LADY WILLINGDON HOSPITAL

ANNUAL REPORT 2016-2017

This year has sped past on jet wings. A lot has happened. Stalwarts have left, new team members have joined, numerous projects and proposals are on the anvil. Our hospital continues to strive towards the three key focus areas: standard of care, at affordable prices, in the spirit of Jesus. Each of these focus areas have had work done on them and this report I will change my reporting format to reflect the changes that are happening as our hospital continues to develop and change.

HOSPITAL STATISTICS:

STATISTICS	**2007-8**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-2014**	**2014-2015**	**2015-16**	**2016-2017**
Inpatients	2834	3231	3177	3246	2792	3318	3777	3511	3780
Deaths	61	70	76	66	46	62	61	68	77
Death rate	2.15	2.16	2.39	2.03	1.65	1.87	1.62	1.94	2.04
Average daily census	20.16	23.70	24.19	21.54	21.28	22.6	24.36	28.22	23.9
Avg length of stay	3.9	2.68	2.77	2.69	2.78	2.49	2.35	2.89	2.31
Outpatients new	17418	18009	19705	16091	19819	19401	21189	20969	20672
Outpatients revisit	22278	23079	25533	24394	32773	36301	36956	38538	36214
Daily avg, outpatient attendance	108.46	144.17	158.73	141.56	184.53	195.45	204.02	208.07	198.9
Total outpatients	39696	41088	45238	40485	52592	55702	58145	59507	56886
Dental	1853	1410	1801	2005	2270	1139	1713	1991	2183
Eye	1055	2337	2119	1575	1589	2103	570	963	1774
Physiotherapy	1324	1389	1574	1466	1696	1793	2007	1895	2004
INVESTIGATIONS									
X ray	5011	4599	6127	5636	5721	5983	6589	7593	7916

Lab	12176	10602	13299	13666	13709	14438	14863	17592	17544
Microbiology	423	151	89	112	141	75	108	109	101
Ct scan						488	417(till aug)	488	496
SURGERY									
Major (inclusive of LSCS)	492	669	778	569	565	550	605	737	641
Minor (OT)	524	408	427	341	420	310	351	366	303
Deliveries	404	333	499	424	438	519	366	562	442
Caesarean	124	191	158	116	143	145	175	203	155

STANDARD OF CARE:

Remote and rural location is not an excuse for substandard care is one of our core beliefs. Towards this end, we have worked unceasingly to provide a standard of medical and surgical care that is administered anywhere else in the country and in the world, tailored to meet our circumstances. Our door to thrombolysis time is still twenty minutes. Our emergency to operating table time for trauma is ten minutes. A code response will be a replicable intervention at every initiation. Early years were spent in training our staff to attain these levels. We now are able to provide general surgery, pediatric medicine, internal and critical care medicine and orthopedic surgery and obstetric and gynaecologic specialities in house. Latter years have been spent in upgrading our equipment and facilities to permit this. We are glad to report that we are now able to provide this standard of care to our patients. Our intensive care unit has four fully monitored beds with three ventilators. Our operating rooms now have laminar flow and meet NABH standards. We have in house blood storage facilities, functional digital x ray and spiral ct scan machines with telereporting. Our lab has been undergoing consistent upgradation and performs most of the tests in house. Our waiting lines have shortened, our processes become more efficient and our team has grown to 131 staff from 65 staff in 2004. We are in the process of entering the next phase of upgrading our software hms system which will now allow doctors to enter patient data directly on the computer, view results and order medicines in real time. All is not quite so rosy however, and we have lacunae in our standards. We need a radiologist or sonologist, the lack of whom has caused our ultrasound machines to be sealed. We need a new toilet complex for our outpatients. Our outpatient facilities and older male wards are ancient and we need more space to expand and construct new facilities that are patient friendly. We are fighting a protracted legal battle for possession of land that is rightfully ours in Katrain and the legal labyrinth promises some light at the end of the tunnel with the current occupant being declared a trespasser.

Our hospital has thus progressed and grown and has attained a measure of stability. This has led us to lift our eyes outwards and northwards, to the areas of Lahaul Spiti and Pangi. Extensive medical camps held across the valley has led us to ascertain that the most needy areas are in Killar and Kaaza. Dr Bishan has been an invaluable asset to us in providing direction to the community work. This year we hope to transition in this area, from intermittent camp based activities to more consistent interventions at a community level. We hope to do this by adopting a few key villages around manali and also using our peripheral centres. We hope to designate the peripheral centres and start consistent community work from them. Our intent is to have intimate health information of families in selected villages on a community level on an ongoing regular basis. We hope this will form a network that will be the basis for us unrolling various health education and intervention measures in the years to come.

Our tuberculosis program has also left much to be desired. We had participated in the early years in the DOTS program that is run by the government, with the intent of being able to provide our patients with free medicines. However, with the passage of time, we were very perturbed to discover patients not recovering, failing treatment and developing recurrences and drug resistant tuberculosis despite faithful compliance with the program. Reading and talking to others in similar situations led us to discover that the every other day dosing schedule in DOTS was the probable reason for the failure and also for breeding drug resistant bacteria, so we pulled out of this program in 2007. Our protestations and cautions fell on deaf ears with the government at the time. In 2009 WHO advised the daily regime on a worldwide basis. India has only followed suit in 2016 and even now it is not in effect in Himachal Pradesh, though our state is one of five chosen for the new regime in India. We are empaneled for this and are providing this benefit to the patients of tuberculosis who as a result have been purchasing the daily dose drugs from us for all these years. On a community level the specter of multidrug tuberculosis is also a harrowing one. What percentage of drug resistant tuberculosis starts of as resistant tuberculosis in patients is an unanswered question, since the red flags to this dreaded disease only go up after two to three months of standard treatment, a period during which this patient may be spewing the organism into the village. To answer this question, we have submitted a proposal to the National Instituted of Health in USA partnering with the University of Kansas and C.M.C. Vellore. This project envisions testing for drug resistant tuberculosis at the outset both in the hospital setting and on a community level with house to house visits for symptomatic patients who have not presented to the hospital as yet.

Another research project on the cards for this year is participation with the Global Surgery Collaboration, an international collaboration of surgeons looking at the incidence of surgical site infections and other issues relevant to surgery on a global level. We are enlisted on a randomized controlled trial that will examine the impact and effect of surgical site infections. This project will run for three years. The lead in this study is from the University of Birmingham, UK.

AFFORDABLE PRICES

The tension between cost of treatment and affordability is an ancient line of battle. Maintaining sustainability in the face of rising costs and yet being affordable to the average Himachali villager is a tightrope walk. We have managed to keep this balance through the years and are able to meet all our running expenditure and at the same time give away forty percent of our earning as charity and yet break even. This is because of the large turnover of patients. As accessibility improves and patients avail of care in corporate hospitals, their eyes are opening to the reasonable charges levied here for the same kind of treatment. We have never advertised and still believe the best advertisement is the satisfied patient. We still have work to do on all our staff learning to behave kindly to our patients. Entrenched attitudes take time to be relearnt. We hope to focus on this area in providing training and education in patient dealings in different departments this year.

The burgeoning of our staff numbers have reached a ceiling and we cannot afford any more hires. Cost cutting and saving expenditure are expedient measures. Government partnerships to recover costs are win win situations for all. Project fund application and grant proposal writing are unexplored areas for this year especially for community work. We have raised salaries to the maximum possible limit we can practically afford to pay them.

Economic measures to increase income have been long debated. Introduction of private patient charges, provision of a private OPD, creation of deluxe rooms, starting satellite centres are all options we see utilised in marketplace medicine. However we fear these measures will distract us from our focus and place demands on time and resources from the rich and upper middle class we would not like to describe as our primary clientiele.

We are also testimony to the fact that whenever provision was needed, it has unfailingly come from our Father from whom all blessings flow. Provision has come from unknown sources and unimaginable directions in which we recognize the hand of God. We would prefer to look in His direction for the future.

SPIRIT OF JESUS

We believe medicine is a vehicle for healing, which comes from God, and the hospital visit is an opportunity for people to experience the love and healing of Jesus. Towards this end, all our endeavours have been centred in and around prayer. The counselling room is a integral part of our ministry, and we are fortunate to have a full time chaplain in the person of Rev. David Rout. All of us who practice medicine and surgery here as well as our patients testify to the presence of the hand of God in our treatment and ministrations. We envisage branching out of this ministry into homes and houses and villages through people who are transformed and carry the light of Jesus to the community around us. Our community rehabilitation project of the physiotherapy department is a demonstration of this love reaching out to otherwise ignored and

neglected segments of the society. Though specialized camps continue drawing patients to us, we are venturing out to reach out to patients with camps and outreach projects. Vitamin A nutrition, and screening camps are all attempts to be the hands and feet of Jesus. We do believe we have a message for the mountains and seek to be the beautiful feet carrying it to remote and ill served areas.

OVERALL SUMMARY

We believe that we are still in transition. Early transitions were to establish a sound and stable base hospital. Now the transition moves us into the surrounding community. It is our vision that the gospel of Jesus is transformational truth bringing light and healing to people who are in need of it. We look for developing leadership here to join hands in our ventures here and welcome new members into our team.

We thank and praise God for everything He has done and is doing in our midst.

Submitted by Drs. Philip and Anna Alexander,
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