, nourishing food, personal safety, and resources to provide these for ourselves and families. In our current society we often take many of these fundamentals for granted

Water

Many parts of the world still do not have safe water and sanitation, or enough water for food production. WHO estimated that around 3% of deaths and disability adjusted life years are attributable to unsafe water and sanitation (<http://www.who.int/whr/2002/chapter4/en/index7.html>, accessed 11th August 2009) Guernsey Water, with the support of the States Analyst Laboratory, work tirelessly to maintain our wholesome water supplies. This includes monitoring many aspects of the chemistry and microbiology of our water supplies. There has been an issue concerning Perfluorooctane Sulfonate (PFOS) in water supplies which will be considered in a future report.

¹All of us living and working in Guernsey have a role and duty in protecting our water catchment from pollution.



Air

The serious consequences of exposure to high levels of urban ambient air pollution were made clear in the mid-20th century when cities in Europe and the United States experienced air pollution episodes, such as the infamous 1952 London smog, that resulted in many deaths and hospital admissions. Subsequent clean air legislation and actions reduced ambient air pollution in many regions.

Urban air pollution is largely and increasingly the result of the combustion of fossil fuels for transport, power generation and other human activities.

Guernsey had an average of 73 male and 71 female cancer deaths per year between 2004 and 2006 (plus about 10 cancer patients per year with an unknown cause of death). This compares to 66 male expected and 72 female expected per year if Guernsey had the same rates as the South-West Region of England, and although about 5% higher than in the South-West, this falls within natural variation (95% confidence limits on these reasonably small numbers are 57-92 for men and 55-90 for women). Or in other words, while Guernsey has a slightly higher number of known cancer deaths than would be expected this difference is not statistically significant and still wouldn't be if all unknown causes of death in cancer patients turned out to be cancer deaths.

As noted above, Guernsey has a 5% not statistically significant higher incidence of cancer compared to the South-West. This is explained by a statistically higher cancer incidence in the following smoking related cancers, lung, head and neck, and bladder. (Source: *Channel Islands Cancer Registration Report, December 2008, incorporating 2004-06 data*).

Guernsey had 20 (95% confidence interval 12.2 to 30.9) infant deaths in 2000 to 2008, compared to 29 expected if Guernsey had the same rate as England and 25 if the same rate as in the South-West. The rates of deaths per 1000 live births were 3.6 for Guernsey, 4.5 for the South-West and 5.2 for England. Between 2000 and 2008, Guernsey was not statistically different than the South-West or England as regards stillbirths, infant deaths or deaths in children aged 1-14 years.

Suggestions that public waste incineration in Guernsey has or will cause a detectable excess of cancer or infant deaths are implausible.

Some of the work by the Environmental Health Department on air pollution on the island is considered later, and demonstrates risks in Guernsey are lower than urban areas.

As noted in previous public health reports and the Sustainable Guernsey report, the likely consequences of human activity, energy use, and combustion processes, leading to global warming, is perhaps the greatest and most complex long-term public health challenge of our time, as highlighted by the Chief Scientific Adviser and Head of the Government Office for Science and many others (ISSC 2005).

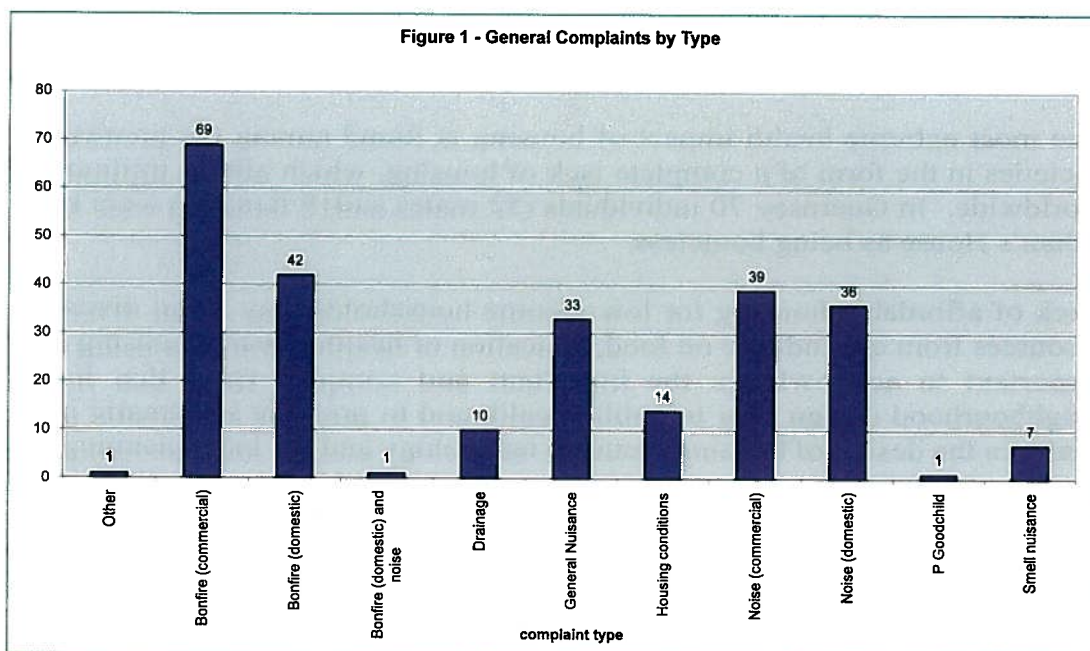
Passive smoking is a major air pollution risk on the island. This is known to be causal for lung, other cancers, coronary heart disease. There is also a strong link with adverse health effects in children. (<http://www.dh.gov.uk/ab/SCOTH/index.htm>, accessed Aug 11, 2009). Guernsey has successfully introduced the Smoking (Prohibition in Public Places and Workplaces) (Guernsey) Law 2005 (see the *'Protecting The Health Of Workers And The Public Against Environmental Tobacco Smoke'* report, Billet d'Etat III 2005).

²Alderney and Sark are recommended to introduce a similar prohibition in public places and workplaces law as in Guernsey.

Passive smoking remains a problem in domestic settings and public places.

³Further measures should be considered to protect people from the risk of passive smoking in domestic settings and public places.

Bonfires are an ongoing air pollution problem in Guernsey. This is dealt with currently by the Environmental Health Department in relation to statutory nuisance (smoke). In 2008, 69 complaints were received regarding commercial bonfires and 42 complaints regarding domestic bonfires. A complaint relates to a property where there is burning and it does not illustrate the number of people that may have complained or whether multiple visits were made. For instance in one premise creating a smoke nuisance, there were 6 complainants and over 100 actions from Environmental Health over a period of months, but this is only currently registered as a single complaint.





Over a year, only a very small number of ‘Abatement of Recurrence of Nuisance’ Notices in relation to persistent offenders are served. Non-compliance with such a Notice results in legal action through the Courts.

In the future commercial burning problems will be managed with the pollution regulation legislation and the licensing regime.

While Guernsey’s air quality is good (page 33) traffic is a major contributor to the pollution we have. There is currently no testing of vehicle emissions.

⁴There should be vehicle emission testing to further improve air quality.

Food

Food is obviously a fundamental need. As the population of the world continues to increase, climate change and scarcity of fossil fuel is likely to lead to reduction of world food production, its variety and availability. Consequently the price of food is likely to increase. ‘Food security’ for the island population will be an increasing concern in the future.

⁵It is recommended that Guernsey takes note of the likely future impacts of climate change and, accepting the natural constraint that the shortage of land within the island imposes, plans to be able to be as productive and self-sufficient in food as possible.

Housing and health

The primary purpose of buildings worldwide is to protect humans from the hazards and discomforts of outdoor environments and to offer a safe and convenient setting for living and human activity. Furthermore, people (especially in temperate and cold climates and in industrialized societies) spend most of their time indoors in buildings such as homes, offices, and schools.

The most extreme health impact of housing is found among the poorest sectors of societies in the form of a complete lack of housing, which affects millions of people worldwide. In Guernsey 70 individuals (52 males and 18 females) were known to St Julian’s House as being homeless.

Lack of affordable housing for low-income households may mean diverting family resources from expenditure on food, education or health towards housing needs. It is important to acknowledge the important and complex roles that housing and neighbourhood design play in public health and to promote systematic inclusion of health in the design of housing, housing technology and the local planning processes.

The Housing Department are leading joint work with HSSD on Older People’s Housing and work in developing a Supported Housing Strategy to address the link between health and housing. New social rented housing is being developed in conjunction with the Housing Association to be disability compliant and with eco-sustainable features to reduce energy use and costs for tenants.

Housing is also a key problem for local health services in recruiting staff. While Guernsey prides itself on being a low tax economy, for immigrant workers looking for houses, or for local people wishing to up or down size their houses, the costs appear very high with a 3% stamp duty, while conveyancing costs are very high compared to the UK, where individuals are able to do their own conveyancing if they wish. To try to address this, the Housing Department are developing a key worker accommodation strategy.

Energy

Abundant cheap energy from fossil fuels has had the advantages of enabling technologic advances, and allowing people easy access to secondary and tertiary care. The downside has been that increasing human population and the amount of energy consumed is probably changing the climate, leading to a range of predicted very serious scenarios, including for Guernsey the spectre of sea level rises as the freshwater locked up in glaciers and permafrost melts.

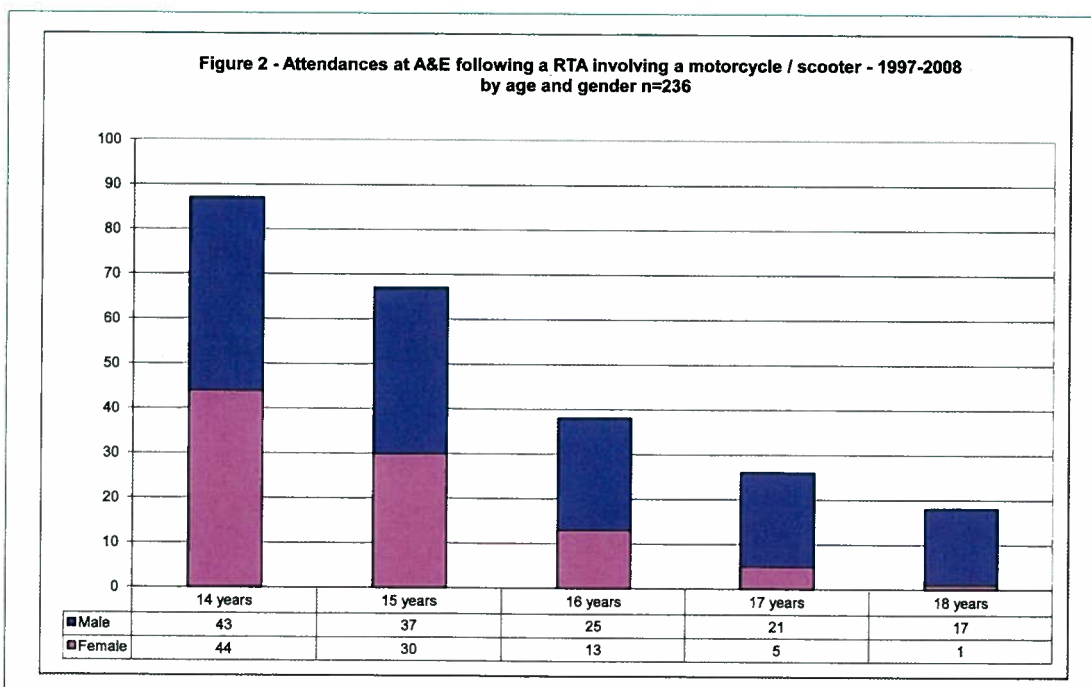
Pandemic Flu

The Director General of the World Health Organisation declared the influenza A (H1N1) pandemic on 11 June 2009. Guernsey had its first confirmed case of this infection on 22 June 2009.

With excellent surveillances systems across the world, we have been able to monitor the spread of the pandemic and its clinical picture as never before.

This subject is considered in more detail in Chapter 2 and further information can be found on the States of Guernsey website. The flu virus, along with many infections is largely spread by respiratory droplets when people cough and sneeze.

Public and businesses need to remain vigilant and to practise good respiratory hygiene.





Peace Time Injury

Although serious injury remains uncommon, injury is the most common cause of death and disability worldwide in those aged between one and 35. While traditionally called accidents, root cause analysis of injuries shows many to be preventable. For example cyclists or pedestrian injuries may be partly attributable to road design for which there are engineering solutions. There is major risk in young people riding motorbikes (*Figure 2*) indicating there is a need in to come into line with other countries.

⁷There is a need to consider changing the law allowing a 14 year old to ride a motorbike.

Injury in conflicts

One of my first impressions was of a retired Guernsey gentleman who intently told me the story of his mother cleaning the boots of German officers when he was a child. There are every day reminders of the occupation locally.

The first Medical Officer of Health was appointed in Guernsey in 1899. This was about the same time that George W. Stevens reported the siege of Ladysmith for *The Daily Mail* (October, 1899). *"You hear the squeal of the things all above, the crash and pop all about, and wonder when your turn will come. Perhaps one falls quite near you, swooping irresistibly, as if the devil had kicked it. You come to watch the shells - to listen to the deafening rattle of the big guns, the shrilling whistle of the small, to guess at their pace and their direction. You see now a house smashed in, a heap of chips and rubble; now you see a splinter kicking up a fountain of clinking stone-shivers. This is a dangerous time. If you have nothing else to do, you get shells on the brain, think and talk of nothing else, and finish by going into a hole in the ground before daylight, and hiring better men than yourself to bring you down your meals."*

While 1899 seems a long time ago it does not quite cover the whole life span of Harry Patch the last Tommy (British soldier who fought in the trenches in World War 1). Henry John Patch was born at Combe Down, a small village near Bath, on 17 June, 1898 in the twilight of the Victorian age, and died on 25 July 2009. Harry Patch did not believe the war worth it. He added: *"I met someone from the German side and we both shared the same opinion - we fought, we finished and we were friends - it wasn't worth it."*

Since 1899, there has been an astonishing array of weapons invented, sold and designed to kill people. Nuclear bombs that in 1945 wiped out whole cities, and are now just babies of the forces modern bombs can unleash. There are numerous armed conflicts in the world today. It is important that we continue to plan for the serious threat of human conflict. Aggressiveness may have stood our species in good stead in becoming dominant in the world, but are we able to control these instincts in all our interests?

Poverty

This can be defined as whether households or individuals have enough resources or abilities today to meet their needs. It is a key factor in many of the high risk lifestyles and diseases as discussed below.

(<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,menuPK:336998~pagePK:149018~piPK:149093~theSitePK:336992,00.html>, accessed Aug 11, 09).

Poverty is linked to health inequalities, and people with certain characteristics, e.g. mental health problems, or certain disabilities, are at risk of poverty and further health problems. The States has a Corporate Anti-Poverty strategy, which is a good thing. It is known that narrow differences in income between individuals, such as in Sweden, are linked to better population health outcomes. If we wish to improve further in Guernsey, it is very important that the Anti-Poverty strategy is driven forward. Further work on minimum income for reasonable living standards is a crucial next stage.

Population size

In 1900 there were one billion people in the world, currently there are about six billion and it is predicted to be nine billion by 2050. In Guernsey in 1900 the population was about 40,000, today it is about 62,000 and in 2050 it is estimated our population will be greater than 70,000. What is a sustainable population for the world and Guernsey? Should each jurisdiction be able to supply itself with adequate clean water and food?

MMR (Measles, mumps and rubella) immunisation and the media

Infectious diseases remain a generally well controlled continuing threat. Immunisations have been some of the most cost effective interventions with the low risk of side effects.

As has been demonstrated in the UK from MMR, the media can have a huge impact on public health. Misunderstanding of science by the media in England arguably led to lower immunisation rates from measles. Low immunisation rates led to outbreaks of measles, and associated deaths and disabilities in the UK that were not seen in jurisdictions where there was more sensible media coverage that did not scare the population unnecessarily. MMR levels of immunisation in Guernsey also dropped thus creating a risk of an outbreak here too.

Guernsey has a respected media with a wide coverage, and it is important that accurate evidence based stories continue to be reported in a responsible manner.

Health promotion

As in other parts of the Western World, since the control of major infectious diseases, a range of diseases partly attributable to lifestyle factors have become the predominant causes of premature morbidity and mortality in Guernsey. While many of these factors, such as smoking, obesity, alcohol, and other drugs, mental health and sexual behaviour are well known, they remain major challenges for the Bailiwick.



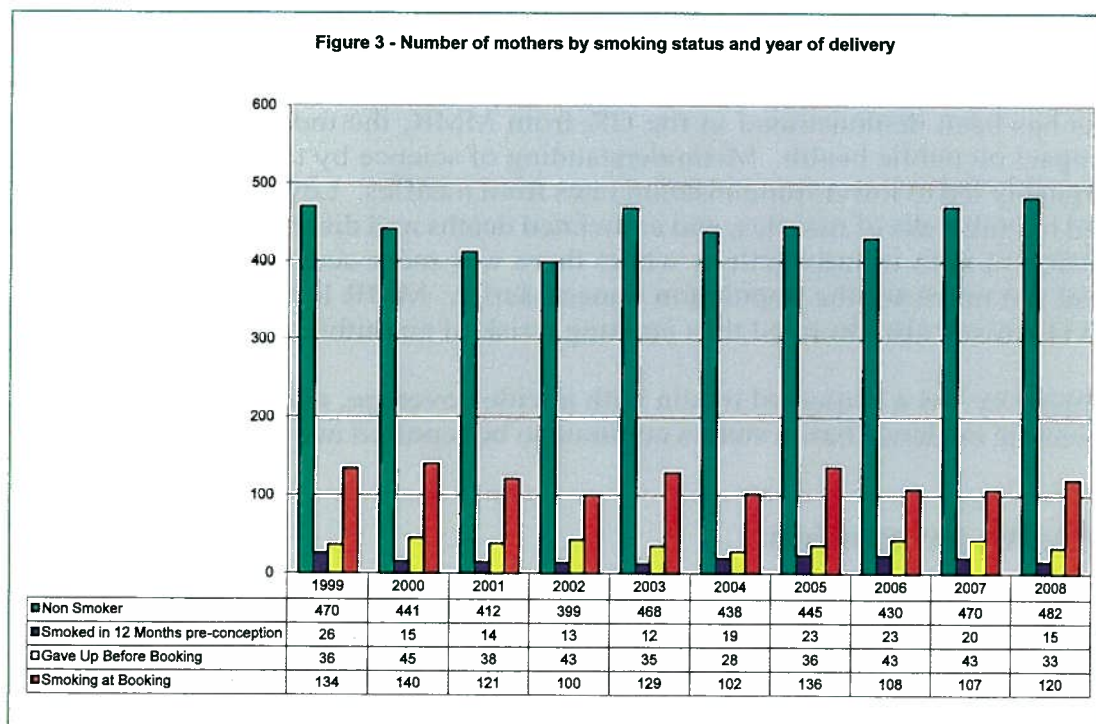
Many and often complex factors are linked with the environment people live in and these are important in helping people to be more likely to make healthy choices. For example a smoke-free work environment helps people who have quit smoking, and a supermarket with healthy food choices by the check-out means people are more likely to buy healthy foods.

There are many interventions that the States, businesses and individuals can make to help people make healthier choices, and every little helps.

The 5th Guernsey Healthy Lifestyle Survey 2008 is about to be published, and has provided some preliminary lifestyle data. This was a survey of a random sample of 1,500 18-74 year olds registered with the three Primary Care practices, of which 735 responded.

Smoking

Tobacco is a dangerous product. Smoking remains the most preventable cause of ill health and death in the Bailiwick. There remain conflicts between public health, free-trade and commerce as this product is legal. It is important that the States work in a well regulated environment with retailers to help people make healthy choices. In the 5th Guernsey Healthy Lifestyle Survey, 2008, 20% of adults said they smoked, of which 60% would like to give up, 18% do not know, and 22% said they did not want to give up. It is estimated that 2,600 men and 2,600 women aged 18-74 years would like to give up smoking. The Quitline smoking cessation service continued to expand with 890 clients attending during 2008, and offering up to ten weeks free Nicotine Replacement Therapy plus support.



The Survey also highlighted:

- 60% of responders said they had never smoked,
- Smoking prevalence in 25-64 year olds over time has reduced from 33% in 1988 to 20% in 2008.
- 88/114 (77%) of smokers started when they were under 19 years old.

Smoking is known to harm unborn babies. There has been little change in the smoking rates in pregnancy in the last decade and this continues to cause major concern (*Figure 3*).

The island has a comprehensive Tobacco Control Strategy that has progressed during 2008. However, much further work is still needed to control the smoking related epidemic which it is estimated prematurely kills one to two people each week in Guernsey.



An example of a modern display of tobacco and sweets

A package of recommendations to reduce the prevalence of smoking amongst young people and help people who want to stop smoking was approved by the Guernsey States of Deliberation on 12th March 2008. These included the following:

- Consumer support, including Quitline telephone numbers on cigarette packets and pictorial pack warnings.
- Ban of advertising at point of sale.
- It was agreed that the Health and Social Services Department, the Home Department and the Commerce and Employment Department should decide the most effective process to license the sale of tobacco.
- Working towards a smoke-free Prison and smoke-free cars.

Areas for future consideration are:

- ⁸ More health professionals trained in brief interventions.



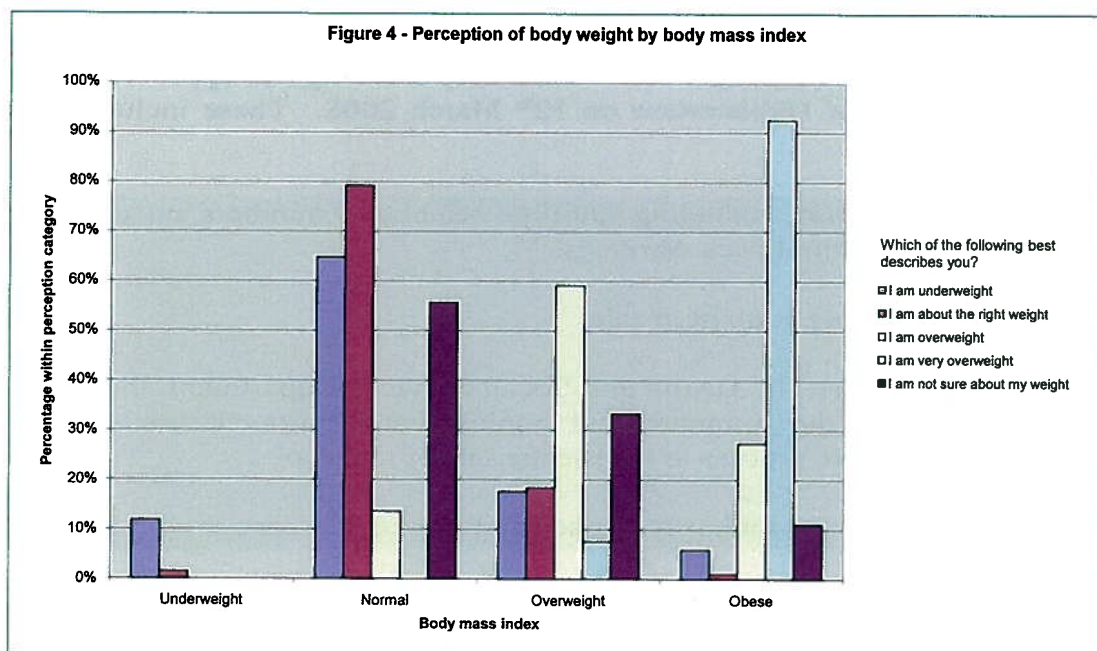
- ⁹ Increase in Quitline services to support less affluent people, pregnant women and families.
- ¹⁰ Ban on the display of tobacco products including duty free outlets.
- ¹¹ Protecting children from passive smoking, in the home, in the car, etc.
- ¹² More involvement of the private sector and the community.
- ¹³ Improved HSSD policies and leadership through smoke-free sites, i.e. no smoking for staff and visitors and the vast majority of service users (there is currently a consultation on this).
- ¹⁴ States owned airline not selling tobacco.

Currently there is not a cross-departmental Strategy Steering Group to develop and implement a tobacco control strategy.

¹⁵I recommend a cross Government Tobacco Control Steering Group is formed to include representation from the private sector.

Obesity

Obesity is rapidly approaching smoking as the most important cause of death and ill health in the Bailiwick, and is a major public health challenge. Obesity is associated with problems such as type II diabetes, heart disease and cancer. Dealing with the side effects of obesity will also be a key financial challenge for the island.



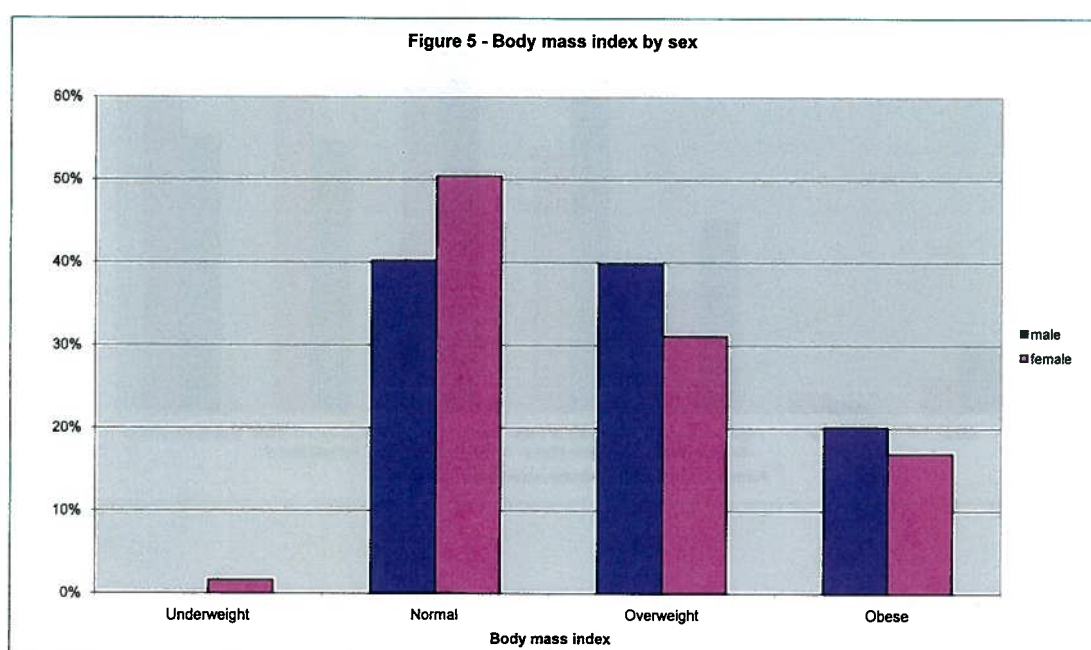
In the 5th Guernsey Healthy Lifestyle Survey 2008, the majority of people were aware of their Body Mass Index (BMI) category (*Figure 4*). Twenty percent of men and 17% of women responders were obese, of which 7% of women had a BMI score of 35 or more. Half of the men responders aged 35-44 were overweight or obese, increasing to two thirds in older men. Two thirds of women aged 55-64 were overweight or obese (*Figures 5 and 6*).

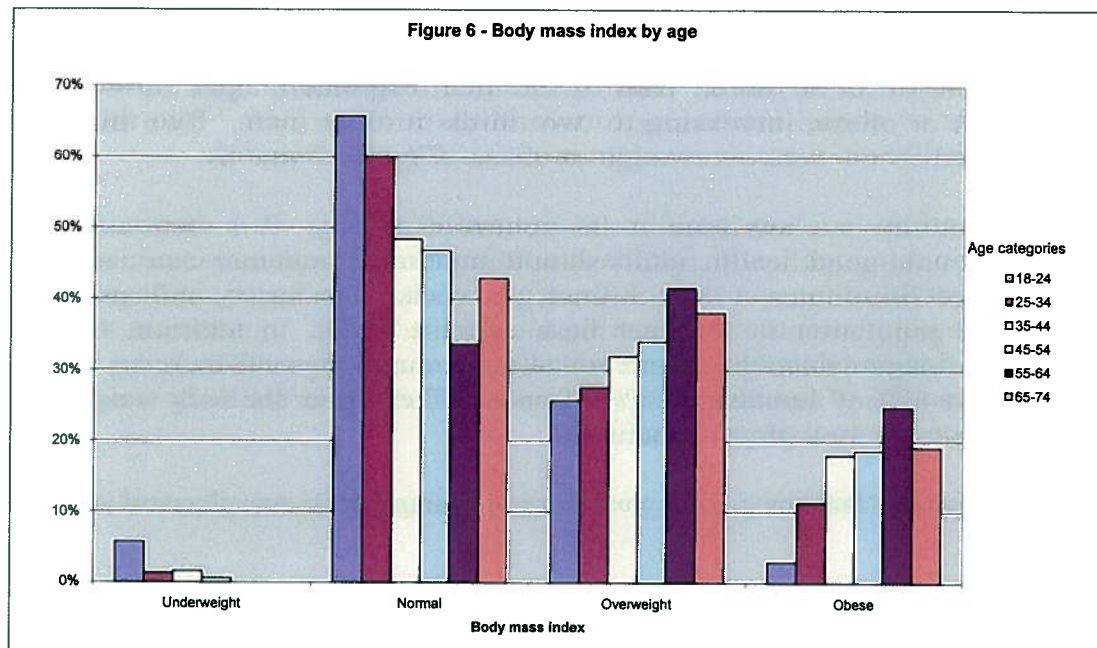
Physical activity is a key issue in the control of obesity. It is recommended that to maintain good health, adults should undertake moderate exercise for a minimum of 30 minutes at least 5 times per week. The survey indicated that 75% of the population do not meet these exercise levels. In addition, 40% of the population perceived they were not taking enough physical exercise, which varied from 45% of females to 35% of males. The higher the body weight the less often people took physical activity.

The predominant reasons people gave for not taking part in any physical activity were:

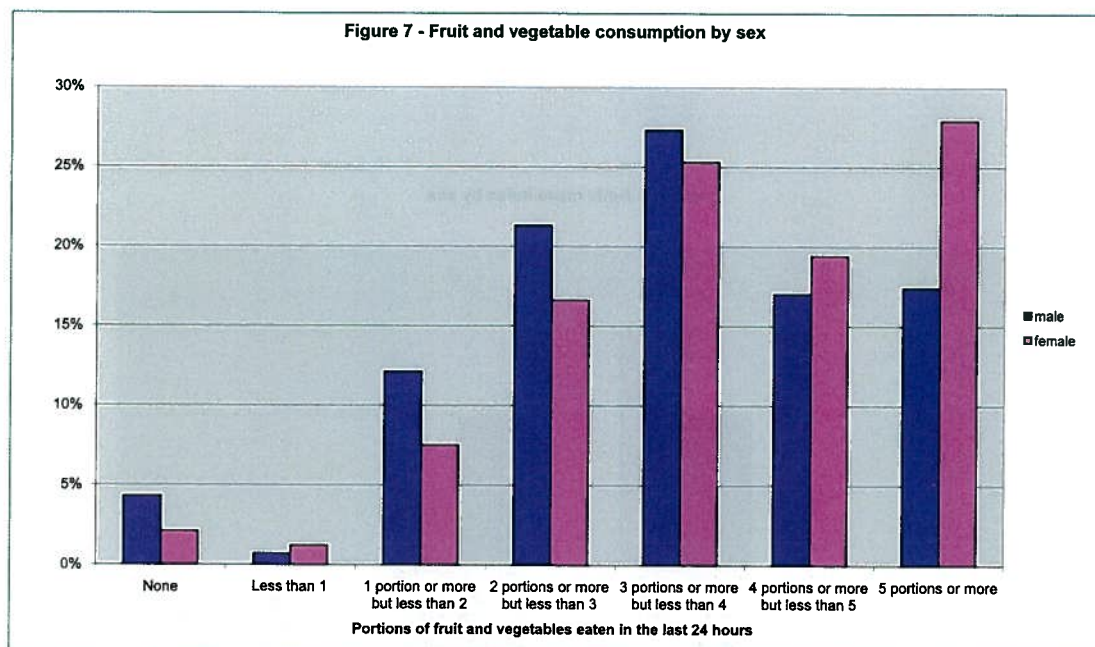
- Lack of leisure time
- Lack of incentive

Lack of leisure time, was given as a reason by 50% or more of those aged 18-64 years, but for the over 65 years just 23%.



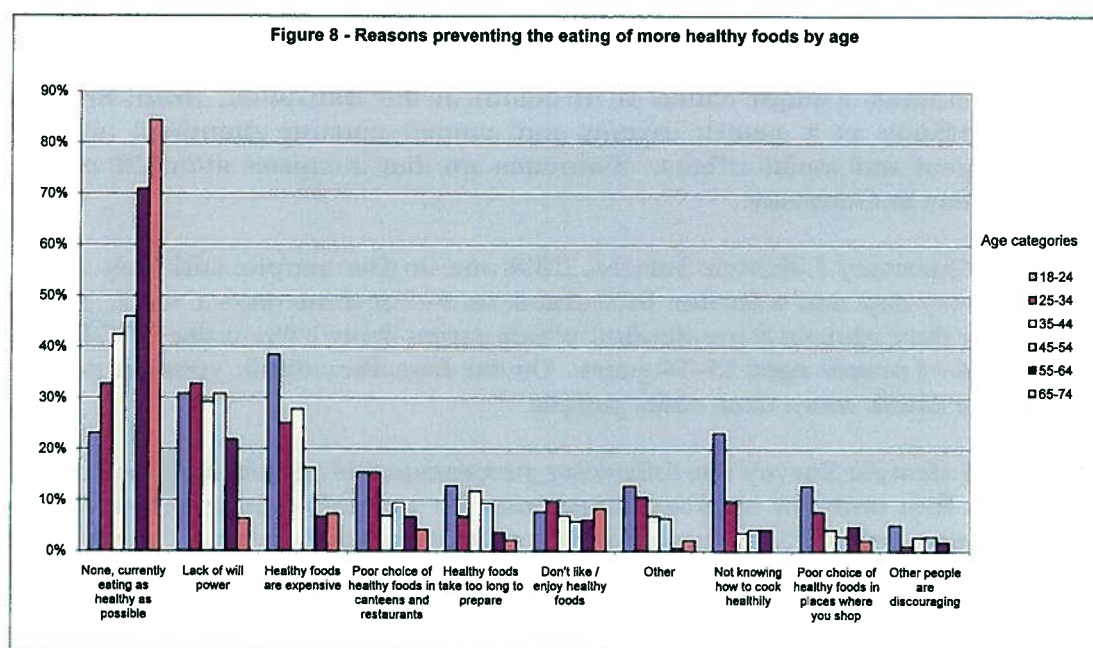


Diet is another key factor in tackling obesity. Five portions of fruit and vegetables per day are recommended. Many people said they had made healthy changes and were eating more fruit and vegetables, less fried and fatty food, less processed and convenience foods and less sugary foods. However, only about a quarter of people were meeting the recommended five portions of fruit and vegetables a day (*Figure 7*).



Approximately 20% of people thought the reason they did not eat more healthy food is because it is expensive, which varies from 38% of 18-24 year olds to 7% of those aged 55-64 years (*Figures 7 and 8*).

While health services might treat the consequences of obesity, the cause is very complicated. One key causal element is the marketing of high energy dense foods and sweets that, while often very enjoyable at the time we eat them, do not satisfy our hunger but give us many more calories than we expend. As a species our bodies are adapted to plan for the bad times, so they put this excess energy down as fat.



Obesity has already been recognised as a crucial issue for public health in Guernsey. We have failed to control rising levels of obesity in the last three decades. It can be anticipated that at least three decades of hard work will be required to control and reverse the obesity trend. The Guernsey Obesity Strategy will be presented to the States later in the year. Recommendations include:

- Setting up a cross States group to continue to develop and implement the strategy.
- The resources to co-ordinate the strategy and deliver obesity services, together with a measurement programme for children.
- Improving obesity surveillance.
- Increasing physical activity levels.

In addition I recommend the following:

¹⁶Consideration should be given to the restriction of marketing of high energy dense foods.



¹⁷Working with retailers on promoting healthy products and consideration of tax on foods that are associated with obesity, as this is known to reduce consumption.

¹⁸The States should take a lead and have a healthy food policy for its staff and visitors.

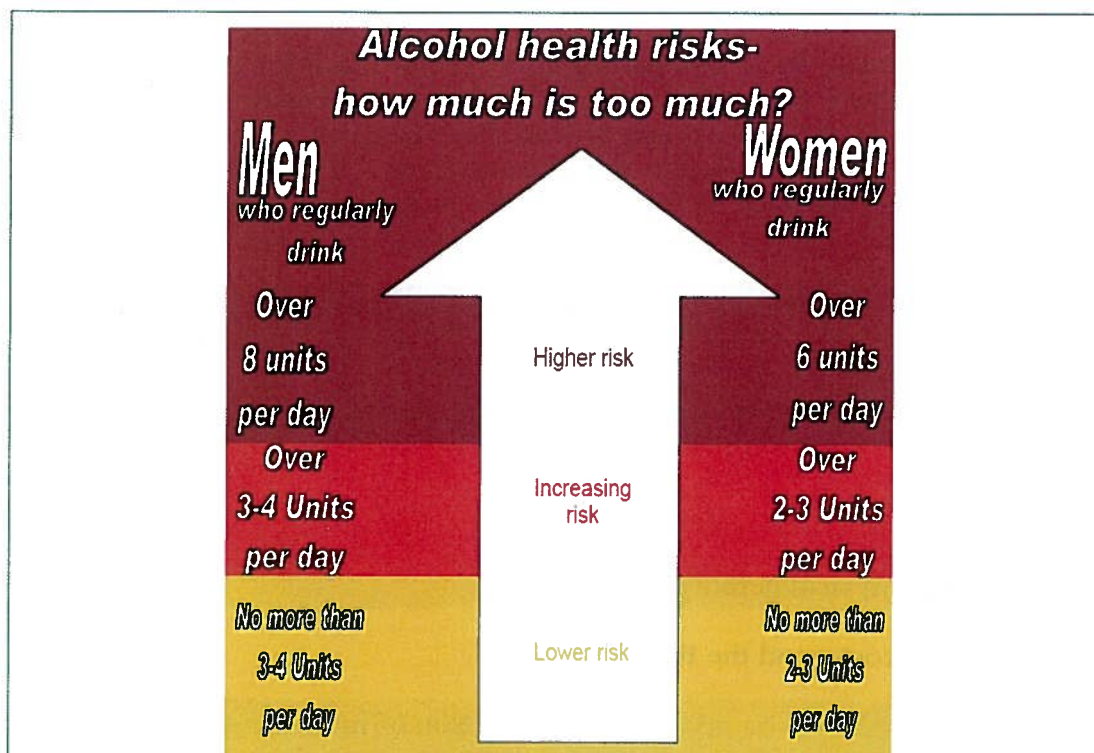
Alcohol and drugs

From ancient times, drugs such as alcohol have been used to change mood and perception. The key objective of policies to control consumption is to reduce harm to individual consumers and to third parties.

Alcohol remains a major cause of ill health in the Bailiwick, from both its physical effects as a gastric irritant and cancer causing chemical, and its psychological and social effects. Estimates are that it causes about 20 excess deaths a year in Guernsey.

In the 5th Guernsey Lifestyle Survey, 2008 one in five people said they drank alcohol every day, and a further 36% drank on two or three days a week, 8% of people say they abstain from alcohol which varies from 14% in the 65-74 year olds, to 3% of people aged 25-34 years. On the days they drank, younger people on average drank more than older people.

From the Lifestyle Survey the following percentages of people said they drank more than four units for men and three units for women on at least one day in the previous week; 67% of men and 39% of women aged under 25 years; 44% of men and 32% of women aged 25-64; and 33% of men and 5% of women aged 65-74.



There is no guaranteed 'safe' level of drinking but there is a lower risk level for which the risks of harm are in general relatively low (Figure 9).

There is no guaranteed 'safe' level of drinking but there is a lower risk level for which the risks of harm are in general relatively low (Figure 9).

- **Lower risk drinkers** are men who don't regularly drink more than three to four units of alcohol a day and women who do not regularly drink above two to three units a day.
- **Increasing risk drinkers** are men who regularly drink above three to four units of alcohol a day and women who regularly drink above two to three units a day.
- **Higher risk drinkers** are men who regularly drink more than eight units a day or 50 units a week and women who regularly drink more than six units a day or 35 units a week.

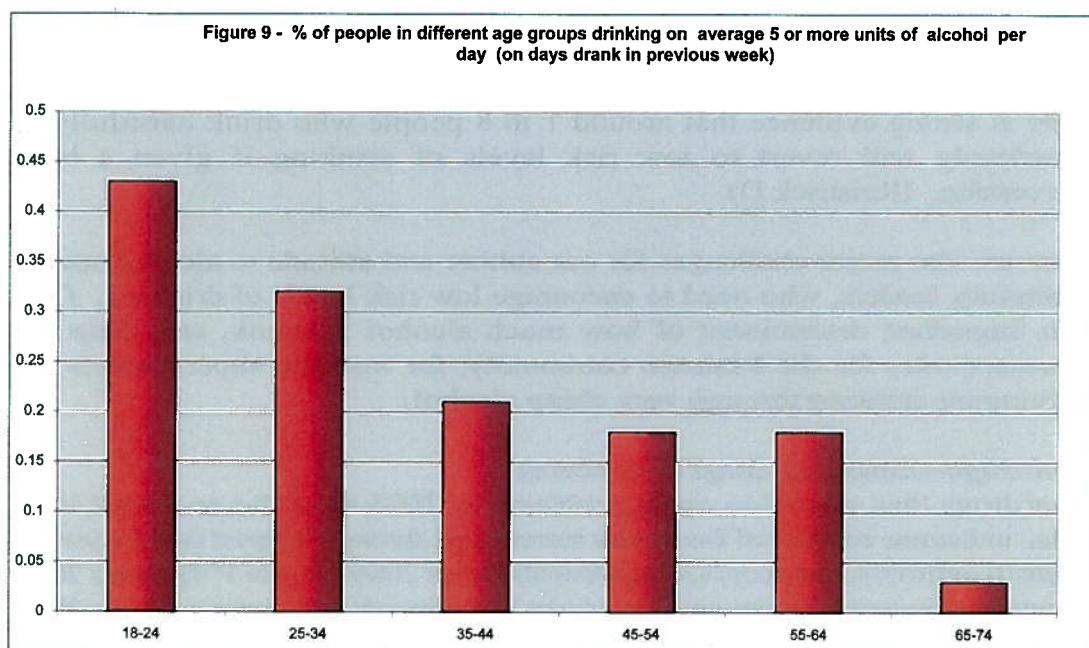
(<http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx>)

In the interest of economy, Guernsey had hoped to use the NHS campaign materials, but currently has not been permitted to do so, therefore local posters, leaflets and postcards were produced as part of the campaign in 2008 and went out to 300 businesses as well as to supermarkets and off licences. As yet, again the self help manual has not been available to Guernsey during 2009.

¹⁹Continue and expand the "Know your Limits" social marketing campaign in Guernsey. (<http://units.nhs.uk>).

²⁰Produce a self help manual "*Your drinking and you*", mirroring the UK initiative and ensure materials are available locally.

²¹Undertake further work on the health impact of alcohol in Guernsey with the lead Public Health Observatory for alcohol in England.





Advice for When You Have a Drink

Staying in – How your units build up

1-2 units	“First drink of the evening: I always have a glass of white wine...”	Tip: Have something to eat before your first drink
2-4 units	“My other half’s home - time to top up my wine glass too!”	Tip: Replace your second drink with a soft drink
3-5 units	“Normally I’ll wash down my dinner with a beer or two.”	Tip: Make it a half pint
5-7 units	“If there’s still some wine left in the bottle, I’ll usually polish it off.”	Tip: A bottle of wine may contain more than 10 If you finish it off you’ll exceed the limit for healthy drinking
7-9 units	“...time for a nightcap. I fancy a shot of whisky”	Tip: A soft or hot drink is a much healthier choice

<http://www.units.nhs.uk/index.php>

There is strong evidence that around 1 in 8 people who drink harmfully or hazardously will revert to low risk levels of drinking if given a brief intervention. (Raistrick D).

There are also major challenges for our culture and attitude to alcohol among community leaders, who need to encourage low risk levels of drinking. Cost is an important determinant of how much alcohol is drunk, and there are important roles for the business community, for instance supermarkets not encouraging drinking through very cheap alcohol.

Legal Highs (Emerging drugs of concern)

Other drugs that started to cause problems in 2008 were the so-called legal highs, and some control of these was introduced through Import and Export of Goods (Control) (Guernsey) (Amendment) Order 2009. From 1st October 2009 the new Medicines (Human and Veterinary) (Bailiwick of Guernsey) Law, 2009 will give the States of Guernsey various options to further control the use of these emerging drugs of concern.

It remains a major concern that so many untested and unregulated products that affect the human mind and body are being sold on the internet and may be supplied to Guernsey people from other jurisdictions.

There is also an issue that making consumption of drugs for personal use illegal can itself have the side effects of major and long lasting social problems for individuals so convicted.

It is recommended:

²²To increase the proportion of multiagency professionals trained in brief alcohol interventions who use this as part of their routine work.

²³To continue involvement with the private sector in the alcohol and drug harm control strategy to build on achievements to date, such as free Citizen cards for the 18+ year old and the local Pubwatch scheme.

²⁴To provide better consumer advice on safe levels of alcohol and harms at retail outlets and on products produced locally.

²⁵To consider positive feedback and rewards to licensees that run their businesses in a socially responsible way, such as the “Best Bar None Award” scheme.

²⁶To remove duty free on alcohol sales.

Mental health

It might be surprising to some that mental health issues are the largest cause of loss of disability adjusted life years. They are also the major reason people are incapacitated from working, and consequently a major draw on public resources.

The 5th Guernsey Lifestyle Survey, 2008 asked a series of questions on people’s perceived mental health. The top cause of anxiety and stress was pressure at work, affecting about 30% of people. Other top issues are money worries, staffing levels at work, health of the family and relationships between family members. For those who have only been on the island 0-4 years, the problems associated with living on an island were important.

In terms of factors that reduce anxiety, discussing the problem with another person was seen as the most important for every age group followed by resting and relaxing.

It is known many interventions can help people. The prevention of one person from having serious depression is an investment that is likely to pay for itself.

²⁷I recommend the States should invest in a part-time health promotion post to lead on mental health promotion for Guernsey to work with businesses, other agencies, and to help us secure demonstrable mental health improvement in the island.



Health and Social Care Services

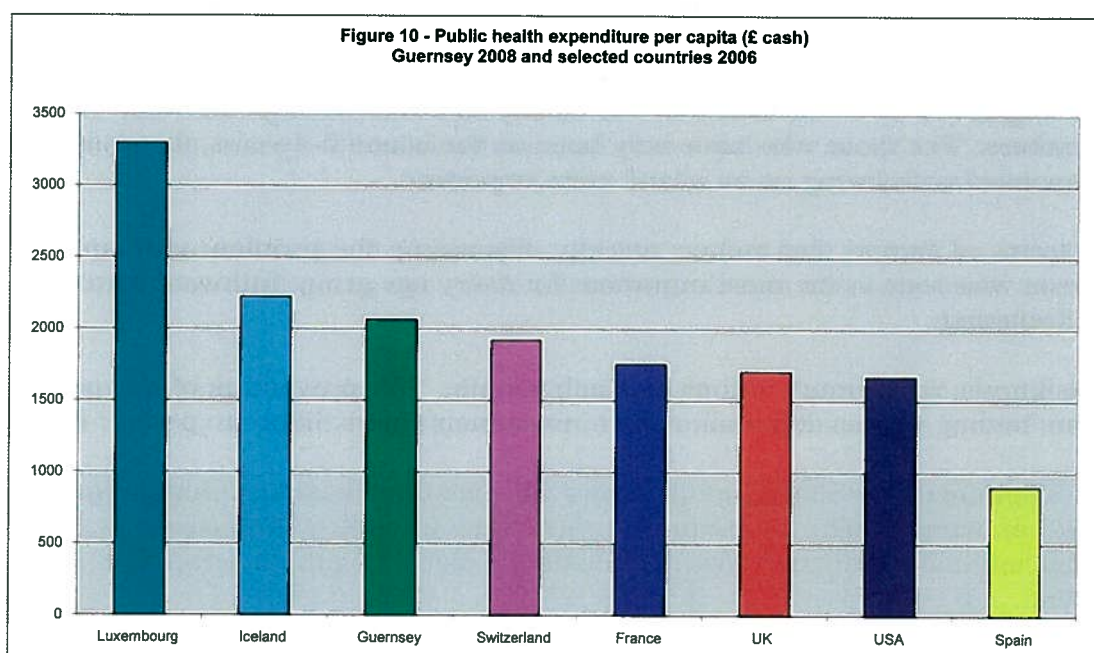
Resources and Pressures

Some recent local press opinion has highlighted recent resource pressures.

'Guernsey is where it is because for a generation plus, money has been easy to come by and easy to spend on staff on public services...Before zero-10 and a crushing recession, the name of the game was service creep as whatever enhancement could be devised could generally be afforded'.

Guernsey Press, editorial, page 28, August 25, 2009.

The States decision to abolish corporation tax (the introduction of the 'Zero / 10' tax regime), in order to make Guernsey a more attractive place for businesses, came into effect on the 1st January 2008. The amount of company tax (companies and banks) taken in the years leading up to the implementation of 'Zero – 10' was £96m in 2004, £110m in 2005, £108m in 2006 and £121m in 2007. Some measures have already been taken to help mitigate this loss including increases (in January 2007 and January 2008) in the social security contribution rates as well as significant increases in commercial property tax over the past two years. However, the States are now operating a fiscal deficit. There will be a States debate and decisions on the States Strategic Plan (October) following which there will be a more complete picture of the size of the deficit in 2010 and the measures that are going to be needed to address this. In 2008, The Health and Social Service Department's budget was £94million (27% of £349m, tax take), of which £80m was invested in HSSD provided health services (excluding social care), and £8m in purchasing off-island healthcare (ring fenced expenditure). The HSSD's expenditure for 2010 is predicted to exceed that provisionally allocated by around 3.5% of budget, or £3.5m. Guernsey public health-spend per head of population is similar to other western countries (*Figure 10*).



The Social Security Department also plays a very major role in purchasing healthcare, investing about £35m in health care of which key budget elements in 2008 were:

- Prescription drugs, medical appliances and domiciliary oxygen £15.7m, of which £1.5m paid by the public in prescription charges (£2.70 per item in 2008)
- Contract with Medical Specialist Group - £12.1m
- Long-term Care Insurance Fund, invested £6.7m on nursing care beds (a further £5.5m on residential care beds is not included in *figure 10*).
- Consultation grants (£12 doctor, £6 nurse) - £3.5m
- Travelling Allowance Grants (TAG) for off-island medical treatment - £1.6m
- Contract with Guernsey Physiotherapy Group - £1.5m
- Healthcare expenses paid for people receiving supplementary benefit (approximately £1.5m):
 - medical £1.0m
 - dental £249,000
 - chiropody £74,000
 - ophthalmic £61,000
 - physiotherapy £48,000
 - hearing aids £41,000
- Wheelchairs, stair-lifts, bath to shower conversions etc - £329,000
- Medical Expenses Assistance Scheme (MEAS) for other low-income people - £123,000

There is also considerable private health and social care expenditure, either through one of the several local insurance schemes or purchased directly by individuals.

One of the potential disadvantages for funding being in different public budgets is that priorities and criteria for resource allocation may vary between budgets, potentially leading to less efficient and effective decisions.

On the face of it the HSSD has increased the on island costs and cost to the tax payer, and may be criticised if it overspends. In some cases, apparent overspending in some budget areas may have reduced costs for “Guernsey plc” in the wider sense. Here are two examples:

The actual cost of having a scan overseas may include the cost of the scan (approximately £600) funded from the off-island budget, the cost of a travel assistance grant of £100 to £200 to cover airfares, taxis, subsistence for the patient and possibly a similar carer’s grant, all from the Social Security Department’s budget. In addition, individuals may pay for the costs of an accompanying person if they are above the means-tested threshold for State support, and there may be lost work-time for a patient and carer and inconvenience to others, e.g. looking after children etc. If the scan was provided locally, this may be the best option for Guernsey “plc”.



However, if the development was funded from within HSSD existing resources, such a service would need to be prioritised against other HSSD funded developments. If the service was provided on island there would be savings in Social Security costs, private individual costs and employer costs, however the HSSD budgets would not be recompensed with a similar amount.

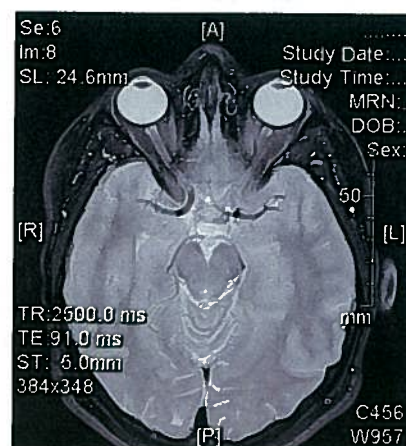
Following mastectomy, patients were attending outpatient appointments with a reconstructive breast surgeon in England. The surgeon now does outpatient clinics in Guernsey. The cost of the surgeon attending is much less than the travel grants for patients and carers attending England. Considerable private costs and inconvenience are saved for patients. The HSSD has met the increased costs from within existing budgets, but there is no legal mechanism to transfer the TAG grant that would have been expended to cover the HSSD costs. On paper the HSSD would seem to have an unfunded 'creeping' development, but in practice the change in practice saved resources for the States of Guernsey taxpayer, and private individuals and businesses, as well as being better for patients and the right thing to do for Guernsey.

Considering value from the HSSD budget in isolation could lead to one logical decision, e.g. not to have funded a new Guernsey development, while taking a different perspective including costs to the rest of the public sector in Guernsey and the private sector, might lead to a different decision. In the current economic climate, all the elements need to work collaboratively in working up any proposals for (dis)investment, so that the true cost of any decision is shared by all the participants, and any benefits proportionately shared.

On the other hand, some developments have undoubtedly been from "creeping" developments, where clinicians have changed the patient pathway for a patient, with the very best of intentions, without considering the extra resources required.

Reasons for Pressures on Health and Social Care Expenditure

Guernsey is not alone in facing pressures on health and social care expenditure, and how to contain it. In Western economies, during the last fifty years, total health care expenditure as a proportion of Gross Domestic Product (GDP) has increased two to threefold (*Figure 11*). There are several reasons for these pressures.

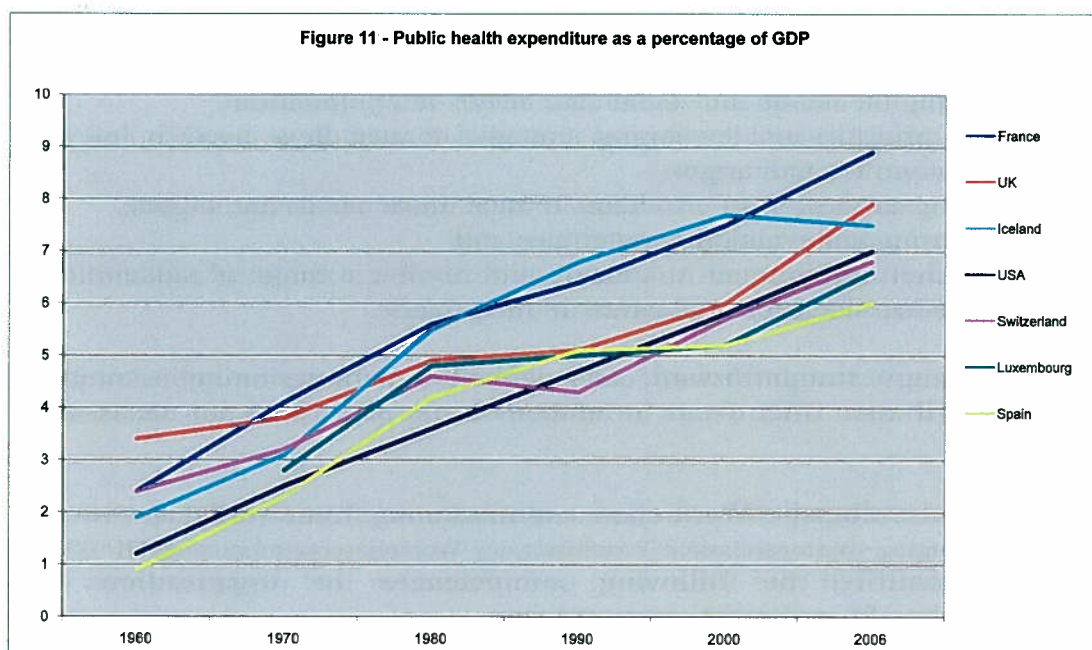


Firstly the huge increase in technology for assessment and treatment following astonishing human invention, including imaging machines, such as magnetic resonance imaging that can show in minute detail the brain and other organs in three dimensions, mechanical technologies such as joint replacement, heart valve replacement, bone-anchored hearing aids, anti-viral drugs, anti-cancer drugs, drugs to modify the immune system etc, etc, etc. It is likely that available technology will continue to rapidly expand. As treatments improve they do not necessarily reduce costs. This was observed as long ago as 1956 by an NHS committee of enquiry and is still relevant today.

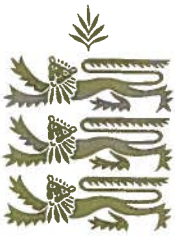
‘The growth of medical knowledge, adds continually to the number and expense of treatments, and, by prolonging life, also increases the incidence of slow-killing disease. There is no evidence to predict whether the speeding of therapy and the improvement of health will ultimately offset this expense...’ Report of Committee of Enquiry into the Costs of the National Health Service (*Cmmd 9663, 1956, para 95*).

Secondly the aging population - the majority of health care expenditure is, as would be anticipated, invested in older people, in particular the month before death. As our population ages, so will the cost to maintain existing services to people with the same needs.

Thirdly, public expectations - the public has access to more knowledge than ever before, and it is now not uncommon for an individual to attend a health care professional with a wad of information pulled off the internet, and with clear views on the treatments they want. Some websites may largely be for marketing products. So public expectations, sometimes unrealistic, continue to rise.



Source: OECD 2009 (Guernsey figures not available at time of print)



Fourthly, regulation - our professional staff largely link in with the UK for regulation and licences to practice. The amount of regulation and hoops all professional staff have to go through to be judged to be practising safely continues to increase. For instance, in late 2009, a new system of revalidation and relicensing for doctors will be introduced in the UK. Guernsey doctors will be required to participate. If they do not participate they will lose their licence to practise. In addition, some doctors will need to act as responsible officers for revalidation and relicensing. Revalidation and relicensing has not been costed, but will take up resources, that will, on the face of it, suggest a less efficient service, although it may be a higher quality one.

Fifthly - some element of inflation of staff costs, as staff in financial terms are the largest cost on public health and social care services, accounting for almost 70% of HSSD revenue expenditure.

The consequences of the above trends are likely to be increasing pressures on public and private funding.

Commissioning Services and Priority Setting Framework

Commissioning, of health and social care services, is a broad concept and there are many definitions. In England the Department of Health has stated that commissioning is the means by which the best value for local citizens and taxpayers is secured i.e. the best possible health and wellbeing outcomes and health and social care provision, within the resources available.

It is an on-going process that applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the independent sector. Most definitions of commissioning paint a picture of a cycle of activities at a strategic level - concerned with whole groups of people - including:

- assessing the health and social care needs of a population;
- setting priorities and developing strategies to meet those needs in line with national policy and targets;
- securing services from providers to meet those needs and targets;
- monitoring and evaluating outcomes; and
- an explicit requirement to consult and involve a range of stakeholders, patients/service users and carers in the process.

While seemingly straightforward, each element of commissioning is complex. Elements will also often occur in tandem so the process is not necessarily sequential.

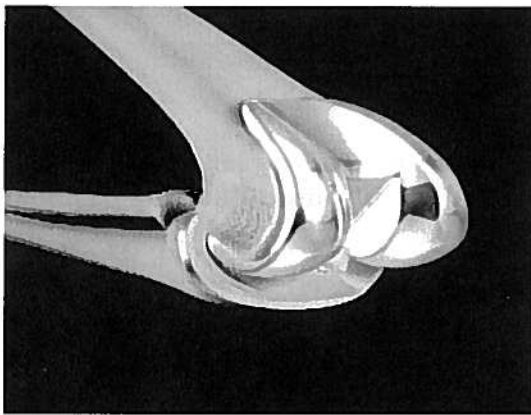
England has developed a World-class commissioning framework (http://www.dh.gov.uk/en/Managing_yourorganisation/Commissioning/Worldclasscommissioning/DH_083201) and has identified the following competencies for organisations that commission health and social care services:

- reputation as a local leader;
- to conduct constructive partnerships;

- public and patient engagement;
- clinical engagement;
- prioritisation of investment to improve the population's health; and
- incorporation of priorities in the strategic investment plan.

Need

A health and social care need may be defined as a health and/or social care problem which someone has, plus evidence that something can make a difference to that problem. For instance, there is very good evidence that a joint replacement can relieve severe pain in someone with a joint destroyed by either rheumatoid or osteoarthritis and help them be pain-free and regain some mobility.



In this case, a joint replacement for someone in severe pain from a hip and knee joint badly damaged by the disease rheumatoid or osteoarthritis is a need which can be met, either through a publicly or privately commissioned service. Needs can also be identified by surveying professionals, patients or the public.

Health and social care professionals assess the individual needs of patients. For planning public services, needs are assessed for the whole population. There are inherent tensions between needs taking into account only the individual in front of a particular professional, and the needs of a whole population of people.

Although traditionally a need is defined by evidence that something can help, where there is no good evidence for an effective intervention, then research is needed to find one. There are major public and private health and social care research initiatives worldwide.

Sometimes people may choose to ask for something in which there is no good evidence of benefit, and this would be considered a want or demand. In a private system such services are often supplied. In a publicly funded system, it would seem reasonable not to purchase them?

Priority-Setting

All societies have a limit on resources and all have very difficult decisions to make. The process of making decisions is priority setting.

Health and social care interventions and systems are an incredibly complex business. Health and social care services are very personal services. We all have had very deep emotional experiences concerning health issues, whether our own health or those of our family and friends. In priority setting in health and social care, there is always some mix of rationality and emotion, and of different values and beliefs.



The States determine the budgets for each Department. Within the HSSD and the Social Security Department (SSD) decisions are made by a primarily politician constituted Board with professional advice, in which political members are the only ones with voting rights. There is a cross-organisational committee, the Community Health Insurance Purchasing Sub-Committee (CHIPS) that involves both the HSSD and the SSD, politicians and officers that steers secondary care interventions funded from the specialist health insurance scheme.

Currently decisions across the States are not made within an explicit priority-setting framework. There is no primary care commissioning system that I am aware of.

²⁸It is recommended that the relationships between the States and healthcare providers are reviewed.

There is an increasing body of evidence on how to priority set in health and social care. A rationale for achieving robust and fair resource allocation is given below (NHSC):

- | | |
|---|---|
| ● It improves the overall health and wellbeing of the population. | ● It aligns investment to pre-agreed strategies, priorities and policies. |
| ● It is more ethical because it gives competing needs a fair hearing. | ● It is a requirement of good corporate governance. |
| ● It increases public and patient confidence. | ● It adds legitimacy to decision making |
| ● It helps achieve financial balance. | ● It provides better value for money. |
| ● It reduces the risk of successful legal challenge. | ● It is operationally more efficient. |

There are a range of common factors which public bodies allocating resources in health and social care services take into account in their decision making (NHSC):

- | | |
|---|---|
| ● Need to redress inequalities and inequities of access | ● Confidence in the clinical and social care evidence |
| ● Number of individuals benefiting | ● Cost effectiveness |
| ● Nature of the health gain | ● Accessibility |
| ● Local priorities | ● National priorities |
| ● Clinical risk | ● Service risk |

- Absolute cost of development
- Legislation and directives
- Patient choice

An example of the framework used by one health and social care body to prioritise which services to fund and which to not fund is given below (NHSC):

- **Health outcome** – we will prioritise interventions that produce the greatest benefit for our population.
- **Clinical effectiveness** – we will prioritise interventions with sound evidence of effectiveness.
- **Cost effectiveness** – we will prioritise interventions which yield the greatest benefit relative to cost of provision.
- **Equity** – we will prioritise on the basis of clinical need, not on the basis of age, ethnicity or lifestyle.
- **Inequalities** – we will prioritise to ensure full access to existing pathways for the majority over funding for new or experimental technologies for the minority.
- **Access** - we will prioritise delivery of care as close to the patient as possible, where this meets governance standards.
- **Patient choice** – will be considered whenever possible. Patients will be given informed access to appropriate options. We will not, however, fund treatment for one patient that could not be offered to all patients with equal clinical need.
- **Disinvestment** – we will review existing services to ensure diversion of resources from less effective to more effective services wherever possible.
- **Quality** – we will aim to commission and monitor services against agreed quality standards.

An example of the principles adopted by one healthcare commissioning body for their prioritisation process is as follows (NHSC):

- The local delivery plan (LDP) is the mechanism through which investment and disinvestment decisions are taken (LDP is equivalent of the States Strategic Plan).
- Interventions recommended in National Institute for Clinical Excellence Technology Appraisals will be implemented only on publication of guidance unless previously prioritised through the LDP round.
- We do not expect to introduce any healthcare intervention in-year outside this process since to do so will take resources from identified priorities.



The following is one simple example of using key health economic concepts in priority setting (based on P Brambleby, personal communication):

Three concepts, behind tough decisions are equity, effectiveness and efficiency. Given below is a simple example of how different decisions can be reasonably arrived at depending on the principles used.

Equity can be considered as the number of people who can be treated. Say the Board agreed that we had an extra £150,000 to spend on a cancer treatment. Say there were three competing treatments for cancer we could spend it on, treatments A, B and C costing £5,000, £6,000 and £15,000 respectively. In treatment A, 30 people could be treated, in treatment B, 25 people and in treatment C, 10 people, therefore A would be most equitable.

One measure of effectiveness is the number of life years added. Say treatment A added 3 years, treatment B 5 years and treatment C 6 years. Treatment C would therefore be the most effective.

The efficiency (total years gained from budget for the population) would be 900 years for treatment A, 1,250 for treatment B, and 600 for treatment C. Treatment B would therefore be the most efficient.

If decisions are made by individual patients and clinicians, and budgets are not capped then it is highly likely that treatment C will be funded by default.

Decisions are not as simple as above. Evidence of the effect on quality of life are also important. Life may be extended but if someone became ill from side-effects of drugs then the quality of their extra life may be poor. Quality adjusted life years (QALYs) are a commonly used currency to help judge which treatments to provide, and take into account the length and quality of life.

If say it is agreed that B is the treatment of choice, but there is no new funding, so funding is taken from another budget, say mental health services, then there are some other people who will be denied what they need, i.e. there is an opportunity cost.

Currently Guernsey has not clearly separated decision making on prioritisation at a population level from those made at an individual level. It is important that informed clinical advice is part of the process, but that it is not the sole contributor.

While there are some systematic processes in place in Guernsey on looking at whether or not we should commission certain drugs, this process is not linked into an overarching priority setting framework. The processes on drugs do not yet extend more widely to other services such as diagnostics.

²⁹Decisions made on singular issues are not recommended as they do not take into account opportunity costs of something else that might have been done with that resource.

Strengthening Clinical and Public Engagement

Currently issues go to a lay political board where decisions are made on what is funded and what is not. In the UK, decision making health bodies have a majority of lay Board members but also professional voting members who also take shared corporate responsibility for decisions.

The Board does have as a sub-committee, the Medical Advisory Committee. Most resources are consumed on the advice of health professionals. UK bodies have developed professional executive groups including corporate directors and professional leads to take responsibility for clinical governance and advise on relative priorities for service investment. There is a need for greater clinical involvement in resource allocation in Guernsey.

³⁰I recommend a revised sub-committee of the Board called a Professional Executive Committee (PEC) that would co-ordinate advice to the Board on professional issues and priorities, and would include members of the professional health community working in primary and secondary care.

A PEC would be in a good position to co-ordinate service redesign, i.e. to look at existing clinical pathways and to identify relatively lower priority elements of them that may be omitted with little health impact (e.g. a diagnostic test of possibly slight benefit) and the saving of resources.

Public engagement is also important and the HSSD needs to build on some exemplary service user groups.

Working with other Organisations

The complexity of health and social care business and associated literature is so great that a small jurisdiction such as Guernsey cannot possibly rely on synthesising all the primary evidence itself for supporting its policies.

For determining whether something can make a difference to a problem, i.e. is effective, many countries commission reviews of evidence. In England, the National Institute for Health and Clinical Excellence (NICE), undertake knowledge reviews that help commissioners decide on healthcare interventions they will and will not fund publicly. Other countries have similar health technology appraisals systems. There is also the Social Care Institute for Excellence (SCIE) which provides knowledge reviews for social care, (<http://www.scie.org.uk>). For example:

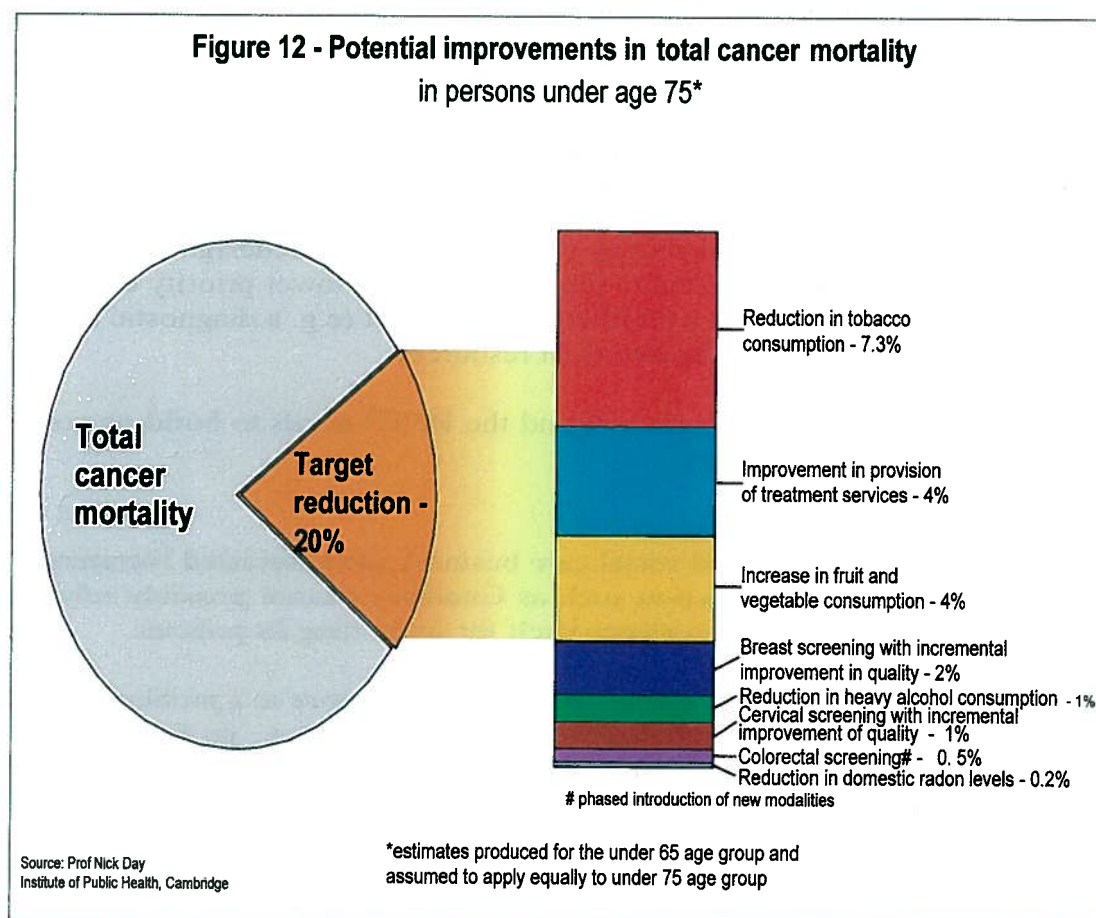
In SCIE's assessment of the value of assistive technology they cite one case study which demonstrates the value of a social approach ('the elderly gentleman wants to stay at home'):

'A 90 year-old man had been in hospital for some time and his family had some concerns about him returning home...he was at risk of falls and fire...a smoke detector (accompanied by a protocol for the emergency services to be notified if triggered), a fall detector...and an enhanced hearing device for the phone were installed.' <http://www.scie.org.uk/publications/briefings/briefing28/index.asp>, accessed Aug 21, 2009



In the UK and other western countries commissioning organisations, are increasingly collaborating to assess the scientific evidence of potential benefits of interventions, to prioritise which interventions should be publicly funded and also to secure prioritised interventions more economically.

Currently, the HSSD is a member of the South-East Central Region of the NHS Confederation, and there are also strong links to the South-West Region. Within the South-East Region, there are particularly close links for Guernsey clinicians with our neighbours at Southampton University Hospital NHS Trust, with some services also commissioned from London and elsewhere.



There are also clinical networks involving both provider and commissioning organisations in the NHS which consider whole programme areas such as cancer, heart disease, or intensive care. To make sense, pathways for patients and services should go all the way from the preventive services through to tertiary care services.

Programme budgets focussed on key strategic objectives are required, such as reducing the impact of cancer, which requires interventions from prevention through primary care to tertiary care if the greatest health population benefit is to be realised (*see figure 12*).

³¹I recommend Guernsey builds further on commissioning and provider partnerships, to help us prioritise, develop and re-design more efficient and effective clinical pathways.

³²I recommend developing programme budgets around key strategic objectives, such as cancer control so prioritisation can occur within the programme.

Potential problems with explicit priority setting

It is important that commissioning agencies display understanding, fairness and consistency in their processes and decision making. However, this may also create problems of its own. An example is given below:



In the UK, a media supported campaign put huge pressure on politicians and officials to fund a particular drug trastuzumab (Herceptin) as an adjuvant treatment for breast cancer, even though it was judged not to be of high priority. There were legal actions against health service commissioning bodies, petitions and even perceived threats to officials. In the end, a new Secretary of State decided to fund.

The opportunity costs were real, as no new funding accompanied the decision and other services were cut.

There are a large number of expensive health technologies in the pipeline which will need to be prioritised for consideration for public funding.

Not funding in year developments because of cash limits may also create an issue with patients and their relatives wishing treatment this year, being unhappy that they have to wait longer. It is also the case, that best evidence on what works and costs are not static issues, but subject to rapid change as new evidence emerges. This may require revision of decisions.

If Guernsey does start explicitly priority setting, it is hoped that the local media will support the process through balanced reporting at population as well as individual level.



Securing services from providers

As individuals, most of us have commissioned health and social care services of one sort or another for ourselves or families. In the UK social care has moved into a scheme called Direct Payments whereby the State fund individual care but individuals or their families purchase it from a range of providers. Proponents consider this encourages better autonomy and better value for money. Of course, if we had no publicly funded health service, then decisions would be down to an individual's assessment of their own need, and their ability to pay for a service.

To some extent this can be seen to be the case in Guernsey in primary care where individuals choose to visit a GP or not and some of the cost is paid for from the social insurance fund. In England, funds for purchasing healthcare have been delegated to general practices as 'Practice-Based' Commissioning, as it is argued that practices are closer to the coal-face and understand the needs of their patients better.

More complex services may then be purchased by commissioning bodies at district, regional, or national level (e.g. for rare highly complex services, such as heart transplants, or proton therapy for cancer).

One of the criticisms of the system in England has been that having smaller commissioners leads to a "Post-code Lottery", and a lack of skills and manpower to commission. Of course given the complexity of issues, the different needs of communities and different values and beliefs of decision makers this is not surprising. State funded services have the advantage of aiming for equal provision for equal need, irrespective of the ability to pay.

Monitoring and evaluation

We fund public services to improve health and wellbeing of the population. The quality of the services themselves can be very important in the health improvement gained from each investment. This is also not a straightforward area, e.g. towns with people with other illnesses arising from mining for instance are likely to have worse outcomes for the same interventions than areas with a fitter population.

This topic will be considered further in future annual reports.

Strategic co-ordination of health improvement

Of course Guernsey is struggling with investment across all of the public sectors. The States Strategic Plan is the high level plan for the island's future. The plan has been developed from those of the different Government Departments. The investments of many other departments can impact on health and well-being. Vice versa investments the HSSD makes can impact on other targets such as the environment, commerce etc.

The issue of the health impact of Major Policies in other areas will be discussed in a future report.

Recommendations:

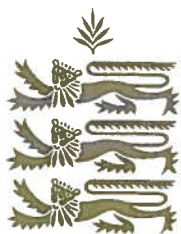
³³A public debate on the principles, factors and criteria on which health care resources will be allocated. That debate to include, politicians, voluntary sector, private sector, media, health professionals.

³⁴Following a public debate, the States to agree a framework for setting priorities and allocating resources within health and social care services, to be implemented by health and social professionals.

³⁵Consideration given to unifying the HSSD and SSD health and social care related budgets, thereby making the process of allocating resources simpler.

³⁶Close examination of clinical pathways, to look at relatively lower priority elements that may be dropped with little health impact.

³⁷All new health and social care interventions, or new uses for existing interventions to go through a priority setting framework before agreement to fund.



Other public health highlights

Environmental Health and Pollution Regulation

- Director of Environmental Health and Pollution Regulation

John Cook, who has held the Director's post since 2006 and was previously Chief Environmental Health Officer from 1999, retired after almost 30 years dedicated and exemplary service in the department. A successor, Valerie Cameron, took up the post in October 2009.

Achievements

- Overcrowding legislation

Proposals to amend the outdated legislation on overcrowding in housing accommodation have been passed by the States. This would ensure that people have adequate space standards within their accommodation, especially at the lower end of the privately rented sector. Adequate space is essential for health and privacy.

The old standard was 300 cubic feet (8.5 cubic metres) per person (no limit on number of persons per room) between 9.00 pm and 6.00 am - the Public Health Ordinance of 1936.

There are two new standards that are an amendment to the existing 1936 Ordinance. Firstly there should be sufficient rooms in each individual letting so that no male and female aged 10, or over, should have to sleep in the same room, unless they are living as "husband and wife".

No. of rooms	Max no. of people
1	2
2	3
3	5
4	7.5
5	2 per room

Secondly there is a new space standard that specifies the number of people who can sleep in any room based on its floor area.

Floor area of room	Max no. of people
10.2 m ² or more	2
8.3 m ² - 10.2 m ²	1.5
6.5 m ² - 8.3 m ²	1
4.6 m ² - 6.5 m ²	0.5

The floor area figures in m² are equal to respectively 110 - 90 - 70 - 50 square feet. Reference to 0.5 of a person is a child over one year old and under 10.

All premises have to comply with both standards and the references to times i.e. between 9.00 pm and 6.00 am have been removed so the standards apply at all times.

● New Air Quality Monitoring Equipment

The existing 10-year-old air quality monitoring equipment was replaced early this year including new software for enhanced reporting. This will enable the Department to continue to monitor and advise on Guernsey's air quality and to provide better statistics and reports. Current air quality in Guernsey remains good and the risk low, meaning that harmful effects are unlikely, even in sensitive people.

Some concerns have been expressed regarding the effect on air quality from the proposed Energy from Waste (EfW) plant to be built as part of the waste solution for Guernsey, especially the effects that may be experienced from increased particulate emissions.

Particulates come from many sources of combustion, most noticeably from man made sources such as all types of motor vehicles, demolition and construction works, power generation, etc as well as natural sources such as sea salt, sand, pollen, etc. The additional contribution from the EfW plant has been estimated on a 'worst case' scenario to be about 0.1 to 0.3 microgrammes per cubic metre (µg/m³) against an existing background level of around 15 µg/m³ measured and averaged over a 24 hour period.

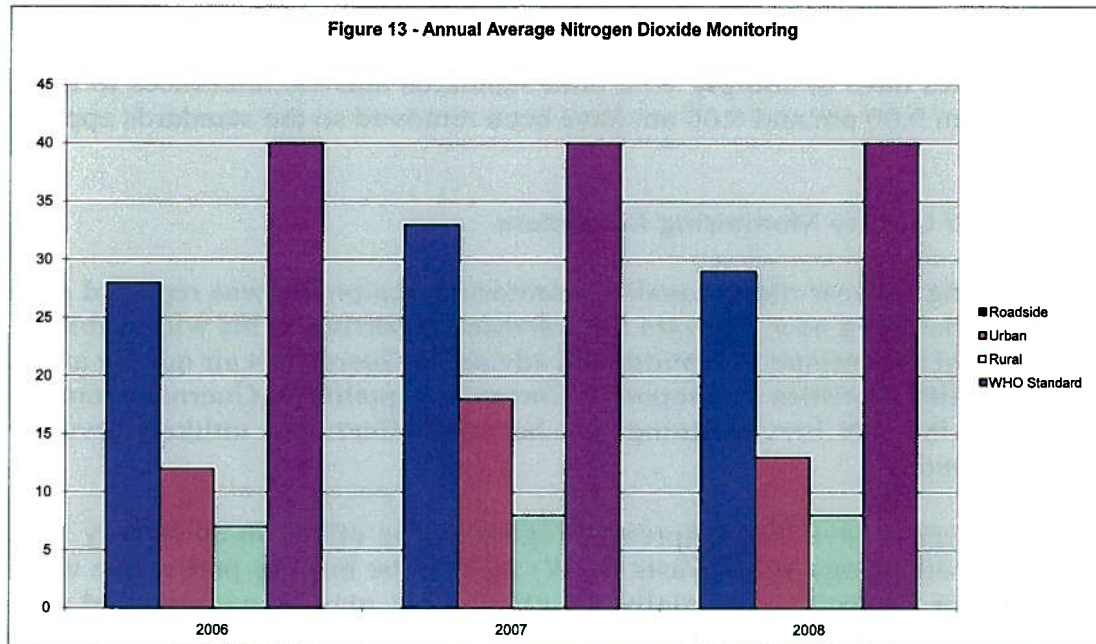
● Nitrogen Dioxide Monitoring

The Department has been monitoring nitrogen dioxide since 1992 with passive diffusion tubes and in real time since 1999.

Nitrogen dioxide is principally derived from combustion processes; in Guernsey that means from vehicles, power generation, ships, aircraft, commercial and home heating, and numerous other small combustion processes.

The World Health Organisation (WHO) set a guideline value of 40 µg/m³ as an annual average and the UK has adopted the same figure as part of its National Air Quality Strategy.

The graph below shows the annual averages for the last three years for the roadside (average of 5 sites), urban background (2 sites) and rural background (2 sites) locations. The annual average is in all cases below the WHO annual average standard (shown as purple bar).



● New Computer Database

A new computer database for the Department's work has been installed and is waiting some final testing before going live. The Department's current software is over 13 years old and no longer supported. The new software will ensure that our recording and filing systems are robust, as well as providing new and enhanced solutions for managing officer workloads.

● Liaison work with the Police over live music events

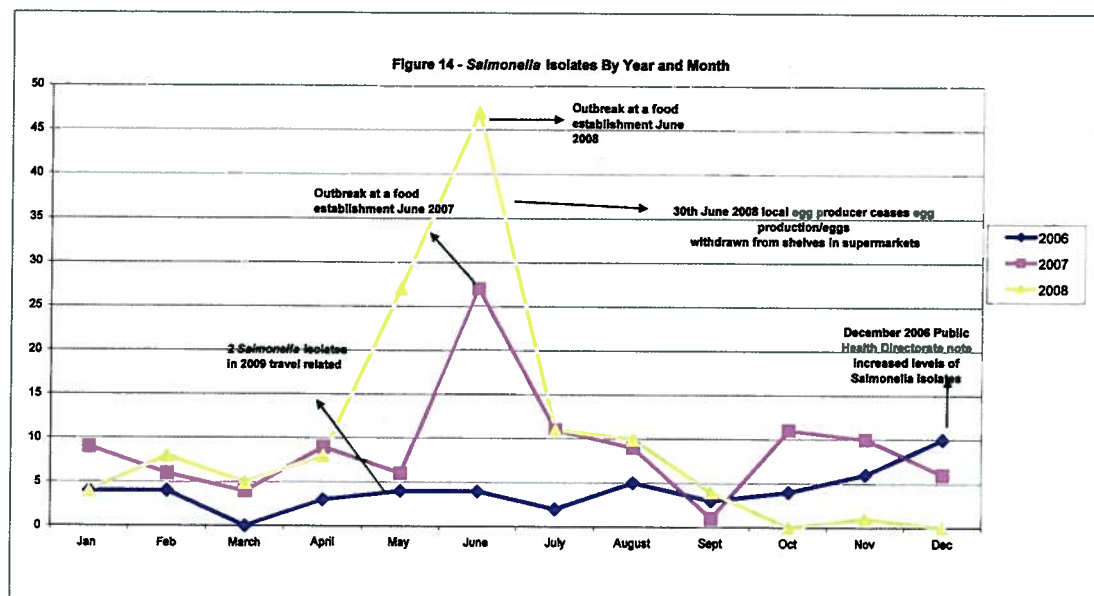
Two significant music events were held during 2008 including Guernsey Live, a two-day open-air event with major UK bands. Liaison with the organisers and Guernsey Police ensured that noise nuisance to local residents was minimised. This has given the department confidence that large music events can be proactively managed should they be proposed in the future.

Ongoing

● Control over production and marketing of eggs

Following a major *Salmonella* outbreak in Guernsey in 2008, proposals to control the production and marketing of eggs have been approved by the Health and Social Services Department Board and a States Report is being drafted.

The controls proposed involve the testing of larger egg laying flocks and the prevention of sale of eggs from flocks found to be *Salmonella* infected. These measures reflect European Union (EU) *Salmonella* prevention controls.



● Food Legislation

The Food Standards Agency and the UK Government have requested that the States review the legislation so that we will be compliant with EU Food Supplements Directive and the EU Nutrition and Health Claims Regulations. This is to ensure that imports into the EU from Guernsey are in accordance with EU legislation. The department is currently reviewing the options available.

● Guernsey and Alderney Slaughterhouses

The slaughterhouses in both islands have been inspected by the Meat Hygiene Service from the UK with a view to improving practices and facilities. Improvements identified, if fully implemented, could enable cattle over 30 months old, which are currently excluded as a requirement to control the incidence of Bovine Spongiform Encephalopathy, to once again be used for food.

Mr John Cook
Department of Environmental Health and Pollution Regulation



Communicable disease and infection control

Infectious Diseases

● **Salmonella**

Fortunately 2008 was a relatively quiet year for community infectious disease. The principal exception to this was food poisoning (see table below). There was a considerable excess of Salmonella cases particularly prominent during the second quarter of 2008. These were all Salmonella enteritidis which is usually associated with poultry or eggs. This rise in cases was investigated by the Environmental Health Department and there was strong circumstantial evidence that it was related to a local egg producer. The local producer ceased production and the incidence of infection with Salmonella enteritidis rapidly dropped. This was very gratifying and was very important for public health. When egg production is restarted following major renovation it will be important to continue to monitor this organism.

● **Childhood immunisation**

Childhood immunisable infectious disease was again at a low level. There were slightly more mumps cases than in the previous couple of years although less than 2004 and 2005. These cases were typically in young adults who had either incomplete immunisations as a child or whose immunity had declined.

We continue to be concerned about the percentage of the population that is unimmunised because of refusal to have the MMR vaccine following newspaper scares. Our immunisation rate has however been higher than that of the UK average and currently we have no measles cases. 2008 included the first confirmed whooping cough cases for several years. These were in adults whose immunity had presumably waned since childhood immunisation. They were not seriously ill but had prolonged and persistent coughs. There was one case of meningococcal B and we have not seen any meningococcal C disease since the introduction of universal immunisation a few years ago.

● **Tuberculosis**

The tuberculosis clinic continues to be active immunising people and investigating contacts on a monthly basis. There were three cases of tuberculosis during 2008 but no evidence whatsoever of secondary spread within the island. There have been no drug resistant cases reported to date. The clinic continues to successfully immunise at risk people.

There is concern that we are at some risk of imported infectious disease because of the presence of a large number of guest workers from countries with relatively high incidences of tuberculosis and because of a lack of screening in port facilities, particularly in the UK. We are however monitoring the situation and tuberculosis cases on the island remain very few.

Table 1: Notification of Infectious Diseases 2008**2008 QUARTERS**

	2003	2004	2005	2006	2007	1st	2nd	3rd	4th	(Total to Date)
MEASLES	0	0	0	0	0	0	0	0	0	0
MUMPS	0	39	9	1	1	2	2	2	0	6
RUBELLA	0	0	0	0	0	0	0	0	0	0
WHOOPING COUGH	0	0	0	0	0	0	0	3	2	5
**FOOD POISONING	151	165	114	160	230	39	115	70	34	258
HEPATITIS A	0	1	0	0	0	0	1	0	0	1
HEPATITIS B	1	1	0	1	0	1	2	0	0	3
HEPATITIS C (notified annually)	7	7	8	12	12	1	2	3	9	15
MENINGITIS	1	2	3	0	1	0	0	1	0	1
TUBERCULOSIS	6	4	3	4	0	0	1	1	1	3
MALARIA	0	0	0	0	0	0	0	0	0	0
SCARLET FEVER	1	1	0	1	1	1	0	0	0	1
PSITTACOSIS	0	0	0	0	0	0	0	0	0	0
DYSENTERY	0	0	0	0	0	0	0	0	0	0
Q FEVER	0	0	0	0	0	0	0	0	0	0

** Formal notified and informal notified cases have been combined.
AIDS and known HIV carriage notified annually



The challenges in the future are to maintain and improve our high immunisation rates. Last year saw the initiation of immunisation against Human papilloma (HPV) viruses, a major factor in the causation of cervical cancer. We hope that this programme will result in considerably less serious disease and ongoing health costs in future years. We intend to maintain our high level of surveillance for tuberculosis and other community acquired diseases.

Dr Brian Parkin
Deputy Medical Officer of Health

Infection Control

Effective infection prevention and control can only occur when staff are engaged. The team acknowledges the support given by staff throughout the health and social care services. The HSSD has a Service Level Agreement with the Health Protection Agency, Birmingham, for microbiology support and Consultant Microbiologists visit regularly.

Achievements include:

- Hand Hygiene Protocol

The UK '*Clean your hands campaign*' has been adapted for Guernsey. This has been evident by new hand-washing posters throughout the HSSD and new dispensers with a new form of sanitizer.

Future plans

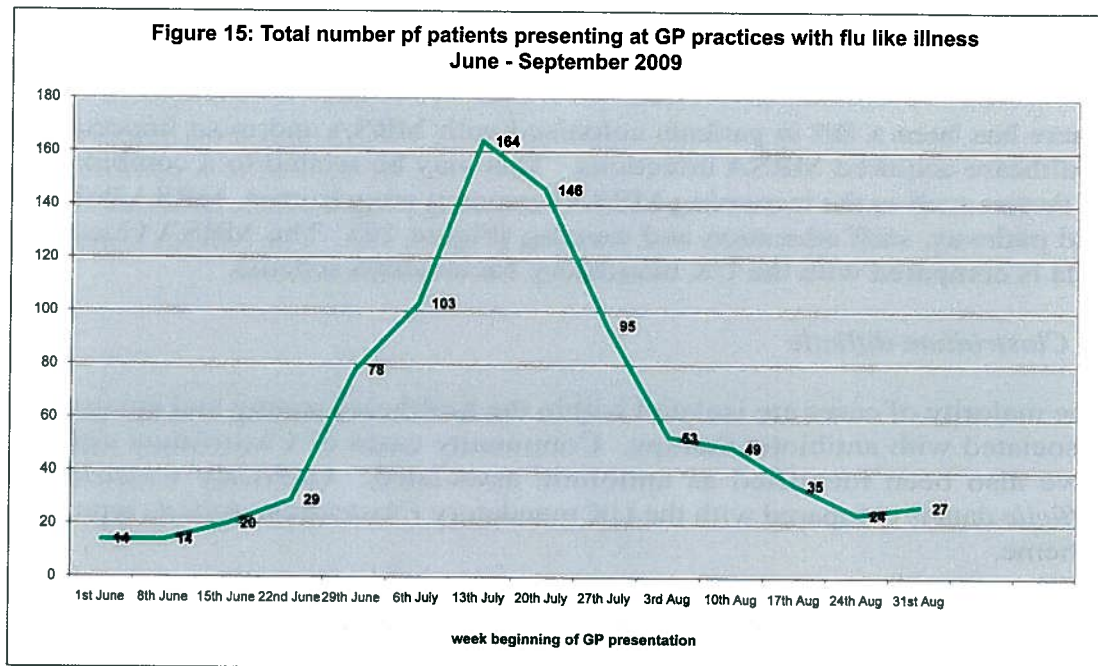
The Infection Control Link Nurses are currently undertaking a hand-washing audit. The results will be available on the HSSD intranet on the Infection Control section.

- Infection Control Policies and Guidelines

There are twenty one Infection Control policies and the team have developed three new policies, i.e. Central and peripheral line guidelines and MRSA/*Staphylococcus aureus* screening in the Renal Unit

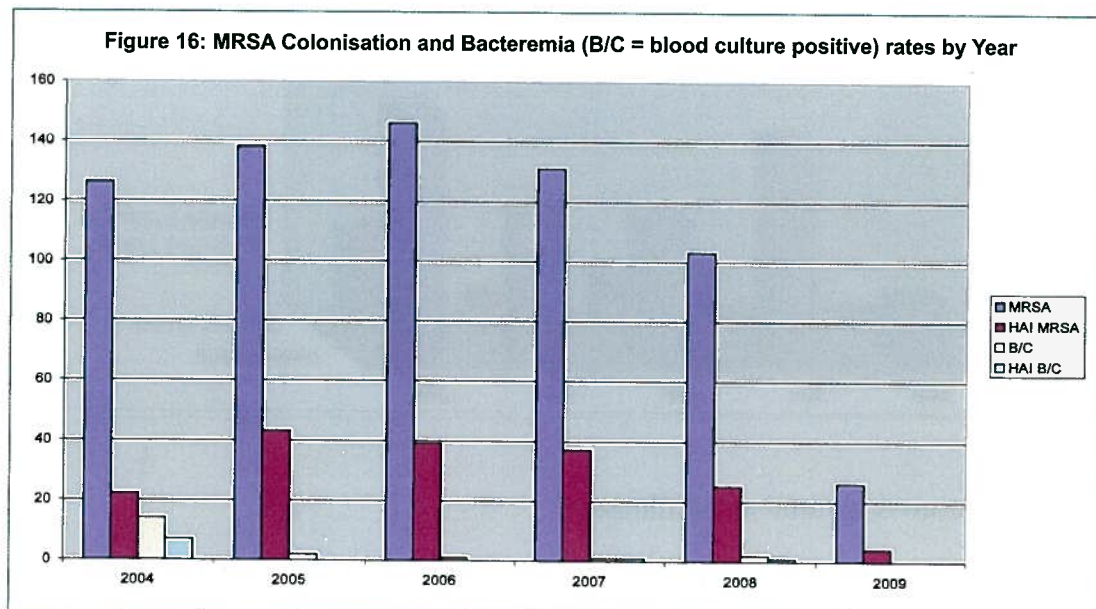
- H1N1v (Swine Flu) Influenza Pandemic Planning

The Infection Control team has been responsible for the co-ordination of the HSSD's Influenza Pandemic Plan and also are members of the Influenza Pandemic working group. During the H1N1v Pandemic, GPs (using Read code H27z-1 -flu like illness) record all patients with flu like illness that is then used for flu surveillance (*Figure 15*).



Healthcare associated infections

Healthcare associated infections (HAIs) occur as a result of a person's treatment or from contact with any part of the healthcare system. The Infection Control Team continues to be responsible for the correlation and monitoring of healthcare acquired infections.





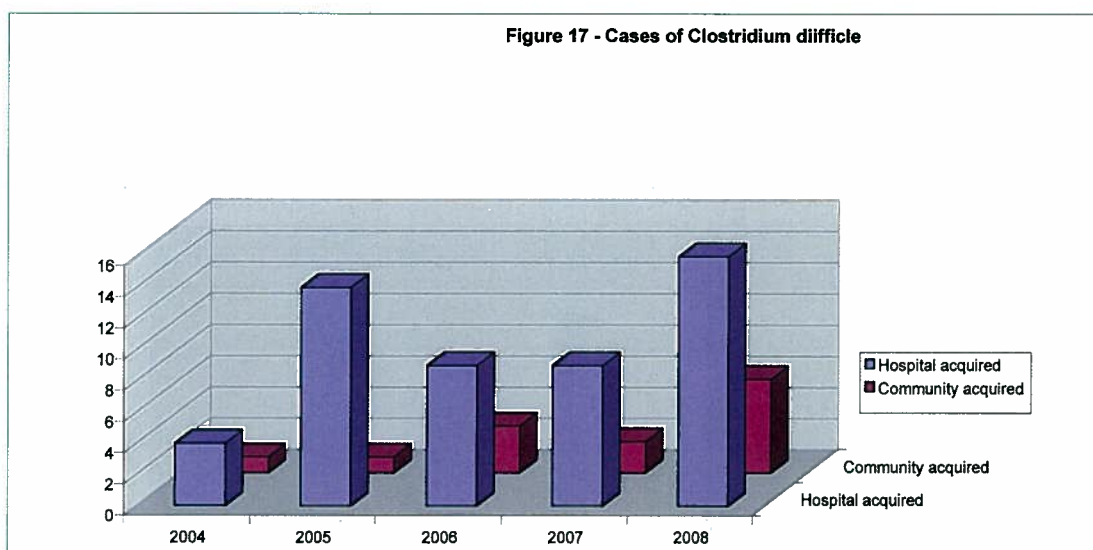
- Methicillin Resistant *Staphylococcus aureus* (MRSA)

There has been a fall in patients colonised with MRSA and most importantly healthcare acquired MRSA infections. This may be related to a combination of factors such as the increasing MRSA screening programmes, MRSA Policies and pathway, staff education and training (Figure 16). The MRSA Guernsey data is compared with the UK mandatory bacteraemia scheme.

- *Clostridium difficile*

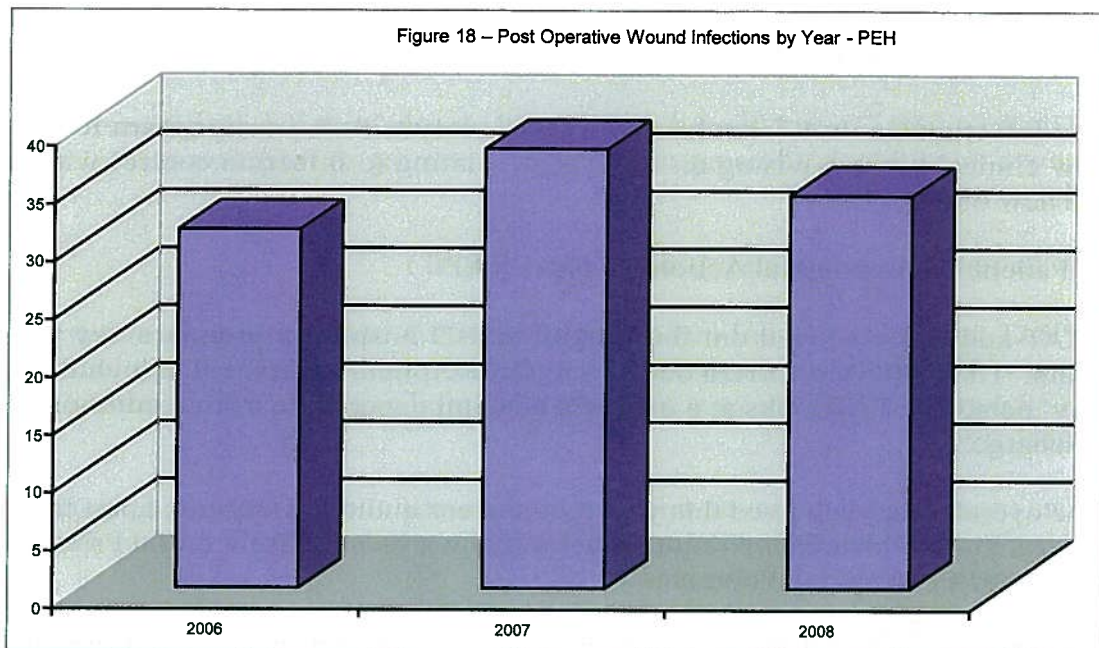
The majority of cases are isolated within the healthcare setting and are usually associated with antibiotic therapy. Community cases of *Clostridium difficile* have also been identified as antibiotic associated. Guernsey *Clostridium difficile* data is compared with the UK mandatory *Clostridium difficile* reporting scheme.

The infection control team plan to reduce the incidence of *Clostridium difficile* by working with Pharmacists and Clinicians within the healthcare setting to produce a policy on Antibiotic Prescribing. The graph below shows the annual number of both community & hospital associated cases of *Clostridium difficile* (Figure 17).



- Post operative wound surveillance

The infection control team monitors the incidence of infections following surgical procedures. This enables the infection control team to investigate any suspected post operative infection. Guernsey Surgical site infections are compared with UK mandatory surveillance of surgical site infections.



● Training

The Infection Control Team continues to provide training at induction and mandatory programmes for all HSSD staff. These training programmes are updated in response to new and emerging infectious diseases to ensure all staff are aware of new guidelines. *Future work:* Introduction in 2009/2010 of an infection control module within the Institute of Health and Social Care Studies.

● Audit

The Team has continued to maintain annual ward audits, including uptake of Nursing and Residential Home Infection Control as part of their registration process. In 2009 the Team will complete audits in Primary Care. *Future work:* Audits in Dental Practices.

● Infection Control Link Nurses

This continues to be an excellent forum for disseminating information throughout the HSSD. The Team has approximately thirty five link nurses.

● Root Cause Analysis (RCA)

The Team has introduced RCA in 2008. The practice of RCA is based on the belief that problems are best solved by attempts to correct or eliminate root causes, as opposed to merely addressing the immediate obvious symptoms. The Team has produced an RCA framework which can be used for all Health care associated infections. These are then correlated and fed back to the Infection Control Committee.



● Building and development

The Infection Control Team have worked closely with the design team for the new clinical block advising on all aspects relating to infection control within the new building.

● Patient Environmental Action Teams (PEAT)

PEAT audits are carried out throughout HSSD hospital premises every two years. The audits are carried out by a multidisciplinary team which includes a 'lay' person. PEAT looks at a patient's hospital experience from admission to discharge.

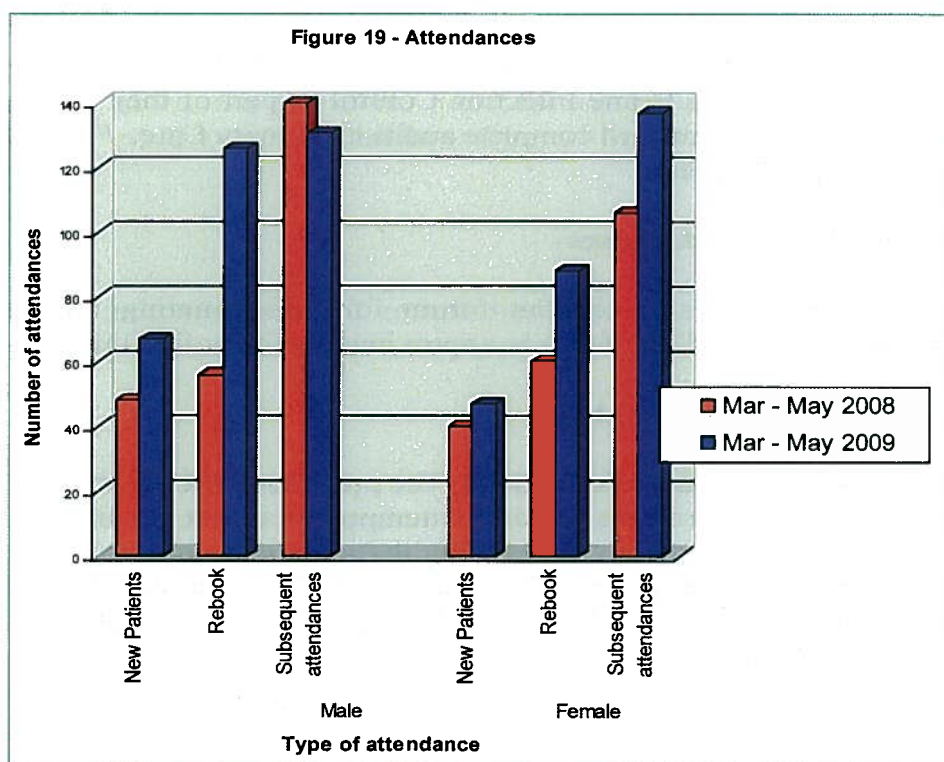
The overall score achieved this year by the areas audited was good, apart from those areas which are awaiting transfer to the wards in Phase 5 of the Princess Elizabeth Hospital development.

Through PEAT a number of recommendations have been implemented, such as revised cleaning schedules for all wards and departments, review of menu choices for patients, decontamination schedule for ward based equipment, fixtures and fittings replaced.

Mrs Elaine Burgess
Lead Infection Control Advisor

Sexual Health Service

Areas in which substantial progress has been made over the last year:



- Relocation of Sexual Health Service

The Sexual Health Service has been re-located temporarily to the Castel Hospital. This move has been popular with service users resulting in an increase in the numbers attending the Clinic. There has been an increase in attendance figures between March and May 2008 and 2009, except in subsequent attendances by men as negative results are now communicated to them by telephone. This has freed up clinic slots for new patients (Figure 19).

- Policies

A policy has been developed to standardise the care offered to individuals requesting a sexual health screen at the Sexual Health Clinic, based on the UK National Screening and Testing Guidelines (2006). This ensures the provision of a consistent standard of care

- Hepatitis C

The Guernsey Hepatitis C Treatment programme began treating patients for hepatitis C in January 2008. Twelve patients have now completed treatment with a further four still currently undergoing treatment. In addition to this six further patients are due to start treatment in the next three months. Successful treatment of hepatitis C is an important investment for the future as it will reduce the burden of chronic liver disease in Guernsey.

Not only is this important to reduce morbidity and mortality in individual patients, but there are also significant budgetary considerations. The management of chronic liver disease (which may include liver transplantation and treatment of liver cancer) is costly and would have a significant impact on future healthcare budgets.

Linked to the Guernsey Hepatitis C Treatment programme is the development of a Combined Clinic with Consultants and Clinical Nurse Specialists from a National and International Centre of Excellence, The Royal Free Hospital. This enables Hepatitis C infected patients to access expert opinions on-island and allows for the effective delivery of the treatment programme. It also provides staff with on-island training opportunities.

- Hepatitis B (HBV)

A hepatitis B treatment programme has been established allowing for effective management of HBV infected patients in Guernsey

- HIV (Human immunodeficiency virus)

Considerable progress has been made in the provision of care offered to HIV infected individuals living in Guernsey. These have included both changes in antiretroviral therapy and monitoring in line with recent changes in the UK and Europe.



The Multidisciplinary Combined Clinics with Consultants from University College London Hospitals and Guy's and St Thomas' NHS Foundation Trust continue to ensure that patients in Guernsey receive a high standard of care.

Again these clinics contribute to on-island training and education and have been attended by nurses and GPs from outside the Sexual Health Service.

Efforts have been made to reduce the stigma associated with HIV infection, in particular, and Sexual Health in general. This has included participation in the World AIDS Day "respect and protect" programme. The establishment of a 'walk-in' clinic has provided greater choice to individuals wishing to access our service

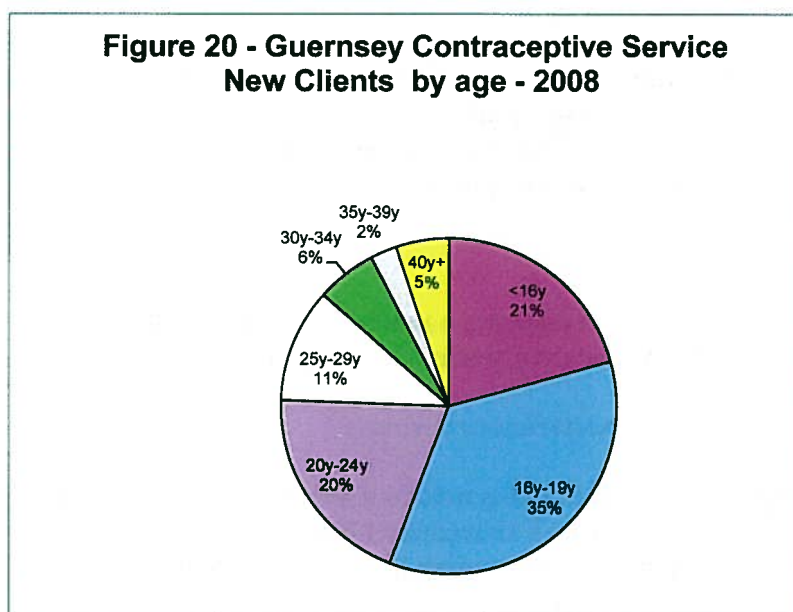
Future priorities in Sexual Health

- To develop Island-wide protocols for sexual health screening and treatment
- To continue to establish links with other Health Care Professionals, in particular to improve our links with Alderney
- To formally audit our new services
- To establish a strategy for Chlamydia screening and diagnosis in Guernsey

Dr Nicola Brink
Sexual Health Physician

Guernsey Contraceptive Service

In 2007 the Guernsey Family Planning Service has changed its name to Guernsey Contraceptive Service.



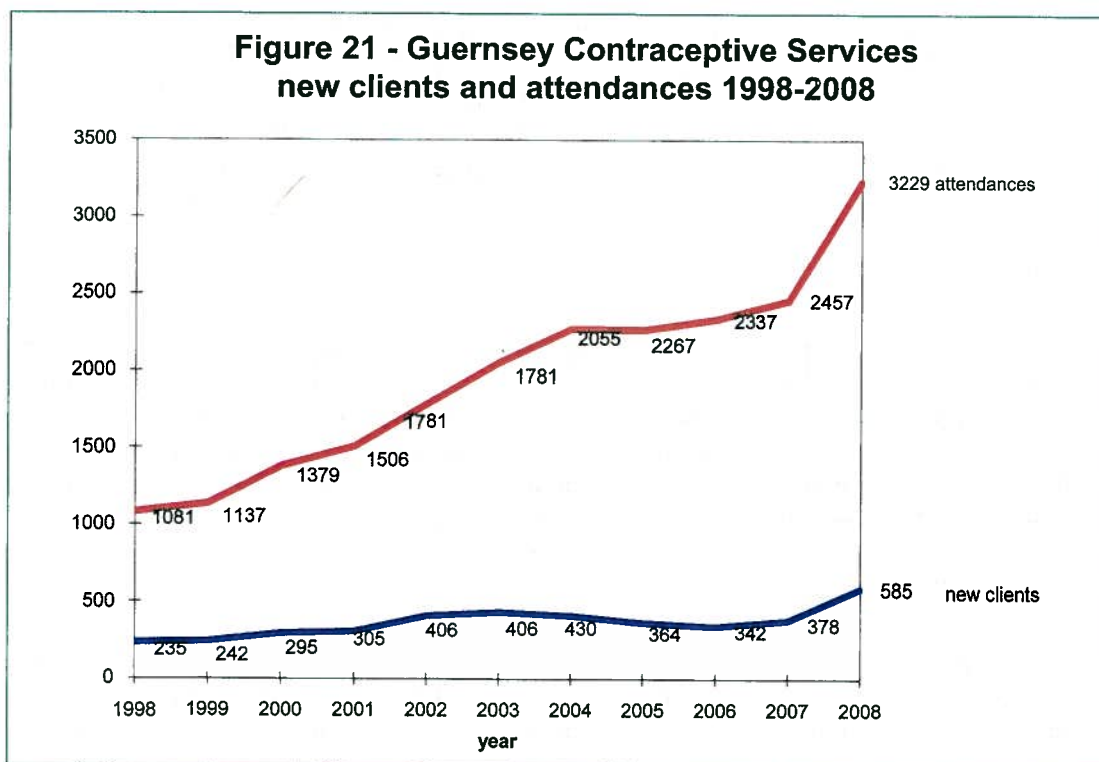
During 2008 the majority of clients were aged 16-19 years (*Figure 20*). There has been an increase in the number of men and women accessing the service, partly due to advertising on Island F.M. followed by two Channel 4 programmes, relating to health and sex education (*Figure 21*).

The total number of clinic attendances increased from 2,457 to 3,229 (31%). Whereas the total number of new clients increased from 378 in 2007 to 585 in 2008 (55%). The largest increase seen was in those under the age of 20, up from 297 to 326 (65.4%). (Rebook is any patient seen before but not in last 3 months).

● Service Developments

This year we have been able to offer additional services, coil fitting and sexual health screening. The Service is now able to offer intra-uterine devices and emergency coils at relatively low cost. Over a nine month period last year ten coils were fitted, of which one was an emergency.

During the year, 327 clients had sexual health screening of which 29 were *Chlamydia* positive, and none gonorrhoea positive. All the *Chlamydia* positives are offered help. One hundred and forty four Hepatitis C blood tests were carried out, with one positive.



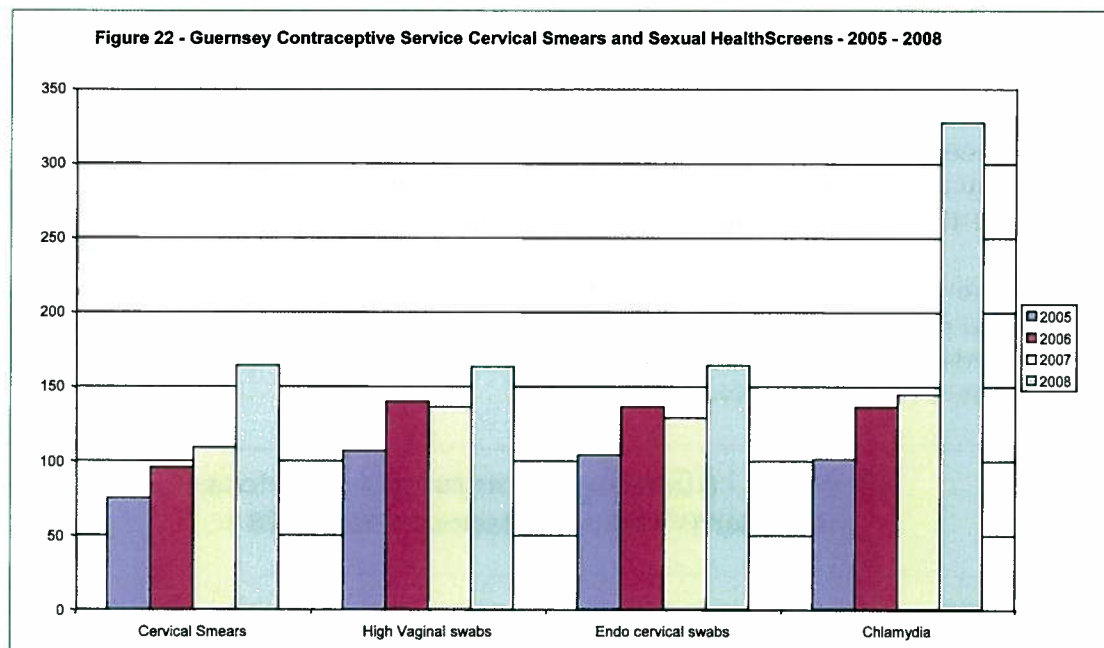
● Existing Services

Of a total of 151 pregnancy tests, 30 were positive. Ten women decided to continue with their pregnancy, 17 were referred for termination, and 3 were unknown. The number of clients accessing the counsellor decreased again this year to 37 clients from 53 in 2007.



Clients prescribed *Levonelle (morning after pill)* increased from 375 in 2007 to 478 (27%). Opening on a Saturday has enabled emergency contraception to be more readily available and within the 72 hour guideline.

There has also been a large increase in cervical smears over the last four years (*Figure 22*) which may be a reflection of increasing costs in general practice. High vaginal swabs are taken with any patient presenting with vaginal discharge. Endo cervical swabs are taken routinely for detection of gonorrhoea.



● Development

There is now a Patient Group Directive (PGD), as recommended in the Contraception and Sexual Health Review 2007, allowing staff to prescribe emergency contraception (which is taken in the clinic within 24 hours of unprotected intercourse) and all repeat prescriptions. The clinic is now open 23 hours a week from Monday to Saturday at lunchtime and two late evenings, offering both walk in and booked appointments.

● Future Developments

With the increase in clientele we are now considering an Information Management System for the clinic. The clinic is in the process of obtaining quotes from software companies including the EMIS system which two local G.P. surgeries are using. Our objective would be to go paperless and have links to the hospital for pathology results.

The Service is working with the Institute of Health and Social Care Studies to provide accredited contraceptive and sexual health training on island. Two nurses already hold mentor certificates.

This last year has seen an increased interest in nursing staff wishing to work in the service, and a 'bank' of nurses has been established.

We are exploring the services offered in Alderney to provide equity for clients in both islands.

The overriding challenge for the first part of the year is to complete the Information Technology project and the upgrade in the premises.

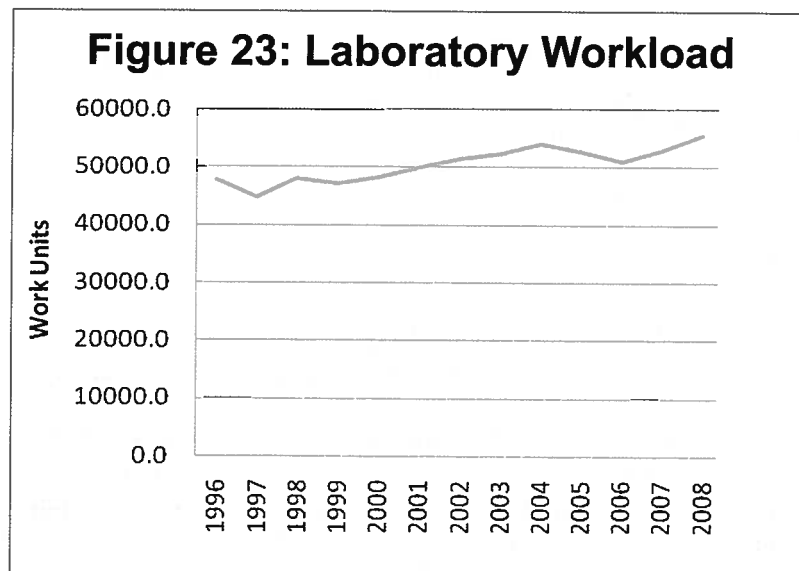
Mrs Sue Le Page
Guernsey Contraceptive Services, Manager

States Analyst's Laboratory

In June, 2008, the Laboratory was visited by representatives of United Kingdom Accreditation Service (UKAS) to audit the Laboratory's quality assurance system. Again, no serious defects were found. Assessors were complimentary about the laboratory's quality system. Participation and good performance in external quality assurance schemes is a necessary prerequisite of accreditation.

The States Analyst's Laboratory consistently produces analytical results close to the expected results, which gives great confidence in the quality of the work it does and the credence which may be placed on its results.

The Laboratory was complimented on its performance in these schemes during the visit by UKAS representatives and all staff can be justifiably proud of this.



The Laboratory's work consists of two main areas, water supplies and environmental contamination. Guernsey Water and the Public Services Department accounted for about 65% of the Laboratory's workload. Police and Customs work forms a minor part of the Laboratory's total effort although it is a large portion of the work load of the States Analyst, who personally carries out all alcohol and most drugs analysis for the Police and Customs. The total laboratory workload is slowly increasing (*Figure 23*).



In 2009, the laboratory will commence testing samples for the presence of *Legionella*.

The laboratory is heading for a period of change. The States Analyst could retire in December of 2010 and the Deputy States Analyst in November of 2011. Therefore, the two most senior figures in the laboratory, with their experience and expertise, could leave within a year of each other. At the moment, interested parties are considering whether the Island should retain a forensic capability and, if so, what form this should take.

The outcome of these talks will determine the nature of the person who will replace the States Analyst. If the island is to retain a drugs analysis capability, it is likely that an appointment from off-Island will be necessary and, because the “drugs scene” has changed so much over the past two or three years with the advent of “legal highs” (possibly soon to become illegal highs), that additional analytical equipment will be required. It is hoped that a replacement for the Deputy States Analyst will be found locally.”

Dr David Mortimer
States Analyst

Major Incident Plan

The HSSD Planning Group meets regularly in addition to participating in States wide planning. We participated in the States wide desk top exercise Flying Kestrel in 2008.

In 2009, the HSSD also participated in Operation Cobo which was a simulated crash at the Airport with 24 patients. This was an invaluable opportunity to once again test our systems.

Health Promotion Unit

● Obesity Strategy

The Strategy was sent out to other States departments for consultation, a number of changes made and it is now due to be discussed by the States in late 2009.

In the meantime the Weight Management courses provided by the Health Promotion Unit have been evaluated, developed and links made with the Midwives and Beau Sejour to develop further services in these areas. There have also been visits to Secondary Schools and discussions held with local caterers on the issues of healthy catering for pupils.

The part-time Health Promotion Officer for Obesity post was made permanent.



*New Part-time Health Promotion Officers,
for obesity, health inequalities and cancer.*

● Health Inequalities

A Health Promotion Officer for Health Inequalities was appointed and is now half way through her project. She spent the first months meeting representatives from the many local agencies who had an interest in this area and also in researching successful initiatives in the UK. She is currently trialling projects with the Family Centres, has produced a leaflet of available services and is helping to set up a Men's Health project. In the autumn she will produce a report with recommendations for future developments.

● Tobacco Control

Work continued to implement the States Tobacco Control Strategy. This included liaising with management and staff of the Prison to review their smoking policy and work is ongoing to train all staff in brief smoking cessation interventions. Staff from the Mental Health Service were also given training to enable them to support clients who wanted to stop smoking. Following their busiest year ever, Quitline appointed a new member of staff to run Saturday morning clinics. Quitline also moved into new premises in the PEH to enable them to cope with their ever expanding service. A major piece of work culminated in a public consultation exercise on the possibility of banning the display of tobacco products at point of sale and the results of this will be announced over the summer.

● Cancer Prevention

A new Health Promotion Officer for Cancer Prevention was appointed in November 2008. Achievements included a campaign on the prevention of mouth cancer including a day offering free mouth checks and was instrumental in the organisation of the Nutrition and Cancer Conference that attracted nearly 80 health professionals and members of the public.



Jo and Andy Priaulx

A Sun Awareness campaign included an open day at the Day Patient Unit attended by over 200 people. A survey of school sun policies was followed by training for teachers and a poster campaign involving local personalities.

● Resources

A decision by the UK Department of Health to stop selling their resources to Guernsey meant that other suppliers had to be found and more leaflets had to be produced on island. The Resources Officer and Secretary have ensured that the majority of items have been replaced.

● Health Trainers

Health Trainers provide one-to-one healthy lifestyle sessions for members of the public in a service co-ordinated by the Health Promotion Unit. The first five candidates have successfully completed the City and Guilds Certificate for Health Trainers after attending the course run by the College of Further Education on which Health Promotion staff taught several of the modules.

Future Developments

● 5th Guernsey Healthy Lifestyle Survey

The 5th Guernsey Healthy Lifestyle Survey, to be published later in 2009, that provides a picture of current lifestyles in Guernsey will be used to help decide on future priorities.

● Family Health

A project to look at Heart Health is being developed which will include visits to workplaces in conjunction with the Chest and Heart Unit. These will also include aspects of men's health, including prostate and testicular cancer. September will be Healthy Hearts month and will culminate in a free family activities day at Beau Sejour to encourage children to take part in physical activity.



● Obesity Strategy

If the Strategy is accepted by the States, the recommendations will need to be implemented. These will include setting up the Health Trainers Service, working on the Young People's Weight Management scheme and linking with the Guernsey Sports Commission to work with Pre School Leaders on physical activity for under fives and an obesity measurement programme.

Miss Yvonne Le Page
Health Promotion Manager

Healthcare Information Unit

- During 2008 there has been continued improvement with links with the South West Public Health Observatory (SWPHO). Death information is now being sent digitally including staging data, which allows SWPHO to provide Guernsey with cancer outcome data and cancer survival rates.
- Monthly information has been upgraded and greatly expanded during 2008. More than 50 activity reports are updated each month for key members of the HSSD and Medical Specialist Group, the most recent of which are reports for Bulstrode House and Mental Health.
- Comprehensive Service Review data was also produced for each of the Service Reviews that took place in 2008.
- A fair proportion of the work during the year was still provided by ad hoc requests for information and analysis from a large range of HSSD services, other States Departments and external organisations (including the Home Department, Treasury and Resources, Samaritans, St John Ambulance and Rescue, Orchard PR, and Foursight Consultants).
- The collection of death data from the Greffe has considerably improved steadily year by year, resulting in the data being more timely and of improved quality.

Mrs Jenny Elliott
Healthcare Information Analyst



Clinical Audit

Achievements

- Clinical audit awards

With the success of last year's Clinical Audit Awards, the *Insurance Corporation of the Channel Islands* have decided to run the competition again this year. In line with the national (UK) changes, it has been decided to base the theme of this year's competition around a clinical audit poster presentation which demonstrates an audit which is making a real and measurable difference.

- Clinical Audit course

The clinical audit course run in conjunction with the Institute of Health and Social Care Studies is proving to be popular. There were a variety of practitioners on last year's course. The feedback is very positive, with many staff stating they can really relate the course to their practice area to bring about improvements in care. Currently, the plan is to run the course annually as a standalone module and as part of the multi professional degree in professional practice.

- Outcome measures

We are becoming more involved in outcome measures, analysing data on patient outcomes following treatments or a set programme. To date, analysis has been conducted on the following programmes which demonstrate that the majority of patients have improved outcomes following intervention:

Cognitive Behavioural Therapy (CBT) Pain Management Programme

The CBT pain management programme is for selected patients with chronic pain lasting longer than three months and includes many elements such as education, problem solving, functional exercises and relaxation.

Since auditing the programme, referral guidelines have been formally established so that there are no inappropriate referrals. The outcomes of seven pain management programmes have been examined. It was found that patients who completed the programme were able to return to more "normal" activity and function. There was also a marked improvement in psychometric measures such as disability and depression at the end of the programme and at follow up.

National Chronic Obstructive Pulmonary Disease (COPD) Audit

This audit considered the views from the patient, GP, Consultant and Respiratory Nurse Specialist. The audit also examined the facilities in the organisation for caring for the patient with COPD and also the clinical outcomes of patients. It was identified that the respiratory rates of patients were not recorded clearly within the notes. The standard assessment form in A&E is now being adapted to ensure there is a dedicated space for this measure. The audit recommended that the pulmonary rehabilitation programme should also be examined. The results of the Guernsey Pulmonary Rehabilitation Programme showed significant improvements in exercise capacity and health status at follow up and six months.

National Falls and Bone Health Audit

The audit identified that people who attend A&E after a fall are not routinely followed up or seen in the falls clinic. However, people who are seen in the falls clinic are managed appropriately and according to national guidelines. The falls risk assessment tool has been introduced to A&E to score patients at low, medium or high risk. Referrals will now be stratified with the outcome based on the referral information and the patients score. In addition the falls clinic has been renamed to the “Balance Clinic” to avoid any negative connotation and improve attendance.

Myocardial Ischaemia National Audit Project (MINAP)

Cardiovascular disease is a major cause of acute and chronic illness in Guernsey. The HSSD participates in the Myocardial Ischaemia National Audit Project (MINAP). The locally-prepared annual report for MINAP in Guernsey monitors the standard of care of patients with acute coronary syndromes, including myocardial infarction (MI). Using MINAP, practice can be examined and improved. Past MINAP reports here and in the UK identified an issue where secondary prevention prescribing rates were not as good as they could be.

With the introduction of the local annual MINAP audit, prescribing rates improved. In 2008, rates of prescribing of secondary prevention treatment continued to improve and to exceed those in the UK.

Guernsey also participates in the National Confidential Enquiries such as National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and National Confidential Enquiry into Maternal and Child Health (CEMACH).

Challenges still to be met**● Clinical Audit Strategy and Policy**

We are currently developing a clinical audit strategy and policy for the organisation with the aim of providing strategic leadership and direction to the organisation’s approach to clinical audit.

Many audits are run because someone within a directorate believes that it would be a good thing to do. These audit projects are generally of a high standard. By building a clinical audit programme as part of the strategy, it is hoped that departments can prioritise topics for their area. Clinical risk and patient complaints are vital in helping to decide priority topics.

By completing audits which have been identified as priority areas there will be an expectation that these audits will demonstrate that they are making a real and measurable difference.

● Clinical Audit Action Plans

The clinical audit department advises all practitioners completing audits to devise recommendations based on the results of their audit. Recommendations should be discussed with all stakeholders so that an action plan can be agreed.



Audit action plans detail what needs to be done, who is responsible and when the action should be achieved. In 2007 a report entitled 'Closing the Loop' was completed which indicated about two-thirds of audit recommendations had been implemented. We have decided this year to make it an annual report. This report will monitor progress with the implementation of recommendations. In addition, evidence of re-audit will examine their effectiveness.

Miss Eithne Downey
Mr Brian O'Connell
Clinical Audit Nurses

Clinical Risk

Achievements to date

The clinical risk team has enabled the HSSD to achieve compliance with the Health Accreditation Quality Unit (HAQU) standards for clinical risk management.

The following areas Divette, Hanois, Casquets, Fougere, Duchess of Kent, Saward, Kinnersely, Radiology, Day Patient Unit, Loveridge, Cardiology, Albecq, Accident & Emergency, Community Drug and Alcohol Team and St Lukes are now registered with the electronic incident reporting system. This will allow analysis of reported incidents and up to date risk reports for all service areas, including allowing managers to view the main cause groups for incidents, the number of reported incidents and the risk rating for all reported incidents within their areas.

● Serious Untoward Incident (SUI) Panel

The SUI Panel process was established in January 2008, with terms of reference to review all potential SUI's within 48hrs and to decide if a Root Cause Analysis (RCA) investigation is required. Several incidents have been reviewed and although this has been successful it has been found that the composition of the panel needs refining in order to reduce the time taken to complete investigations and produce a RCA report when required.

● Clinical risk management implementation plan

A clinical risk management implementation plan which sets a clear direction for the organisation has been written and following wide consultation approved by the HSSD Board and is now available on the intranet.

● Clinical risk assessments

Findings from clinical risk assessments are collated, analysed, work practices reviewed and changed as necessary to reduce risk.

Action plans from risk assessment meetings are undertaken at the clinical risk management committee meetings for each area, changes to practice agreed and implemented by the clinical teams.

- Summary reports

Summary reports of high risk and serious untoward incidents are produced for the clinical governance committee and the Corporate Management Team.

A risk register has also been established including the purchase of an electronic risk register as part of the incident reporting system. Training on the use of this is being provided for all Senior Managers and the Corporate Management Team.

- Modified Early Warning Score (MEWS)

MEWS has been introduced to alert doctors in A&E and on surgical wards to deterioration of a patient's clinical condition and following a 3 month pilot it is hoped to implement within the medical wards. Maternity services are also producing their own version.

- Morbidity and mortality meetings

All specialities have regular morbidity and mortality meetings with adequate clinical participation and timely implementation of any recommendations made. Any actions resulting from these meetings are discussed at the clinical risk management committee for that speciality and implementation of changes to practice is led by clinical staff.

Objectives for the coming year

- Training and education

The clinical risk team has been working with the Institute of Health and Social Care Studies on risk training for all staff within the induction programme and for all other staff as part of education opportunities.

- Implementation of actions

³⁸To address identified risks resulting from incidents the HSSD needs to ensure there are timed action plans after each incident.

Action: The implementation of risk management action plans should be audited.

³⁹Risk management should be seen as a core responsibility for all HSSD employees and further education is required to achieve this.

Mrs Lynn Lewendon, Clinical Risk Manager (until June 2009)
Ms Trish De La Mare, Patient Safety Advisor (from June 2009)



Clinical Coding

Clinical coding is the translation of clinical information on diagnosis and operations into codes which are entered on the Patient Administration System for storage, retrieval and analysis by the Healthcare Information Unit. This work is a fundamental building block for information analysis to help the HSSD understand its business better. Guernsey uses the World Health Organisation International Classification for Diseases (ICD) for diagnostic codes, and the Office for Population Census and Surveys (OPCS) for operation coding. Both versions have undergone major revisions over the years.

The ICD has gone from being numerical to alpha-numerical. This has greatly expanded the scope for coding and also allows for future expansion. The OPCS has only recently undergone a radical change which has allowed for the advancement in surgery and the inclusion of high cost drugs and chemotherapy regimens.

Coding has been carried out at the Princess Elizabeth Hospital since 1992 and on average 13,000 episodes have been coded per year. The Clinical Coding department has two full time qualified coders, one of which is an accredited coder. The coders code all inpatient activity at the Princess Elizabeth Hospital, Albecq Ward at the Castel Hospital and Allan Grut Ward at the King Edward VII Hospital.

Each time a patient is admitted to hospital a diagnosis is entered into his/her medical record. Once entered into the Patient Administration System (PAS) system these codes are then grouped into HRGs (Health Resource Groups) and it is these HRGs which are used in case mix analysis, costing, contracting, resource management and auditing.

It is the job of the coders to code accurately and to adhere to the rules and conventions laid down by the World Health Organisation. If a code is missed or used incorrectly it can have major financial implications, as well as affecting any statistics.

'With the advent of the electronic health record the coders role will be changing, training is an ongoing process as healthcare progresses to higher levels and Margaret and Sue are keen to keep their status as "among the top echelons of all NHS Trusts in terms of accuracy of clinical coding'
(Quote from UK Auditors).

Mrs Margaret Cann
Senior Clinical Coder

Vital Statistics 2008

• Births and birth-related data

	Guernsey		England & Wales
	2008	5 Year Mean 1999-2003	2004
Estimated mid year resident population	60,488*	60,047	53,050,000
• males	29,686*	29,138	25,990,000
• females	30,802*	30,908	27,060,000
• M : F	0.96	0.94	0.96
Population density/Km² [Area 63.1Km²]:	959	952	51.9
Marriages:	300	353	246,459
• marriages/000	5.0	5.9	4.7
Divorces:	141	184	153,199
• divorces/000	2.3	3.1	2.9
Divorces: Marriages	0.47	0.53	0.62
Live birth registrations:	651	621	639,724
• males	332	320	328,340
• females	319	301	311,381
• M : F	1.04	1.07	1.05
Births outside marriage	264	213	269,724
• % all births	41%	34%	42.2%
Stillbirths:	3	2.2	3,686
• rate/000 live births	4.6	3.6	5.8
Infant deaths: (<1 year)	0	3	3,400
• infant death rate/000 LB	0	4.8	5.3
Crude Birth Rate/000	10.8	10.3	12.1
Natural increase per annum:	+0.29%	+0.11%	+0.49%

* includes 'natural increase', but excludes net migration

• Deaths and death-related data (By ICD 10 Codes)	Guernsey		England & Wales
	2008	5 Year Mean 1999-2003	+2004
Total deaths: (number)	476	557	512,571
• males	219	262	244,130
• females	257	296	268,411
• M : F	0.85	1	0.91
Crude death rate:/000	7.9	9	9.7
Circulatory deaths (I00-I99): No	168	204	198,603
• males/- rate/00,000	268	325	382
• females - rate/00,000	292	355	367
Cancer deaths (C00-C97/D00-D48): No	136	134	134,856
• males- rate/00,000	239	252	271
• females- rate/00,000	211	196	238
Lung cancer deaths (C34): No	35	28	28,328
• males - rate/00,000	71	60	65
• females- rate/00,000	45	36	42
Breast cancer deaths (C50): No	6	8	10,972
• females- rate/00,000	19	27	41
Alcoholic liver disease and cirrhosis (K70) (K74):No	4	4	6,751
• males - rate/00,000	7	3	16.1
• females - rate/00,000	6	9	9.5
Injury deaths (S00-X59) (including suicide): No	6	6	16,497
• males- rate/00,000	10	14	39
• females- rate/00,000	10	8	24
Suicide deaths (X60-X84): No	1	3	3,313
• males - rate/00,000	3	8	9.7
• females - rate/00,000	0	2	3.0

+Source: OHE 'Compendium of Health Statistics (18th Edition 2007)

Source: Guernsey Greffe

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2008

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group I																	
Infectious and parasitic diseases																	
A41	Other septicaemia	0	0	0	0	0	0	0	0	0	0	1	0	2	4	3	4
Total Group I		0	0	0	0	0	0	0	0	0	0	1	0	2	4	3	4
Group II																	
Neoplasms																	
C06	Malignant neoplasm of other and unspecified parts of mouth	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
C10	Malignant neoplasm of oropharynx	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
C15	Malignant neoplasm of oesophagus	0	0	0	0	0	0	0	0	3	0	1	2	1	0	5	2
C16	Malignant neoplasm of stomach	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1
C18	Malignant neoplasm of colon	0	0	0	0	0	0	0	0	1	1	0	1	2	3	3	5
C19	Malignant neoplasm of rectosigmoid junction	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
C20	Malignant neoplasm of rectum	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
C22	Malignant neoplasm of liver and intrahepatic bile ducts	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
C25	Malignant neoplasm of pancreas	0	0	0	0	0	0	0	0	1	0	0	0	2	0	3	0
C26	Malignant neoplasm of other and ill-defined digestive organs	0	0	0	0	0	0	0	0	2	0	2	2	0	4	4	6
C34	Malignant neoplasm of bronchus and lung	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites	0	0	0	0	0	0	0	0	5	3	5	4	11	7	21	14
C43	Malignant melanoma of skin	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
C44	Other malignant neoplasms of skin	0	0	0	0	0	0	0	0	0	0	1	1	0	2	1	3
C45	Mesothelioma	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
C50	Malignant neoplasm of breast	0	0	0	0	0	0	0	0	0	1	0	2	0	0	2	0
C56	Malignant neoplasm of ovary	0	0	0	0	0	0	0	0	0	3	0	1	0	3	0	6
C61	Malignant neoplasm of prostate	0	0	0	0	0	0	0	0	1	0	0	0	8	0	9	0
C64	Malignant neoplasm of kidney, except renal pelvis	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
C67	Malignant neoplasm of bladder	0	0	0	0	0	0	0	0	0	0	2	0	2	3	4	3
C71	Malignant neoplasm of brain	0	0	0	0	0	0	0	0	0	2	1	1	2	0	3	3
C73	Malignant neoplasm of thyroid gland	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
C76	Malignant neoplasm of other and ill-defined sites	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1



GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2008

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M F		M F		M F		M F		M F		M F		M F		M F	
C78	Secondary malignant neoplasm of respiratory and digestive organs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
C79	Secondary malignant neoplasm of other sites	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C80	Malignant neoplasm without specification of site	0	0	0	0	0	0	0	0	0	0	1	1	2	2	3	3
C83	Diffuse non-Hodgkin's lymphoma	0	0	0	0	0	0	0	0	0	0	0	0	1	1	3	1
C85	Other and unspecified types of non-Hodgkin's lymphoma	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C90	Multiple myeloma and malignant plasma cell neoplasms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2
C92	Myeloid leukaemia	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
D47	Other neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Total Group II		0	0	0	0	0	0	1	0	0	0	0	0	0	0	71	65
Group IV																	
Endocrine, nutritional and metabolic diseases																	
E14	Unspecified diabetes mellitus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
E46	Unspecified protein-energy malnutrition	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Total Group IV		0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Group V																	
Mental and behavioural disorders																	
F01	Vascular dementia	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	1
F03	Unspecified dementia	0	0	0	0	0	0	0	0	0	0	0	0	2	8	2	8
Total Group V		0	0	0	0	0	0	0	0	0	0	0	0	3	9	4	9
Group VI																	
Diseases of the nervous system																	
G12	Spinal muscular atrophy and related syndromes	0	0	0	0	0	0	0	0	1	0	0	1	1	0	2	1
G30	Alzheimer's disease	0	0	0	0	0	0	0	0	0	0	0	0	3	1	3	1
G31	Other degenerative diseases of nervous system, not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2008

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
G35	Multiple sclerosis	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
G71	Primary disorders of muscles	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
G93	Other disorders of brain	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Total Group VI		0	0	0	0	0	0	0	0	1	1	0	1	7	1	8	3
Group IX																	
Diseases of the circulatory system																	
I09	Other rheumatic heart diseases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I21	Acute myocardial infarction	0	0	0	0	0	0	0	0	1	0	3	2	14	12	18	14
I24	Other acute ischemic heart disease	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
I25	Chronic ischaemic heart disease	0	0	0	0	0	0	0	0	2	0	1	0	4	2	7	2
I26	Pulmonary embolism	0	0	0	0	0	0	0	0	1	1	0	1	1	5	2	7
I27	Other pulmonary heart diseases	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
I31	Other diseases of pericardium	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	3
I35	Nonrheumatic aortic valve disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
I42	Cardiomyopathy	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1
I46	Cardiac arrest	0	0	0	0	0	0	0	0	0	0	0	0	3	4	4	4
I49	Other cardiac arrhythmias	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
I50	Heart failure	0	0	0	0	0	0	1	0	4	1	7	0	11	24	23	25
I51	Complications and ill-defined descriptions of heart disease	0	0	0	0	0	0	0	0	0	0	0	0	2	1	2	1
I61	Intracerebral haemorrhage	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	1
I63	Cerebral infarction	0	0	0	0	0	0	0	0	1	0	0	0	1	2	2	2
I64	Stroke, not specified as haemorrhage or infarction	0	0	0	0	0	0	0	0	0	0	1	1	12	15	13	16
I67	Other cerebrovascular diseases	0	0	0	0	0	0	0	0	0	0	1	0	2	10	3	10
I71	Aortic aneurysm and dissection	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Total Group IX		0	0	0	0	0	0	2	0	12	3	14	4	50	83	78	90
Group X																	
Diseases of the respiratory system																	
J18	Pneumonia, organism unspecified	0	0	0	0	0	0	1	0	1	1	1	1	13	17	16	19
J22	Unspecified acute lower respiratory infection	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5
J43	Emphysema	0	0	0	0	0	0	0	0	1	1	0	1	0	1	1	3
J44	Other chronic obstructive pulmonary disease	0	0	0	0	0	0	0	0	0	0	0	4	7	7	7	11
J45	Asthma	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0



GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2008

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
J69	Pneumonitis due to solids and liquids	0	0	0	0	0	0	0	0	0	0	0	0	2	1	2	2
J81	Pulmonary edema	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
J84	Other interstitial pulmonary diseases	0	0	0	0	0	0	0	0	1	0	0	1	0	1	1	2
J96	Respiratory failure, not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	4	1	4	1
Total Group X		0	0	0	0	0	0	1	0	3	3	2	7	27	33	33	43
Group XI																	
Diseases of the digestive system																	
K63	Other diseases of intestine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
K65	Peritonitis	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
K70	Alcoholic liver disease	0	0	0	0	0	0	0	0	2	2	0	0	0	0	2	2
K92	Other diseases of digestive system	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1
Total Group XI		0	0	0	0	0	0	0	0	3	3	0	0	0	2	3	5
Group XIV																	
Diseases of the genitourinary system																	
N17	Acute renal failure	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1
N18	Chronic renal failure	0	0	0	0	0	0	0	0	0	0	0	0	2	1	2	1
N19	Unspecified renal failure	0	0	0	0	0	0	0	1	0	0	0	0	2	3	2	4
N39	Other disorders of urinary system	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Total Group XIV		0	0	0	0	0	0	0	1	0	0	0	0	5	6	5	7
Group XVI																	
Certain conditions originating in the perinatal period																	
P95	Fetal death of unspecified cause	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1
Total Group XVI		0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1
Group XVIII																	
Symptoms, signs & abnormal clinical & laboratory findings, nec																	
R09	Other symptoms and signs involving the circulatory and respiratory systems	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2008

ICD 10 Code	Cause of Death	Under 1		1-14		15-24		25-44		45-64		65-74		75+		All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group XVIII																	
Symptoms, signs & abnormal clinical & laboratory findings, nec																	
R09	Other symptoms and signs involving the circulatory and respiratory systems	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1
R53	Malaise and fatigue	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
R54	Senility	0	0	0	0	0	0	0	0	0	0	0	0	5	23	5	23
Total Group XVIII		0	0	0	0	0	0	0	0	0	0	0	0	6	25	6	25
Group XIX																	
Injury, poisoning and certain other consequences of external causes																	
S06	Intracranial injury	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
S09	Other and unspecified injuries of head	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
S72	Fracture of femur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
T51	Toxic effect of alcohol	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
Total Group XIX		0	0	0	0	0	0	1	0	0	1	0	0	0	2	1	3
Group XX																	
External causes of morbidity and mortality																	
W31	Contact with other and unspecified machinery	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
V29	Motorcycle rider injured in other and unspecified transport accidents	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
X70	Intentional self harm (suicide) by hanging, strangulation and suffocation	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
Total Group XX		0	0	1	0	0	0	2	0	0	0	0	0	0	0	3	0
Cause of death unascertained - open verdict																	
Awaiting inquest		0	0	0	0	0	0	0	0	0	1	0	0	1	0	1	0
Total Deaths		2	1	1	1	0	0	7	1	37	25	36	29	136	201	219	257



Alderney Vital Statistics - 2008

	Males	Females	Total 2008	5 year mean 1999- 2003
Population	1,108	1,130	2,238	2,294
• M : F			0.98	0.97
Births - In Guernsey:	5	4	9	9.4
Births - In Alderney:	0	1	1	0.8
Total Births to Alderney residents:	5	5	10	10.2
Births outside marriage:	2	1	3 (33%)	4.2 (41%)
Crude Birth Rate/000			4.5	4.5
Marriages registered in Alderney:			15	13
Deaths registered in Alderney:	17	13	30	22.8
Crude Death Rate/000			13.4	10.1
Natural Increase:**			-20 [-0.9%]	-12.6 [-0.6%]

*Includes 'natural increase', but excludes net migration.

** 'Natural increase' is the difference between the crude birth and the death rates, expressed as a percentage of the resident population.

Source: Alderney States Office

Sark Vital Statistics - 2008

	Males	Females	Total 2008	5 year mean 1999- 2003
Population*			650	
* M : F				
Births - In Guernsey:	2	1	3	
Births - In Sark:	0	1	1	
Total Births to Sark residents:	2	2	4	
Births outside marriage (0%)	1	1	2	
Crude Birth Rate/000	-	-	6.15	
Marriages registered in Sark:				
Deaths registered in Sark:			1*	
Crude Death Rate/000			1.53	
Natural Increase:**			0.46%	

*Includes '*natural increase*', but excludes net migration.

** '*Natural increase*' is the difference between the crude birth and the death rates, expressed as a percentage of the resident population.

*One Sark resident died in the Princess Elizabeth Hospital
One visitor died in Sark, but was taken to the Princess Elizabeth Hospital

Data supplied by Dr Peter Counsell



Appendix Two

A.2 Staff providing public health services 2008

Director of Public Health/Medical Officer of Health

Dr David Jeffs FRCP FFPH FAFPHM FRSH

Dr Stephen Bridgman MBChB DipBiomech MD MPH FRCS (Ed)
FRCS (Glas) FFPH

Personal Assistant

Mrs Yvonne Kaill

Part-time Medical Staff:

Deputy Medical Officer of Health

Dr Brian Parkin MB BS BSc FRCP MRCGP DRCOG

Sexual Health Clinic

Dr Nikki Brink MBChB MMed FRCPATH

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Health Promotion Officer (health inequalities)

Mrs Lynn Spencer HNC

Resources Officer

Mrs Stephanie Charlwood

Secretary

Mrs Bella Mahy

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Mrs Lynne Lewendon RGN

PA to Clinical Risk Manager

Mrs Jo McGinn

Clinical Audit Nurses

Miss Eithne Downey RGN Dip HE BN MSc (Health Education)

Mr Brian O'Connell



Health Records and Healthcare Information

Healthcare Information Analysts

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Mrs Tamsin Lilley BSc (until February 2008)

Mrs Jenny Elliott

Clinical Coders

Senior Clinical Coder

Mrs Margaret Cann ACC

Clinical Coder

Mrs Sue Sheppard

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MRSA Colonisation

MRSA (Methicillin-Resistant *Staphylococcus Aureus*) Colonization: Presence of MRSA on tissue without the presence of symptoms of clinical manifestations of illness or infection. A carrier is colonized with MRSA.

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Helpful websites and numbers

Age Concern	726312
Alcohol	http://www.units.nhs.uk/index.php
Alzheimer's Society	244057 243815
Drug Concern	729000
Environmental Health	711161
<i>Out of hours</i>	725241
Health Information Exchange	707470
Family Planning	07781 103434
Guernsey Adolescent Smoking Project	727899
Guernsey Alcohol and Drug Abuse Council	723255
Guernsey Society for Cancer Relief	264298
Guernsey Society for People with Learning Disabilities (Guernsey MENCAP)	721865
Health Care Equipment Centre	729268
<i>Hire and sales</i>	
Health Promotion Unit	707311
Hospitals	725241
Les Bourgs Hospice	251111
MENCAP	07781 456801
MIND Guernsey	722959
Pink Ladies	07781 415131
Quitline (Smoking)	233170
Samaritans	715515
Sexual Health Clinic	232626
Swine Flu Information	www.gov.gg



HEALTH AND SOCIAL SERVICES

A STATES OF GUERNSEY GOVERNMENT DEPARTMENT



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