
The Highland Doctor

September 2007

Newsletter of the Southern Highlands Division of General Practice

From the Chair

I recently returned from Hong Kong where I have my other job. As some of you know, I have been employed as a consultant by the Beijing Olympic Games Organising Committee, advising them on how to best set up and run the equestrian competitions at the Olympics next year. The equestrian competitions are being held in Hong Kong due to quarantine regulations (and most Aussies have a new appreciation of how important quarantine and disease free status is for horses!), and I have just returned from the test event that each Olympic sport runs a year out from the Games as a rehearsal.

The test event was a success from many points of view – the organisers and volunteers, who have never done anything like this before, ran a very smooth and (to outside observers) seamless competition. More importantly, the event showed up some very basic organisational and management deficiencies, the existence of which I had been bringing to the senior management's attention – but that they could not see or address. All this in plenty of time to fix the problems before the extra stresses and demands of the Olympics arrive next year. The highlight was a typhoon that passed overhead postponing the first day of competition, moving 80km into China but then did a U-turn and passed back overhead again.

So what is the relevance of all this to our day-to-day practice? Many people ask me if there are any similarities between my job as a GP and my sport consultant roles. On reflection there are many skills that are transported from one to the other. GPs develop quite high level organisational skills, especially in service integration. They are often skilled in leading a multidisciplinary team. They tend to be good communicators. They are generally good listeners. They tend to be capable managers both on a macro and a micro level. And

they spend much time educating – patients mainly, but increasingly medical students and registrars doing vocational training. And above all, GPs tend to be good at making decisions.

Thirty, forty, fifty times a day, a GP makes a decision. Here is the history (or the path result or the imaging result etc) – what else do we need to know? An examination? A specialist's opinion? Or, if no more information is available – a decision. Medicate. Do nothing. Operate. Wait and watch. Refer. Test. Trial of something. And then next please. It is not until I have worked outside of medicine that I realise GPs are better equipped to and more experienced at making decisions than many managers with ivy league MBAs. No need to cringe – just try to pass on your skills and experience to the next generation.

While I have started with a horse story, I shall finish with a different one. Many of my friends attended the equestrian event at Maitland that became the epicentre of the Equine Influenza epidemic raging through NSW and Queensland, and unwittingly carried the virus back to their own animal communities. This virus affects almost 100% of the horses it comes into contact with here in Australia (where no horse has ever experienced the virus before and therefore there is zero herd immunity), it can be carried on clothing and other equipment for up to 36 hours, and has a very short incubation period (mostly two days, five days maximum). Before its spread was recognised in Australia, it had affected three “waves” of horses. And of course, it started on a Friday night, when communication lines are down, people travel away and tend not to look at email or TV warnings. Now, just imagine if this was the human flu pandemic! How would we have coped? Would it have been “locked down” to the point of no transmission into flu free areas in just over a week? Interesting thought!!

Vince Roche

From the CEO

Clinical Data Extraction and Transmission

I have put this issue at the front of the potpourri of matters from my pen in this edition of *The Highland Doctor*. I do this because this is a key in two of our chronic disease programs – the diabetes and cardio-vascular programs.

The more meetings one attends these days, the more one hears about the need for patient registration, data collection and use in chronic disease management. We must have known something when we started down this road twelve years ago.

Members are entitled to be sceptical when I report that at long last we appear to be getting somewhere in the data extraction business. We have been trying to remove the paper chase inherent in our diabetes program for more years than I care to remember. We have been aware of potentially successful initiatives in this area for some time past, however we have been dubious about the ability of various data extraction providers to really deliver. We have also had excursions into the data transmission fields with disappointing results.

However, we haven't been idle. We have been working with people at UNSW to look for an electronic solution to this data problem and finally we have accepted an offer from the Canning Division in WA to further develop their now proven 'Canning Extraction Tool' for use. This tool is compatible with the Argus encryption software which has also undergone much more development since our earlier trials with it.

In the first instance, we have commissioned Canning to develop extractions for MD2, MD3 and Best Practice. Our other local clinical software (Genie) presents problems and at this stage we haven't progressed with that software.

We now believe that the combination of Argus and Canning at last has the potential to replace the 'paper chase' in our programs.

The Highland Doctor

Pre-Diabetes Program

As a part of the Australian Better Health Initiative (ABHI), the Commonwealth has funded a NSW based pilot program for pre-diabetes. This funding of \$5 million over three years was offered on a competitive basis to the major Area Health Services in NSW. Given our albeit limited experience in pre-diabetes detection and management, we were able to contribute to the SSWAHS bid for the project.

We were all delighted to learn this bid was successful. SSWAHS will operate this important program in the Southern Highlands, Macarthur and Central Sydney areas. Of these areas, we have the most relevant pre-diabetes program which means that we should have no difficulty in implementing the program at our end. What this translates to is funding for 2.5 FTE workers – nurses to work on pre-diabetes activity in the practices, particularly focussing on the small practices without PNs, and one FTE counsellor to work with Jill Snow in patient counselling and education in pre-diabetes.

There will also be three years funding for additional exercise activity and one-off funding of \$25k for upgrading our IT, including data extraction and transmission.

We estimate that there are some 3,000 likely program candidates – many of whom will have co-morbidity and thus present a complex problem. Jill Snow is to serve on the central Steering Committee for the project.

Mental Health Activity

Currently our Mental Health Worker, Astrid Toscan, is working half for us and half for the Health Service – the latter mainly being in relation to liaison between GPs and the Mental Health Service. However in the last year there have been major systemic changes in mental health matters.

The BOMH program has taken off since the access to it for GPs was freed up. There has also been the introduction of the Better Access Program and funding has become available for Mental Health Practice Nurses. Lastly, the Mental Health Service is reviewing its needs in regard to a wider interface with GPs.

All of this is causing Astrid to review her work. Changes include:

- Employing an administrative assistant, Catherine Amos, to relieve Astrid of the administrative shores associated with the BOMH program.
- Launching a pilot in two practices (one small and one large) to see what scope there is for practice mental health nurses.
- Coming up with a strategic plan for her overall future role. More on these issues as they develop.

However one thing is crystal clear – the present utilisation of the BOMH program will see us run out of money for the program before Christmas. Accordingly, we have no choice other than to restrict access to BOMH. As you will be aware, we have implemented a temporary waiting list until we can fully determine the financial implications of the recent imposition of the six session maximum. Once we have established the size of the "tail" and re-open the access, there are several options:

- Continue the six session restriction
- Restrict access to Healthcare Cardholders only
- Restrict access to persons known to GPs as being financially disadvantaged.

We are aware that other Divisions have adopted the Healthcare Card only option, with other persons having to utilise the Better Access option.

Cardio-Vascular Program

For some years we have experimented with a program to monitor the care of people who have suffered a serious ischaemic heart disease problem – an infarct or by-pass surgery etc.

Regrettably, we have only been able to operate this trial in one practice due to lack of funds to implement it more widely. I am pleased to announce that we can now roll out the program as we are able to fund Nerida Campbell to work part-time for the Division in this field. Nerida is a highly experienced specialist cardio-vascular nurse who currently works part-time in the Cardiac Assessment Unit at Bowral Hospital and the Heart Failure Program at Community Health.

The program will operate along similar lines to our Diabetes Program except that it will not include an education component since the patients will have already undergone that as part of their rehabilitation. Practices will be invited to recruit patients, register them in the CARDIAB database, and send in the periodic data. The database is being upgraded to list both the diabetes and CV patients who are at risk, allowing Jill Snow in the case of diabetes or Nerida in CV cases to contact the GP and suggest an intervention. It is apparent that many of these patients will be of interest to both Jill and Nerida.

New Zealand visit

I had the pleasure of joining Dr Greg Stewart, SSWAHS Director of Planning and Population Health, in a short visit to Christchurch and Auckland in recent weeks. The purpose was to be updated on the situation with primary care over there. The key findings were:

- Whilst the GP/population ratio is 1:1,400, their GPs are not overworked because they have about the same number of practice nurses.. The practices charge separately for many of their services
- The practices do not appear to have difficulty recruiting GPs and there appears to be little dependence on overseas trained doctors
- There are very few one or two GP practices in urban areas. The commonest seems to be 3-4 GPs with some large ones – 16 in one case.
- Some of their practice nurses are reasonably highly skilled in diabetes education, CV care, early childhood care and social work etc so that, whilst they are not as highly trained in these disciplines as our specialist personnel, they are more readily available to patients. This is because they are either located in the larger practices or circulating amongst smaller ones.
- There are no Community Health Services or Community health Centres as we know them. These services are almost all provided within the practices or by the large Independent Practice Associations (IPAs) – similar to large Divisions of General Practice.

- The IPAs operate 24 hour GP clinics in large centres – equivalent to many of our larger EDs. The one in Christchurch has 72,000 attendees p.a.
- The IPAs also operate Ambulatory Care Programs under which GPs are paid to provide home care for conditions such as DVT etc. The GPs talk about their hospital avoidance rates.
- GPs are paid by a mix of capitation (circa 50% of income); ambulatory care and other special payments; performance related quality payment for prescribing, test ordering, immunisation etc; and patient co-payments (circa 20%).

DocFax Communications

The Division objected strongly when the DocFax patient activity reports (discharges, admissions, etc) from SSWAHS ceased suddenly and without warning earlier in the year. We were told that this was due to SSWAHS switching over to the Cerner IT system for patient administration. We understand that Cerner did not have the necessary facility for DocFax. It eventuates that Cerner could however have the necessary facility installed.

I am pleased to report that this appears to be happening and so hopefully we will see the re-introduction of the DocFax reports.

GP Survey

You will have recently received a survey canvassing your views on the Division's performance over the last year and your views on where we should go in the coming years.

We are well aware of the nuisance that surveys represent and we therefore keep them to a minimum and as simple as possible. They are however occasionally essential and I do ask that if you have not already done so, please complete this recent one. If you require another copy, please contact Sally at the office.

Warwick Ruscoe

Glycaemic Highlights

Pre-diabetes

I am very excited about the community based diabetes prevention program. It is a welcome chance to further extend our existing efforts towards the slowing down and prevention of T2Diabetes.

I will be on leave from the office Friday 14 September to 24 September.

I was lucky enough to win a trip to Hawaii.

I may get to check out what they are doing with Diabetes in Hawaii or then again I may not! I will think of you all in the 32 degree heat!

Of general interest there has been an influx in the diagnosis of T1 DM amongst 16 year olds and an increase in the number of referrals for impaired glucose tolerance. Keep up the detective work. Once the new pre-diabetes program commences the services to help you manage this group of people will be greatly increased.

Currently the Division's glycaemic results are:

- 67% (743 people) have a HbA1c \leq 7%
- 20% (222 people) have a HbA1c between 7% and 8%
- 13% (144 people) have a HbA1c $>$ 8%

Getting better every time

Aloha

Jill Snow



MENTAL HEALTH MATTERS

We have been very busy on the Mental Health front. Firstly, the Better Outcomes in Mental Health program has been temporarily suspended due to funding issues. As noted in my recent letter and email to you all, those patients who are currently in the program will be able to continue and we will notify you when new referrals can be accepted. Alternatives to the BOMH program include referral to psychologists under the Better Access program (a gap fee may be incurred) or possibly the Community Health Centre to one of the two generalist counsellors - however their waiting lists are lengthy. Bereavement, grief/loss issues can be directed to Southern Highlands Bereavement Care Service on 48 62 1701.

For the past six weeks I have been conducting a pilot program under the new Mental Health Nursing Initiative at three sites within our Division. Referrals under this program have included abnormal psychiatric conditions, complex postnatal depression, trauma, personality disorders, gambling issues, sexual assault, long term issues associated with depression and anxiety and difficulties in the adolescent/youth age groups. Being able to offer nursing and psychology interventions is proving to be very useful and I am enjoying the variety and challenge of the pilot. The value in this program is that it is open-ended, i.e. it is not limited to 12 sessions, however the target audience is people who are at the more difficult and complex end of the mental health spectrum. The Commonwealth is still finalising appropriate mechanisms to remunerate the provision of this service. I anticipate that I will review the current pilot in 6-8 weeks in collaboration with the participating practices to discuss the usefulness, viability and potential development of this service.

The Highland Doctor

Encompassed in the provision of services for practices in our Division is the PABSCI program. The PABSCI (Psychological and Behavioural Support for Chronic Illness) program continues to develop and I am currently assisting a number of patients with psychological interventions to help in the management of their chronic illness.

After our three successful 'Teams of Two' evenings earlier in the year, I am currently researching some other education opportunities. A local psychiatrist, Dr Robert Gordon, is keen to provide an evening's education focusing on personality disorder. As well, I am anticipating the new youth focussed modules in the 'Teams of Two' format which will be available for 2008.

If you have any concerns regarding the points you need for this triennium to maintain your Level 1 / Level 2 ranking could you please let me know and I will be able to troubleshoot this. I have been trying for some time to organise a CBT course for interested GPs which will provide Level 2 training, however the issues has been sponsorship. SPHERE is providing a good course that involves 12 hours of face to face and 8 hours of take home work which is less onerous than the regular 20 hours of face-to-face contact. The course costs \$400+gst however I will continue to see how it can be provided at the lowest cost to GPs. I will advertise the course when these matters are settled.

Besides the Division activities, I continue to conduct some clinical work and provide consultation for the Community Mental Health Team and recently have begun case reviews with the Tahmoor Mental Health Team.

Astrid Torcan

HOME HOSPICE

The Cancer Council NSW has formed a new partnership with HOME Hospice to enable HOME Hospice to be available in our local area. HOME Hospice has been operating for 27 years and has recently expanded into the Highlands. The organisation trains local voluntary community mentors (often current or retired health professionals or people who have been a carer) to help families caring for those patients nearing the end of a terminal illness and wanting to remain in their own homes. HOME Hospice provides a mentor for the carer to assist them in organising the support they need to make dying at home possible. This way the carer and patient may spend quality time together and the risk of the carer becoming stressed or burnt-out is minimised. The caring is done by loved ones, friends and neighbours, backed up by the support of professional community services. The patient's medical care continues to be given by his or her own general practitioner.

This program allows those who would prefer to die at home to be able to do so knowing that their carers have the guidance and support that is needed. The mentors do not become involved in clinical care issues but simply support the carers through the sometimes difficult and confusing maze of options. This support often continues for a period after the patient has passed away and up to the first anniversary of the death. Interestingly, on average it costs HOME Hospice \$600 per family (for an average 12-18 month period) to deliver the program. This compares to \$72,000 per patient for only a three-month period in a hospital or hospice setting.

To find out more about HOME Hospice you can visit www.homehospice.com.au. If you are interested in the Home Hospice program you can call 1800 132 229 and discuss the program with the CEO Ms Melanie Greblo-Rhodes or Founding Directors, Dr Helen-Anne Manion and Gerard Manion.

The Highland Doctor QUALITY USE OF MEDICINES NPS

RADAR

Many of our GPs are already subscribing via email to NPS RADAR (Rational Assessment of Drugs and Research). This NPS service keeps prescribers up to date with any changes to the PBS, provides alerts about urgent issues such as the recent lumiracoxib recall and other evidence-based information to assist prescribing. The August 2007 issue covered:

PBS changes to:

- budesonide with eformoterol dry powder
- fluticasone with salmeterol

New and recent products PBS listed:

- **Strontium ranelate** appears to have comparable efficacy to that of alendronate in reducing the risk of vertebral fracture in postmenopausal women with a previous fracture. Listed April 2007
- **Atomoxetine** is a noradrenaline reuptake inhibitor used for treating attention deficit hyperactivity disorder (ADHD). Atomoxetine is subsidised on the PBS for people who cannot take methylphenidate and dexamphetamine, the first-line drug treatments. Listed July 2007
- **Olmesartan** reduces blood pressure to a similar extent as other angiotensin II-receptor antagonists. Without long-term clinical outcome evidence or long-term safety data, olmesartan should be considered after other drugs in the class with more evidence and experience of use. Listed June 2007.

Information about new listings of vaccines Gardasil and Rotarix & RotaTeq.

If you would like to receive RADAR updates regularly please call Gail at the Division or subscribe via the NPS website (www.nps.org.au).

NPS telephone prescribing and information support lines TAIS (Therapeutic Advice and Information Service) for health professionals, ph 1300 138 677

NPS Visits

The recent round of educational NPS visits to GPs and Practice Nurses has been completed on the topic of Analgesics in Persistent Pain. The main messages were:

- Use paracetamol as ongoing therapy: the modified release formulation offers convenience

- Use NSAIDs where cardiovascular, renal and gastrointestinal risks are acceptable
- Consider an opioid when non-opioids offer inadequate pain control or NSAIDs are unsuitable
- Tramadol's role in mild-moderate pain is limited by drug interactions and CNS adverse effects

If you have not previously had NPS one-to-one educational visits and would like to be included please call Gail at the Division. The visits take between 20 and 30 minutes, provide the most recent, evidence-based, unbiased information for prescribers and attract RACGP points and PIP incentives.

Buying Medicines over the Internet

NPS has provided some sensible guidelines on its website for consumers who want to buy medicines on-line. The full website address for a recent press release is:

www.nps.org.au/resources/content/Buying_medicines_on_the_internet.pdf

This article leads consumers onto "Medicines Talk" – an excellent on-line publication to assist consumers to maintain safety in medication management.

QUIT SMOKING PROJECT

A big thankyou to the practices that have participated in the recent quit smoking project with UNSW. All the Practice Nurses were very diligent in implementing the project and embraced it with great enthusiasm. This has made easier the task of persuading the Commonwealth that a Medicare item number for Practice Nurses to provide quit counselling would enhance attempts by general practice to encourage patients to stop smoking. The project is very near completion in the Southern Highlands and I will soon be contacting some of the GPs who participated to obtain a brief view of their experience of the project (in 5 minutes or less!).

Gail Furlong



The Highland Doctor

After Hours Service

Firstly, thank you to you all for your patience with the introduction of the new call service. We have experienced a few teething problems and some of you have been inconvenienced as our new call service provider gets used to the way we operate. I am making sure that the call service is made aware each time a problem occurs and I think we are slowly working out the kinks.

As the financial year has ended and reports have been processed I thought you may be interested in just how many patients are seen at the clinic in a year. From 1 July 2006 - 30 June 2007 a total of 1167 patients attended the clinic. The busiest month over this period was April 2007 with 153 consultations - probably due to the number of Public Holidays in April. The next busiest month was August 2006 with 126 attendances, a very busy month considering there are no extra sessions for Public Holidays in that month.

The new afternoon session times (3-5pm) appear to be very successful. The afternoons do not seem to be as quiet as they were and a more even distribution of patients for morning and afternoon sessions is occurring.

Dr Ian McKenzie recently returned from his regular UK trip. He visited a GP practice in the UK and discussed their After Hours arrangements with the GP. The UK has recently done away with compulsory GP after hours arrangements, which you probably think sounds fantastic. The UK GP's comments on the new arrangements are interesting and are summarised as follows:

- The system is not working well
- An enormous increase in the daytime workload has occurred as there are no night or weekend surgeries.
- The public now struggles to obtain an appointment with their GP
- Emergency departments have been impacted due to increased workload

Ian and his UK counterpart, (who has also worked in Australia) both agreed that our system here was superior, and offered a far better delivery of patient care and work balance for the GP.

Julie Huntington

Immunisation Update

Vaccine Order Forms- All practices should have the new vaccine order forms which include Gardasil, Rotarix as well as all the other vaccines on the NIP. NSW Health has included the cold chain declaration on this order form as they are aware that some vaccines are not being stored correctly. Vaccines need to be stored between +2° C and +8° C to remain effective. Your vaccine fridge should have a min/max thermometer and the temperature recorded twice daily at a similar time. Any discrepancies outside of the above range need to be reported to SSWPHU on ph: 02 9515 9420 as vaccines may need to be destroyed and patients recalled for re-vaccination. The budget for the 2007 National Immunisation Program is \$443 million compared to \$13 million in 1995 which means GPs are storing a valuable and expensive resource!

HPV Vaccine- The school-based HPV program continues for Yrs 10, 11 & 12 until the end of 2007 school year. Should a student come to your practice requesting Gardasil vaccine having missed out at school, there are a few things that need to be checked:

- Check that they are in either Yr 10, 11 or 12 as Yr 7, 8, 9 & 10 will be vaccinated in 2008 at school.
- Check how many doses of HPV vaccine they have already received, if any.
- If they have received 1 or 2 doses at school you will need to check with the PHU 02 9515 9420 to confirm what dates the HPV vaccine was administered and to check whether PHU is organising a catch up clinic in the Highlands.
- If the student has missed the entire course they can commence and finish course at your practice. Once the student receives HPV vaccine at a practice they cannot return to the school-based HPV program.
- Remember **consent** must be obtained for administration of HPV vaccine as well as permission for the practice to forward personal details to the HPV register when it becomes available.
- Also remember that if a female patient commences HPV vaccine whilst they are 26yrs but will turn 27 prior to completion

The Highland Doctor

of the 3 doses they can still receive the funded vaccine.

- Funding for the 18-26yr age cohort ceases in June 2009 so it is important to promote and ensure the course is completed whenever a woman under 27yrs attends for an appointment.

Pandemic Flu

Does your practice have a plan? How will your practice cope? Has your practice had a dry run of the plan as there maybe a need to update certain areas? Should you need assistance, the attached website has numerous aids.

www.health.vic.gov.au/pandemicinfluenza

ACIR Field Officers

Julia and Katie, our NSW ACIR field officers, are more than willing to visit your practice to assist administration staff with lodging immunisation encounters via the secure web site. Contact me at the Division if you would like an ACIR visit.

NSW Health NSW Immunisation Schedule-

New schedules have been forwarded to all practices it is lime green in colour and replaces the previous blue schedule. NSW Health has decided to change the colour each time there is a schedule change. Should you need extra schedules please contact the division.

Immunisation rates for the Southern Highlands NSW

(Number of children in the Southern Highlands division by age range and assessment status)

Age Range (mnths)	Child-ren (No)	Child-ren (%)	Childr en Fully Immu nised	% Fully Immun ised
0-4	152	3.7	148	97.4
4-12	373	9.1	315	84.5
12-18	260	6.4	205	78.8
18-48	1426	35.0	1305	91.5
48-84	1866	45.8	1611	86.3
Overall	4077	100.0	3584	87.9

Overseas Immunisation Schedules can be obtained at this web site http://www.who.int/immunization_monitoring/en/globalsummary/ScheduleResult.cfm this site will assist in interpreting the child's record and then will be able to identify what vaccine this child is now due to bring him/her up to date to Australian National standards. Don't forget to refer to the Australian Immunisation Handbook 8th Edition pg 45 as a guide for planning catch-up schedules.

Cheryl Jones

PNs and the S8 drug cupboard key

Following effective lobbying from the Alliance of NSW Divisions, a change in legislation has occurred that now permits Registered Nurses working in a practice to have access to the S8 drug cupboard, with some provisions.

Those practices in which a practice nurse (registered nurse) is employed, one or more of the medical practitioners in the practice may elect for the practice nurse to have access to the S8 drug cupboard and to undertake some of the responsibilities that go with that, such as ensuring secure storage and accountability.

John Lumby, the Chief Pharmacist, Director, Pharmaceutical Services Branch, issued an approval on the 22nd June 2007, under clause 101(1)(e) of the Poisons and Therapeutic Goods Regulation 2002 which formally authorises registered nurses to be in possession of drugs of addiction subject to the conditions set out in the approval document.

John Lumby can be contacted on Telephone (02) 9579 3214 Facsimile (02) 9659 5165 if you have any further questions.

**Our Division's AGM
will be held at 7.00pm
on Thursday November 22, 2007.
at Fentons
(above the Grand Brasserie in Bowral)
Papers will be sent out shortly**

Save the date!

The Highland Doctor

DVA Red Tape Dumped

In a win for commonsense, GPs will no longer have to enter into formal contracts just to treat veterans.

Rather than complete complex contracts, health care providers will now only need to have a Medicare provider number to participate in the Department of Veterans Affairs LMO scheme.

According to the AMA, the previous requirements were unnecessary because the Department has been simply verifying information that Medicare Australia already has on file, and a statement from the Minister for Veterans' Affairs appears to confirm the futility of the scheme.

"Issuing contracts to new providers and renewing contracts for existing providers is a huge task for my Department and poses a significant burden on busy health care providers", says Bruce Billson on the DVA website.

Community Participation Transport

The Southern Highlands Community Participation Unit based at Bowral Hospital has spent the last twelve months looking at options to provide transport solutions for those community members requiring out-of-area health related transport.

In collaboration with Dr Stephen Della-Fiorentina, Director of the Macarthur Cancer Therapy Centre and the NSW Cancer Council, a bus has been purchased to transport patients and their carers to Camden Hospital's Palliative Care Unit and the Radiotherapy and Supportive Therapies Unit at Campbelltown Hospital.

This service will be run by the Cancer Council and will be provided to patients at a minimal cost.

The Macarthur Cancer Therapy Centre will block book appointments so that the bus will only need to be at Campbelltown Hospital for a maximum of 1½ hours before returning to the Southern Highlands.

Initially the bus will not be wheelchair capable however it will be made wheelchair accessible if the need exists. In the meantime the Cancer Council will pay to transport those people requiring wheelchair access.

The Participation Unit has also applied for a grant to purchase a Patient Transport Vehicle (PTV) to be based at Bowral Hospital. This will be able to transport patients requiring a stretcher or wheelchair. The PTV will be used to repatriate patients to nursing homes or private accommodation and may also be used for inter-hospital transfers.

The latest project and hopefully the final link is a project looking at the viability of creating a shuttle service from the Southern Highlands to Macarthur Health Facilities. The main focus of the Shuttle Bus would be health related and would aim at helping patients needing to access the Renal Dialysis Unit at Campbelltown Hospital, MRI scans and other specialist appointments. The service is currently being costed by Berrima Coaches again would aim to provide a service to as many people as possible.

If support existed, unused capacity would be available to transport disadvantaged community members wishing to access Wollondilly Shire. There would be a charge associated with this service but the Ministry of Transport would assist in negotiating the most affordable fare possible. We are also looking at developing partnerships with NGOs to apply for funding grants to help support this service.

Jane Hutton-Potts

Community Participation Co-ordinator

Psychiatric Registrars for Wingecarribee

Dr Angelo Virgona, the Clinical Director of the SW Cluster of the SSWAHS Mental Health Service, has been able to allocate a part-time Psychiatric Registrar to the Bowral Mental Health Service. The College of Psychiatry is requiring all registrars to complete a rural placement as part of their accreditation. The current Registrar is a 3rd year Registrar, Dr Nighat Nasim. Dr Nasim has already commenced her placement at the Bowral Community Health Centre. She is here on Tuesdays and Thursdays. On Tuesday mornings she works with the Bowral Drug Health Service

The Highland Doctor

attending to their clinic morning at the CHC. Tuesday afternoon she works with the Adult Mental Health team and has supervision with Dr Roger Wenden. On Thursdays, Dr Nasim will see patients in the hospital for which a referral has been made to the Adult Team by the patient's admitting doctor. The balance of her time is spent doing assessments and reviews at the CHC or on home visits. Dr Nasim will be working at Bowral for a six month period because of the part time nature of her appointment here. Depending upon their availability, we hope to be able to continue having such registrars working in the local Mental Health and Drug Health Services.

A second Psychiatric Registrar in adolescent psychiatry, Dr Damien Fong, will be undertaking a placement at the adolescent mental health unit at the Bowral Hospital, Centre of Youth (CoY). Damien will be working with the team and with Dr Kathleen Bokey during his three month placement, and his expected commencement date is the 22nd October. At this time the service is hoping that there will be a continuation of this arrangement at the end of the three months but this will be dependent upon there being other registrars in training for adolescent psychiatry.

Referrals for patients to be seen by the Registrars can be made through the usual intake system of the Community Health Centre.

Finally, the Executive of the SW Cluster of the SSWAHS Mental Health met at Robertson for a one-day planning session. The local services were invited to present the structure, achievements and challenges facing the services in the Wingecarribee. The project work that has been a feature of our involvement in the community (Suicide Prevention, Men's Health; Men's Shed; Mentoring to Manhood; the Boarding House project; Shared Care with the Division of GPs and the Aboriginal Health initiatives) have all been presented to the Executive. Their feedback was very positive and recognised the unique way in which our services have evolved in order to maximise our effectiveness and efficiency.

Kevin O'Neill

Director, Wingecarribee Mental Health Service

Wingecarribee Chronic Respiratory Care Program

Community Health is now pleased to announce that the assessment, home visits and Transitional Care Program components of the above program are available through the new Respiratory Specialist Liaison Nurse, Sue Donohue. Some components of this program have been available since 2002.

The new program includes:

- Physical and psychosocial assessment at home, Community Health Centre or GP rooms;
- Monitoring of exacerbation - intravenous medication, spirometry, peak flow, oxygen saturation, assessment and observation, home oxygen;
- GP support – spirometry, establishing home oxygen, practice nurse education;
- Education;
- Care Plan development;
- Referral to community supports and access to equipment; or
- Referral to Palliative Care for end stage.

Sue has considerable nursing experience and a very good knowledge of general practice and chronic disease management. Sue is available on Tuesdays and Fridays and can be contacted on 4861 8000. Referrals to Sue are through the normal Community Health Intake Procedure.

Other components of the program are Pulmonary Rehabilitation and Smoking Cessation Assistance Programs. The Pulmonary Rehabilitation Program is an eight week program, with two sessions per week which requires GP referral. Smoking Cessation Programs have been run on a needs basis however planning is in progress to hold regular sessions. Please contact Sue Donohue on 4861 8000 to access these components of the program.

Skin Spot Seminar
Skin Cancer Upskilling for GPs
Conducted by
Dr Frances Tefany, Dermatologist
Thursday October 25, 7.00 for 7.30pm
Bowral Golf Club
Look out for invitations in coming weeks

NOTICES

Northern Territory

Aboriginal Child Health Checks

Wanted - doctors who are looking for a rewarding and exciting three week placement in a remote NT Aboriginal Community working with great people in spectacular country. Please contact the Northern Territory Emergency Coordination Centre on (02) 6289 5800 or email oatsih.ops@health.gov.au

The Aboriginal child health check is a voluntary comprehensive health check for children 0-15years. You will be working with a team comprising of a doctor and registered nurses. More information can be found at the Department of Health and Ageing's website - Health.gov.au

How to live to 100 Years Young

Professor Robyn Richmond from UNSW is conducting a study to explore what it is like to live to 100 years and beyond as well as the factors that contribute to longevity. We are interviewing centenarians (people who are 100 years old or more) about their lives and living habits. The results will be analysed to determine the various predictors that contribute to extreme longevity.

If you have contact with centenarians who would be willing to participate in this research we would appreciate your contacting us with the details on 9385 1746 or at f.hyslop@unsw.edu.au

If you have any questions, please feel free to ask us. If you have any additional questions later, please contact Professor Robyn Richmond on 9385 2512 and she will be happy to answer them.

Bowral Hospital Maternity Services Day

Saturday October 27

Lunch at 1.00

Presentations 1.30-5.00pm

Topics include Diabetes & Pregnancy, Obesity in Pregnancy, Foetal Growth
 Speakers include Drs Ajay Vatsayan, Simon Grant, Adelyn Leong, David MacFarlane, Richard Hart, Nils Hanson and Jill Snow
 Please RSVP to Julie Marks on 4861 0332

Breast Imaging Education Day

Bowral Medical Imaging is holding a Breast Imaging education day on Saturday October 13 at Craigieburn, 9.00am-4.30pm

The meeting is primarily an in-house meeting directed towards the radiographic staff but there are topics, particularly in the morning session, that will be of interest to GPs. In particular, Dr Joon Kim will be discussing sentinel node biopsy and Dr Warwick Lee will be discussing the guidelines of the NBCC regarding investigation of a new breast symptom: the Triple Test which was revised in 2006.

Those interested in attending for part or the whole the day, please RSVP to Ms Sarah Burton at Sarah.Burton@wlpradiology.com.au or phone: 0427 332 235. CPD points apply.

Sports Medicine Directory

Sports Medicine Australia (SMA) has recently produced the 2007-2008 SMA NSW Member Directory. This Member Directory lists all SMA NSW Full Professional members, including their profession and contact details. The aim of the Member Directory is to encourage inter-discipline referrals for the correct diagnosis and management of sporting injuries.

This is a free resource for health professionals

If you are interested in receiving a copy, please contact Prue Hardcastle in the SMA NSW office on phone (02) 8116 9815 or phardcastle@smansw.com.au

Report Adverse Events

Help SSWAHS help themselves and provide better care to your patients!

To provide SSWAHS with feedback from any adverse events affecting your patients deriving from SSWAHS care, send a report.

Incident report forms (pdf or medical director template) can be downloaded from the following website:

www.csdgp.com.au/downloads.htm#SSWAHS

Send your incident reports to:
Clinical Governance Unit, SSWAHS
Locked Bag 7017, Liverpool BC, NSW, 1781.
or fax to 9828 5914

'Transport for Health' Isolated Patients Transport Assistance Scheme

Access to this scheme has been widened – anyone within a radius of 100km is now eligible for re-imbusement of travel and accommodation expenses (after the first \$40). This is relevant to us for specialist consultations in Sydney and Westmead. Conditions apply. For information contact 1800 800 511

Southern Highlands Division of General Practice Inc

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