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Supervision Roadmap

RURAL GENERALIST TRAINING IN VICTORIA

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EXECUTIVE SUMMARY

BACKGROUND

Rural generalists play a major part in prevention, early intervention, and care coordination across an extended scope of medical care in small rural communities where access may otherwise be limited by physical distances, transport, and costs. Rural generalists are relied upon not only to deliver comprehensive primary care but to also provide the 24-hour emergency supports and other extended services that rural towns need. Individual specialties are not viable in small rural towns. Instead, training rural generalists (RGs) as doctors that can cover a breadth of relevant specialties on top of comprehensive primary care ensures equitable, cost-effective, sustainable care.

The Victorian Rural Generalist Program (VRGP) represents a significant state-wide investment in growing the next generation of rural generalists to serve in each of its five rural regions of Hume, Loddon Mallee, Grampians, Barwon South West, and Gippsland. No form of medical training is possible without high quality clinical supervision, and RG training is no different. Moreover, supervision on the VRGP is more complex where doctors need to learn a suitable range of core generalist skills to deliver services that communities need.

The VRGP pathway starts with supervision in Rural Community Intern Training (RCIT) programs in each of Victoria's five rural regions. However, to retain RGs beyond internship, a body of work needed to be undertaken to inform the expansion of supervised learning in the second year of RG training (RG2) in distributed rural communities where these doctors are intended to eventually work. The quality of supervised learning at this point is critical to achieving retention of RGs and progressing them to the next stage of fellowship training with a GP college: leading into FACRRM or RACGP-FARGP qualification endpoints as practising RGs.

AIMS

This collaborative project aimed to explore and expand on existing evidence about rural supervision to meet the learning needs of the RG2 group across a core generalist curriculum. It specifically focused on three rural regions of Victoria: Hume, Loddon Mallee, and Barwon South West. Further, this project aimed to use this information to develop a Supervision Roadmap to guide the implementation of high-quality supervised learning across core generalist curriculum in the RG2 year of the VRGP.

METHODS

This project was led by General Practice Supervisors Australia (GPSA) in collaboration with the rural regions, stakeholders, clinicians, and health service executives over a 12-week period (June-August 2021). It involved:

1. A literature review of curriculum and supervision requirements for RG2s and available resources to guide contextual understanding of the topic.
2. A VRGP trainee survey (50% response rate) to establish the current and future training needs of RG1s and RG2s on the VRGP.
3. A review of general practice programs at prevocational and vocational stages to inform supervision and educational requirements and funding opportunities relevant to the RG2 group.
4. Interviews with 13 GP supervisors (speaking on behalf of their practices) and 18 small and large health service executives to inform the enablers and barriers to supervising RG2 doctors across core generalist curriculum.
5. Interviews with stakeholders knowledgeable about blended/remote supervision models to inform guiding principles that the VRGP could apply to extend supervised learning in Victorian regions.

FINDINGS

The aggregate findings are summarised in five chapters:

CHAPTER	FINDINGS
CHAPTER 1: Literature Review	• Literature on rural supervision is mainly focused on registrars, with negligible material addressing RG2 supervision in small towns, across a core generalist curriculum. A range of supervision guidelines and various tools and resources are summarised as they may be useful for the VRGP.
CHAPTER 2: Summary of GP Training Programs	• There are multiple programs focusing on training in general practice, including at the prevocational stage, but they are not aligned, have different providers, can have limited focus on supporting supervised learning and have limited funding for supervision. All pay less than practices might gain from hosting a registrar.
CHAPTER 3: Survey of Trainees	• RG1s and RG2s have strong interests in procedural training, with few seeking non-procedural skills at the early stages of their training. This may be related to the curriculum demands within core generalist training and the traditional professional ideation about what constitutes a rural generalist.
CHAPTER 4: Interviews - Enablers and Barriers in the Regions of Interest	• Supervision capacity in the three regions is highly variable. It is more mature in the Hume, but less so in the Loddon Mallee and Barwon South West regions. Further, the supervisor workforce is burnt out and working at capacity with few other clinicians who are fellowed, invested in education, or able to take up supervision of RG2s atop of an increasingly busy clinical workload. • Across all regions, there are limited fellowed doctors to do level 1 supervision for RG2s because of recruitment/retention pressures and doctors retiring. The Loddon Mallee and Barwon South West are somewhat reliant on overseas trained and locum doctors, which adds to the supervision burden of a small number of fellowed doctors. Locums are not invested in fostering local training pathways. • All regions value selective recruitment of learners who are suited to their services as a cornerstone of successful supervised learning, but this takes time that many towns do not have given the pressure to deliver services to the community. Some regions like the Barwon South West have more social amenity attractors such as schooling and social opportunities, but other regions have towns that are not attractive for new doctors. Supervisors become de-motivated when trainees are not attracted to their training opportunities, and they have to teach doctors who are not committed to the region. • Supervision of the RG2 cohort is considered unsustainable in all but a small number of practices in Hume, and selective towns in Loddon Mallee and Barwon South West with historic experience of hosting medical students and RCIT interns. It helps to motivate supervisors in some cases when learners return or stay on to continue training and working in the region. Sustainable supervision models tend to involve the whole practice/service team in supervising junior doctors, which enables them to effectively manage their workload and maintain their billings. Such training practices have a strong learning culture and quality improvement processes around supervision of trainees/learners. • A range of other practices find the postgraduate year 2 (PGY2) group an unappealing cohort to host as they can have variable skills and create business risks, extra workload and increased financial pressure. They can also be hard to fit into the physical space of the practice. Practices want funding to support the supervision of RG2s.

CHAPTER	FINDINGS
CHAPTER 4: Interviews - Enablers and Barriers in the Regions of Interest (continued)	• Hospitals and health services in small towns in all regions are interested in expanding training opportunities and rely on GPs for supervision. However, health services walk a precarious line of keeping their GPs happy so as not to compromise Visiting Medical Officer (VMO) services to the hospital. There is inadequate funding to employ RG2s in small rural hospitals, especially compared with the funding following interns, and a limited palate for health services to employ RG2s over more advanced junior doctors with less onerous supervision requirements. • All regions identify a range of external systems pressures around shrinking VMO rosters, procedural work opportunities, and a centralisation of services. This is worse in locations closer to Melbourne/major regional hubs, commutable or attractive for specialists to visit. However, there are many untapped learning opportunities within generalist scope across clustered services in all the regions. These include specialist-led outreach and telehealth clinics, inpatient general medicine, aged and palliative care, and urgent care in the community and hospital, among other things. Non-procedural fields seem highly sustainable in all the rural regions. • In the Hume region there is strong success from regionalised medical training under a longer-term vision for the community's health services, drawing on strong concepts around RG-led service models (this region has the longest-standing Rural Community Internship Training program since 2012 called 'Murray to Mountains' or 'M2M'). There are many examples in all three regions of champions of RG training and grow your own philosophies. These are starting to expand accredited training opportunities by working across communities and with key stakeholders. However, due to the independence of health services and general practices, and the need to link supervised training opportunities across towns, funded regional coordination/ collaboration support systems are needed to help each region develop a mature training network across the RG development cycle. This likely requires a focus on the types of RGs each rural region needs in order to build an RG workforce that is sustainable and cost-effective.
CHAPTER 5: Interviews - Blended/Remote Supervision	• A range of principles underpin the potential use of blended/remote supervision which can inform innovative solutions as a back-up in situations where local supervision capacity may be limited. Across a generalist scope of work in rural areas, with less experienced doctors, there are more nuanced considerations including the need for an off-site supervisor to know the context of the rural setting the learner is in and to have clear roles and responsibilities. • Using remote or roving supervision options for RG doctors does not overcome the need for prevocational RGs to have on-site medical supervision. • Supervision that is not face-to-face is potentially more applicable in emergency and non-procedural fields rather than procedural areas. • Blended/remote supervision require specific governance, local roles and responsibilities, and systems if they are to work as an adjunct supervision model for RG training.

THE SUPERVISION ROADMAP

The Supervision Roadmap denotes that expanding supervised training for the RG2 group should be facilitated through a strengths-based approach addressing the needs of trainee and supervisor, wider system enablers and barriers, and drawing on best practice principles and evidence. Building supervised learning for the RG2 step of the VRGP required a focus on six main points as outlined below.

1	**Where to build supervision capacity**	This involves understanding the agreed rural region-specific endpoints for the VRGP and scanning for strong supervision opportunities across the relevant scope including at the RG2 step of the pathway. Key indicators can guide the selection of locations and clinical settings where sustainable supervision can be achieved. Cluster models, and opportunities for procedural and non-procedural skills, are considered.
2	**What supervision capacity to build**	The specific focus of the VRGP in each region could better align with training doctors for those RG practice models that are likely to be sustainable in rural regions longer-term. This includes considering the relevance of the range of procedural training that RG2s get, and whether procedural models are feasible to pursue in every region. Victoria may require a PGY2+ curriculum that is more focused on emergency care, general medicine, aged care, palliative care, mental health, and Indigenous Health, where providing RG2s with supervised learning opportunities may be more viable in the longer-term for small rural towns.
3	**Promoting the uptake of supervision**	This involves greater clarity about the VRGP group, their skills, experience, tools and resources that will support practices to engage with supervising RG2 learners and build the skills to manage this group of learners around a busy clinical workload and limited time. It also involves recognition and reward for supervisors as part of a VRGP supervisor community of practice.
4	**Influencing the systems level**	Not everything that needs to be done to enable supervision falls under the remit of the VRGP. It is noted that the VRGP will need to continually engage in widespread collaboration to foster system partnerships and engagement of stakeholders who play a role in unlocking the potential for high quality supervision capacity including at the RG2 level.
5	**Considering roving supervision**	This involves considering how the principles of blended/remote supervision could be applied to a rural region-specific roving supervisor (supernumerary), backing up the local supervision by fellowed doctors and wider clinical teams who have intimate knowledge of the learner's context and day-to-day interactions. This roving supervision concept could be explored for regions with limited critical mass of fellowed supervisors willing to engage, and for learners accessing local multidisciplinary team-based learning models. Specific principles need to apply to the design of these models for the RG2 stage and their scope of work.
6	**Committing to a gradual build**	This involves planning for a gradual process of unlocking supervision opportunities, which will differ by region. The short-, medium-, and longer-term period of increasing supervision capacity may involve using different strategies in different rural regions, but it will require clear planning and operationalisation by regional networks.

CONCLUSION

This research was exploratory in nature but covered a breadth of stakeholders in three very distinct regions and beyond. Overall, this project has unravelled some of the nuances of supervised learning for the RG2 step of the pathway, showing that supervision is affected in both practices and hospitals by multi-level systems issues. Some of these factors are amenable to the VRGP's direct intervention, and others require extensive collaboration. Some of the enablers and barriers will be stronger in some regions over others, and thus regional tailoring of the findings is recommended. Overall, the Supervision Roadmap identifies several ways that the VRGP can move forward to unlock more supervision capacity for building the future RG workforce for Victoria's rural regions. The VRGP and its stakeholders may benefit from committing to a gradual building process to grow supervision across the core generalist curriculum at the RG2 step of the pathway. Unless there is investment upstream in developing high quality supervised learning for RG2s, it may be hard to retain RGs and for the VRGP to realise its goals of growing a fit for purpose RG workforce for Victoria.

"The Supervision Roadmap identifies several ways that the VRGP can move forward to unlock more supervision capacity for building the future RG workforce for Victoria's rural regions."

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