

Southern Highlands Division of General Practice

2009-10, Version 1

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- PHC RIS Assist on **1800 025 882** or phcris.assist@flinders.edu.au, or
- refer to the on-line support material on the PHC RIS website, www.phcris.org.au/divisions/reporting

Concerns and comments regarding the content of this document can be directed to your local State/Territory Office (STO), or provided in the [feedback section](#) at the end of this document.

Division Contact Information

Division name: Southern Highlands Division of General Practice
Division legal name (if different): Southern Highlands Division of General Practice Inc
Division legal status: Incorporated Association
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Organisational Chart

To view organisation chart, please click CTRL + [here](#)

Board Membership

Position on the Board	Expertise	Relevant Qualifications (required)	Relevant Experience (optional)	Name (optional)	Length of Service on the Board
Director	General Practice	MB BS, FRACGP, LRCD, MRCS	34 yrs GP	Clive Cawthorne	4 years 3 months
Director & Treasurer	General Practice	MB BS	Dip Obstet Dublin 26 yrs GP	Richard Hanbury	4 years 3 months
Director & Vice Chair	General Practice, VMO Bowral Hospital, VMO obstetrician	MB BS DRANZCOG FRACGP	25 years	Penny Knowlden	3 months
Director & Education Officer	General Practice	MB BS, DCH, FRACGP	28 yrs GP	Ann Parker	14 years 3 months
Director & Chair	General Practice	MB BS, DPH, DRCOG, DRANZCOG, FRACGP, FACRRM	VMO in general medicine & Obstets Bowral Hosp, methadone prescriber 22 yrs in GP	Vincent Roche	12 years 3 months
Community Advisor	Former mayor	N/A		Phillip Yeo	3 years 3 months

Characteristics

1. Division demographics

Population of Division	Number	Percentage	Data source
Total population	50945	N/A	ABS June 07
Aged 65 and over	8870	17.41	ABS June 07
Under 25 years of age	16386	32.16	ABS June 07
Indigenous population	580	1.14	ABS June 06
Australian born	38234	75.05	ABS June 06
Unemployed	965	1.89	ABS June 07

2. General Practice information

Practice type	Number	Percentage	Data source
Total number of practices	19	N/A	Division records
Solo practices	4	21.05	Records
Practices with 2-5 GPs	11	57.89	Records
Practices with 6 or more GPs	4	21.05	records
Corporately owned	0	0	records
Practices with a Practice Nurse	7	36.84	records

3. Health workforce

Profession	Number	Data source
Total number of GPs	69	Division records
International medical graduates (IMGs)	11	records
Number of female GPs	23	records
Number of GPs aged >55 years	NA	records
Registrars	8	records
Aboriginal Medical Services	0	records
Other primary medical care practitioners (e.g. Royal Flying Doctor Service)	0	records
Total number of practice nurses	24	records

4. Division membership

Type	Number
GPs (excluding IMG's & Registrars)	50
IMGs	3
Registrars	8
Allied Health Professionals	0
Practices nurses	0
Practice staff (other than practice nurses)	0
Medical specialists	0

Other (please specify)	
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5. Further Information

Strategic Direction

Mission statement

The Mission of the Southern Highlands Division of General Practice is to work with and assist local General Practitioners and other health professionals to provide optimum standards of primary health care, health education and health promotion to health consumers in the Wingecarribee Shire.

Vision statement

To identify opportunities to better serve our community and our health service providers.
To identify opportunities to play a wider role in our community consistent with our mission statement and goals.
To remain a relevant and sustainable healthcare organisation in the face of a changing health environment.
To preserve and foster the culture of rural general practice in the region.

Long-term goals

1. To become a health service umbrella organisation providing:
 - existing services to GPs and their patients
 - association type services to other local health service providers
 - other primary care services under contract arrangements
2. To promote the development locally of Primary Care Centres in modern purpose-planned premises comprising GPs, practice nurses, relevant allied health services, relevant community health services etc.
3. To maximise GP recruitment to the area.
4. To seek funds from a wider range of appropriate sources in order to provide a wider range of primary care services.
5. To expand service provision to members including IT support, practice strategic planning, etc

Strategies to pursue long-term goals

1. Take advantage of government and other initiatives to allow the Division to become a wider health service umbrella organisation which is consistent with our mission statement and the culture of the Division and its members.
2. Take advantage of opportunities created by government and commercial interests to facilitate members' efforts in providing modern, efficiently operating, state of the art facilities.
3. Maximise the support for medical student and registrar involvement in the practices in order to enhance further GP recruitment to the area.
4. Provide contract services to government and other bodies.
5. Reach an agreement with Macarthur Division to share services such as IT and practice planning, etc.

File Attachment (Optional)

To view file, please click CTRL + [here](#)

PROGRAMS

1. DIVISIONS OF GENERAL PRACTICE PROGRAM
2. GENERAL PRACTICE IMMUNISATION INCENTIVES SCHEME
3. ABHI - PCIP (ALL DIVISIONS AND THE TAS, ACT, NT, SA SBOS)
4. MORE ALLIED HEALTH SERVICES
5. WORKFORCE SUPPORT FOR RURAL GENERAL PRACTITIONERS

Program 1: Divisions of General Practice Program

DGPP Access 1

The number and proportion of PIP practices within the Division claiming practice nurse services.

Planned activities/approaches:

There are currently 9 Practices of 19 in the Division area with Practice nurses.

The Division's part time project Officer for practice nursing will continue to press the remaining practices to employ nurses by continuing to stress to the relevant the patient care, GP support and practice finance advantages of employing practice nurses. We also offer mentoring and support for PN upskilling.

DGPP Access 2

The number of health checks and health assessments provided to patients of Aboriginal and Torres Strait Islander origin by general practitioners within the Division (compared to the estimated ATSI population in the area who could benefit from the health check).

Planned activities/approaches:

This Division area has a small number of persons claiming ATSI status in the 2006 Census (1.3%). Nevertheless, the Division mainly through our Practice Managers meetings, raises the issue of this medicare benefit to the Practices. Also we are currently commencing the 'Health Atlas' Program which will draw this benefit to practice attention.

The AHS Muramali Program also addresses this issue and has led to ATSI Health checks in our area

DGPP Prevention 1

The number of 45-49 year old health checks provided to at-risk patients by GPs within the Division (compared to the total population aged 45-49 years in the Division).

Planned activities/approaches:

Practices advise that whilst they are well aware of this item, they have generally had a poor response to attention drawing mail-outs and practice notices to this cohort of people. The item will come up in the Practice Atlas Program and by opportunistic attention drawing but from practice feedback we are pessimistic re a large take-up of this item.

DGPP Prevention 2

The average childhood immunisation coverage rates for the 60 to < 63 months age group within the Division.

Planned activities/approaches:

The Childhood Immunisation Rate for the Division continues to hover in the 88 - 90% area. This is due to 2 of our 19 practices having significant numbers of conscientious objectors. The Division Immunisation Support Officer continues to work with these Practices in particular to try and improve their practice rates. It is hoped that the presence of a new practice manager in the main practice of the two will improve the practice performance.

Other actions being undertaken are:

- * Practices sending out GP NSW pamphlets re immunisation
- * asking practices to conduct in-house self audits of the incompletely immunised children in the practice. Use of the Practice Atlas and the PEN tool will assist this process
- * Supplying practices with posters

DGPP Prevention 3

The number and proportion of electronic transfers of childhood immunisation data received by the Australian Childhood Immunisation Register (ACIR).

Planned activities/approaches:

Program 1: Divisions of General Practice Program

Only three of 19 practices in the Area do not use electronic transfers of childhood immunisation data. One practice is a 'speciality practice' which does not conduct immunisation and two others are still not using electronic transfers due to claimed problems. Our Immunisation Support Officer is seeking to correct the problems.

DGPP Prevention 4

The number and proportion of female patients aged 20-69 whose patient record shows that they have had a Pap smear during the previous two year period.

Planned activities/approaches:

We will continue to advise the practices of the latest data on Cervical Smears as it is received. This has had a positive effect in the past in stimulating the uptake of this service.

We also encourage Practice nurses in this regard, which has a positive effect.

DGPP Chronic Disease Management 1

The number and proportion of general practices within the Division using electronic register/recall/reminder systems to identify patients with a chronic disease for review and appropriate action.

Planned activities/approaches:

16 practices in the Division are supplied with recalls for diabetes from the Division based recall system for diabetes recalls.

9 (47%) of Practices have recall systems otherwise

The Division will continue to supply the practices with their diabetes recall needs and continue to encourage them via the practice managers meetings to install other reminder recalls.

DGPP Chronic Disease Management 2

The number and proportion of patients within the Division with diabetes whose last recorded HbA1c within the previous 12 months was:- less than or equal to 7.0%;- greater than 7.0% but less than or equal to 8.0%;- greater than 8.0% but less than 10.0%;- greater than or equal to 10%; or- not recorded.

Planned activities/approaches:

These data have until now been collected from the data submitted by the Practices into our CARDIAB database. We are currently installing the Canning Data Extraction Tool into practices. This will allow these data to be directly drawn from practice software in time for the forthcoming Annual Report. This will be expanded in the coming year.

DGPP Chronic Disease Management 3

The number and proportion of patients within the Division with coronary heart disease whose last recorded blood pressure (BP) within the previous 12 months was less than or equal to 130/80 mmHg.

Planned activities/approaches:

The response to this Indicator is the same as for DGPP Chronic Disease management 2

DGPP Uptake of National Initiatives 1

The number and proportion of general practitioners within the Division who prepared and reviewed GP Mental Health Care Plans, and the number and proportion of general practitioners who provided focussed psychological strategies.

Planned activities/approaches:

We confidently believe that the use of GP Mental Health Care Plans (now Mental Health treatment Plans) is strongly supported in the area as evidenced by the high rate of referrals to our ATAPS program. The Division encourages the use of this Program and we are interested in seeing these data when available.

However we believe that the data when available will continue to show a poor use of Focussed Psychological Strategies for the continuing reasons;

Program 1: Divisions of General Practice Program

- The abundance of psychologists in our area
- The requirement for accreditation
- There is no real advantage over Item 2713

DGPP Uptake of National Initiatives 2

The number and proportion of PIP practices within the Division.

Planned activities/approaches:

While PIP Practice numbers are not advised to us by Medicare since they are labelled 'nfp', we believe that 17 of our 19 practices are PIP practices. The remaining two practices have declared 'no interest' in accreditation or PIP since the doctors all live out of the area and run daytime only practices.

DGPP Local 1

To study the effect of the Live Life Well Diabetes Prevention Program

Indicator File Attachment

To view file, please click CTRL + [here](#)

Planned activities/approaches:

To operate the attached LPI to provide data of national interest in relation to diabetes prevention

Program 2: General Practice Immunisation Incentives Scheme

GPII 1 (12 Month)

Develop and implement strategies and/or education tools for increasing immunisation coverage e.g. resource kits and newsletters.

Planned activities/approaches:

The Division's Immunisation Officer supplies practices with:

- copies of an immunisation promotional pamphlet produced by GP NSW mail for mailing out to relevant patients.
- posters for display on practice notice boards
- Information newsletters and other material supplied by the Health Service's Public Health Unit.

GPII 2 (12 Month)

Promote quality of service by disseminating up-to-date information on immunisation guidelines and procedures, such as cold chain management.

Planned activities/approaches:

The Division's Immunisation Officer religiously provides practices with all guideline information etc as it is received. She is most familiar with this type of material since she came to the Division from the health service PHU.

The Officer regularly inspects vaccine storage standard compliance and gives advice when there is a break down in cold chain procedures.

GPII 3 (12 Month)

Develop and implement strategies for improving timeliness and quality of data forwarded to the ACIR.

Planned activities/approaches:

The Division's Immunisation Officer assists practices in immunisation record keeping, data cleansing and electronic transmission to the Register. This on-going work for the Officer.

GPII 4 (12 Month)

Develop and implement strategies to target groups of children who have been traditionally difficult to immunise.

Planned activities/approaches:

Our officer works with the Practices to seek to assist in identifying 'difficult cases' and where the problem is beyond the practice, with the Shire Council and the PHU to locate outlyer children and encourage the authorities to even make home visits if necessary.

GPII 5 (12 Month)

Promote data cleaning activities; e.g. by reconciling ACIR reports with the practice patient immunisation data.

Planned activities/approaches:

Data cleansing and data management is a routine part of our Officer's duties.

GPII 6 (12 Month)

Develop and implement strategies to improve the reported childhood immunisation coverage within the Participant's boundaries of operation.

Planned activities/approaches:

The immunisation Officer, given her PHU history 'leaves no stone unturned' to seek to maximise the Area immunisation coverage. These strategies have been explained in the foregoing Indicators

Program 2: General Practice Immunisation Incentives Scheme

GPII 7 (12 Month)

Promote best practice in immunisation.

Planned activities/approaches:

Our Officer promotes best practice in cold chain activity, practice workers skills, vaccine storage, when non -use and replacement of vaccines that have gone outside the accepted range of storage requirements is warranted etc.

Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)

ABHI-PCIP 1 Work Plan

An attachment of the ABHI PCIP Work Plan

Indicator File Attachment

To view file, please click CTRL + [here](#)

Planned activities/approaches:

Please see attachment for Planned Activities/Approaches

ABHI-PCIP 2

The number and proportion of general practices using integrated shared care pathways or business rules to support chronic disease prevention and management.

Planned activities/approaches:

This ABHI Project is a 'macro' project covering formally five Division areas and now three areas due to amalgamation. The area has over 1200 GPs in over 600 practices. The project aims to achieve macro culture changes in chronic disease management in association with the Health Service. Whilst this will inevitably lead to improved uptake of Medicare chronic disease items, it will be gradual in line with the necessary culture change.

The SSWIP Project itself cannot collect data in relation to the above question and will attempt to do so via the Divisions at reporting time. However this particular item may not be answerable.

ABHI-PCIP 3

Divisional involvement in the work being progressed locally through state government funded programs eg the HealthOne NSW initiative, to support chronic disease prevention and management.

Planned activities/approaches:

This ABHI Project is entitled Sydney South West Integration Program (SSWIP). The Program has incorporated the pre-existing HealthOne NSW Project at Elderslie, near Camden and has a close working relationship with the HealthOne NSW Project at Canterbury. There are no other State funds involved in the SSWIP Project.

ABHI-PCIP 4

The extent to which general practices use a communications application, or an electronic system between primary care providers and hospitals where relevant, that supports the timely and appropriate exchange of patient information (eg clinical software tools, secure messaging).

Planned activities/approaches:

There are presently no large scale functioning electronic communication systems operating between GPs and the Sydney South West Area Health Service facilities. SSWIP is closely involved in a project by the UNSW in this matter and is also directly involved in an emerging program for the electronic transmission of hospital discharge reports from SSWAHS hospitals. This is currently being piloted in Central Sydney.

ABHI-PCIP 5 (12 Month)

The number and proportion of general practitioners claiming MBS GP Management Plans, Team Care Arrangements and Multidisciplinary Care Arrangement.

Planned activities/approaches:

SSWIP, as a macro cross divisional project spanning the whole Area Health Service area of South west sydney is not able to collect this data but will attempt to do so from the Divisions at reporting time. See the comments on relevance of this matter in ABHI PCIP,

ABHI-PCIP 6 (12 Month)

The number and proportion of general practitioners claiming case conferencing items.

Planned activities/approaches:

SEE ABHI -PCIP 5

Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)

ABHI-PCIP 7 (12 Month)

The number and proportion of general practitioners claiming Medication Management Review items.

Planned activities/approaches:

See ABHI-PCIP 5

ABHI-PCIP 8 (12 Month)

The objective of the Integration Program is to encourage more integrated patient centred care by supporting general practice to:

- Engage with the work of local Primary Care Partnership Councils, and other state funded primary care initiatives that seek to improve service co-ordination and integrated chronic disease prevention and management;
- Communicate and link better with other primary care providers;
- Make better use of existing primary and community care services including commonwealth, state and non-government organisation funded services with a focus on patients with chronic disease;
- Utilise tools/strategies that will assist in better managing patients with chronic disease (e.g. disease registers, referral, recall & reminder systems, care planning); and
- Contribute to work around developing local chronic disease care pathways (generic or specific) or other priority activities with a chronic disease management focus.

Planned activities/approaches:

The SSWIP Project completely agrees with these principles. It is pursuing these objectives through:

- working closely with the large Sydney South West Area Health Service through a project Steering Committee which includes senior managers from SSWAHS as well as Division personnel. There is a unity of good will and purpose between the partners. The strategy is to achieve culture change between the two major partners - the Health service and GPs via their Divisions. The selected pathways are diabetes care integration, integrated secondary prevention in CV care, chronic disease self management.
- Building on the work of the HealthOne NSW Project at Elderslie. This is a co-location model and trial based on co-location of a community nurse in a large GP practice. Results are promising with intention to expand the scope of the work particularly into heart failure, COPD and palliative care. This trial is being closely monitored to see how the model can be expanded at the practice, to other practices and into a networking model for small practices.
- Building communication links
- Studying the relationship between GPs and hospital EDs.

ABHI-PCIP 9 (12 Month)

The Participant has been funded to support and encourage general practice to incorporate integrated primary health care into their core business and to work more collaboratively with other primary care providers in the prevention and management of chronic disease.

Planned activities/approaches:

This objective is core to the SSWIP Program. It is being pursued by:

- seeking the essential culture change on the part of both parties - GPs and the Health Service.
- Leading by demonstration.
- Convincing the Health Service that it needs to make changes in order to achieve better care and reduced demand on its hospitals. Whilst the latter is not easy we are having good success by choosing targets which are undoubtedly needed by both parties. We have selected better diabetes and CV care through integrated action without calling on the Health Service to divert substantial funds away from what they see as their core business.

Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)

ABHI-PCIP 10 (12 Month)

The Participant has been funded to adopt a range of strategies that include (but not exclusively):

- Working collaboratively with the ABHI Primary Care Incentive Program State-wide Coordinator, ensuring that where relevant, activities are implemented consistently across the State (or Territory);
- Promoting to general practice the importance and benefits of integrated primary care service delivery in the prevention and management of chronic disease;
- Building a knowledge-base on the factors that act as barriers against, or act to increase, the engagement of general practice in integrated primary care service delivery to prevent and manage chronic disease;
- Promoting and identifying examples of best practice and facilitate transfer across general practices;
- Providing resources, and where relevant, training (or organising training) to general practice staff in the use of information tools and services, in the context of integrated primary care services delivery; and
- Sharing with the Divisions of General Practice Network best practice knowledge and resources around integrated primary care service delivery models relevant to the prevention and management of chronic disease. In this respect, any materials produced in the course of this Project (e.g. communication strategy, business rules etc) by the Participant are to be shared with the Divisions Network via the AGPN clearinghouse.

Planned activities/approaches:

Pleased to report that the SSWIP Program strongly accors with the Indicator - e.g.

- The GP NSW ABHI co-ordinator has observer status on the SSWIP Steering Committee
- Issuing Newsletters to the approximately 1200 GPs in the SSWIP area. This describes the work of SSWIP.
- Conducting scoping exercises relevant to the project and its issues.
- Identifying the key players in the field inside and outside the Divisions and the Health Service.
- Identifying needs and achievable targets
- Organising training in widescale diabetes eduaction - about to start. This will act as acatalyst for other conditions.
- ALL SSWIP activity is conducted in close relationship with the Divisions.
- A quality report will be issued at the conclusion of the Program

Program 4: More Allied Health Services

MAHS 1

The number of allied health services provided and the number of allied health service providers by provider type.

Planned activities/approaches:

The Division continues to ensure that MAHS funds are used in accordance with assessed allied health service needs. This monitoring continues to show that the main needs are diabetes education, secondary prevention in ischaemic heart disease and exercise services for persons with chronic illness or in danger of developing chronic illness, particularly diabetes. All three of these services are otherwise unavailable in our area and hence our MAHS funding is used to secure those services. This accords with surveys of GP needs assessment and therefore we plan to continue this strategy.

MAHS 2

Who did the Division collaborate with to address shared planning and priority setting with other local organisations and what was the outcome?

Planned activities/approaches:

In assessing the priorities for MAHS expenditure, the Division continues to collaborate with the Health Service, the GPs and the Consumer Participation Group. In addition, the Division monitors the 'supply' of local allied health services.

MAHS 3

The number of GPs within the Division referring their patients to MAHS services.

Planned activities/approaches:

64 of 69 GPs in the Division refer patients to MAHS funded services. However the referral rates of the individual GPs varies.

Additional Information

MAHS funded diabetes and cardio-vascular services are provided free to the patients. The Exercise physiology services funded under the MAHS Program are restricted to Health Care Card holders, who pay a contribution of \$50.00 to the cost of the course of treatment. The full cost of the Program is \$600.00 over 3 months.

The Division employs the Diabetes Educator and the part time specialist CV Nurse who provides the CV service.

The Diabetes education service covers newly diagnosed Type 1 and 2 diabetes, and pre-diabetes and working with the GPs to avoid complications developing. The services are supplied from Division rented premises in Bowral plus in GP premises at the remote villages of Bargo and Bundanoon.

The CV service is for avoidance of successive Ischaemic Heart Disease episodes and is delivered in GP practices

These services fit the model of Integrated Primary Care.

The Services are not provided in association with other Divisions

Program 5: Workforce Support for Rural General Practitioners

WSRGP 1

The number of GPs supported under the WSRGP Program.

Planned activities/approaches:

It has not been found necessary to support any particular GP. Our workforce activities are directed at making the area and the practices as attractive as possible in order to attract new GPs.

We also have a deliberate policy of having attracted Registrars to seek to have them stay in the area by making their stay as pleasant as possible.

We also have a policy of working with students and their University (the University of Wollongong) similarly.

WSRGP 2 and WSRGP 3

The number of GPs attracted and/or retained through activities provided under the WSRGP Program.

Planned activities/approaches:

We have attracted 4 new GPs and 3 registrars to the area in the past year

WSRGP 4

The number of registrars encouraged to rural areas through early immersion into rural medical practice under the WSRGP Program.

Planned activities/approaches:

We have attracted 3 new registrars to the area this year but regretably lost 3. We have a problem in that we are the rural area meeting rural term requirements closest to Sydney and we therefore suffer a turn-over of registrars despite the best efforts of the Division and the practices. We have a positive policy of encouraging our practices to take registrars and to welcome them into our medical community.

WSRGP 5

The number of medical students who received mentoring under the WSRGP Program.

Planned activities/approaches:

The Division has recently welcomed its first batch of 6 students from the University of Wollongong under that university's Rurally oriented post graduate program. The Division has welcomed these placements which are for a full academic year. The Division is a strong supporter of the UOf W Program.

Feedback

Comments and Feedback

Please provide any information you think is relevant. Provide your comments by entering information into the table below. The headings on the left are just prompts for the type of information we would expect, but please also provide any other information. This information will be collated once all the plans/reports have been submitted. If you would like to be contacted regarding your comments then please indicate so. If you have any immediate queries or feel that your comments could have an immediate impact on the process or people involved please contact an appropriate person as detailed on the [Support pages](#).

Suggested topics (All optional)	Your Comments and Feedback
About the content of this plan/report	The PHCRIS template continues to improve but there are still annoying procedural problems present, particularly for less expert operators. You would presumably be aware of this from the assistance requests you receive.
About any technical issues	No feedback
Any other information	No feedback