

A blended supervision model in Australian general practice training

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Background

The Royal Australian College of General Practitioners' *Standards for general practice training* allow different models of registrar supervision, provided these models achieve the outcomes of facilitating registrars' learning and ensuring patient safety.

Objectives

In this article, we describe a model of supervision called 'blended supervision', and its initial implementation and evaluation.

Discussion

The blended supervision model integrates offsite supervision with available local supervision resources. It is a pragmatic alternative to traditional supervision. Further evaluation of the cost-effectiveness, safety and effectiveness of this model is required, as is the recruitment and training of remote supervisors.

A framework of questions was developed to outline the training practice's supervision methods and explain how blended supervision is achieving supervision and teaching outcomes. The supervision and teaching framework can be used to understand the supervision methods of all practices, not just practices using blended supervision.

In 2013, The Royal Australian College of General Practitioners' (RACGP's) Council endorsed new outcomes-based standards for general practice training that reflect the latest international practice.¹ The standards focus on measuring, achieving and monitoring outcomes, and less on the process of training. A supervisor need no longer be onsite 100% of the time that the registrar is in the practice. However, the supervision must match the competence of the registrar.

This change coincided with increasing demand for training practices. The number of places in the general practice training program more than doubled between 2009 and 2015 in Australia.² The demand is higher in areas outside the major capital cities, where 56% of general practice training occurs. This is despite these areas only containing 30% of the general practitioner (GP) workforce.^{3,4}

While the new *Standards for general practice training*¹ were developed to reflect the latest international thinking in setting and maintaining standards, it provides an opportunity for regional trainers (previously called Regional Training Providers [RTPs] and now called Regional Training Organisations [RTOs]) to develop new supervision models that increase training capacity.

Existing alternative supervision models

There is a history of developing new general practice supervision models in response to educational and workforce

needs in Australia and internationally.⁵⁻⁷ The Remote Vocational Training Scheme (RVTS) started as a pilot scheme in 1999 to ensure isolated rural communities would not lose a doctor while the doctor completed training.⁸ RVTS registrars contact their offsite supervisor by telephone or videoconference.⁹ This remote supervision model is augmented by clinical teaching visits to the practice by the supervisor or a medical educator.

The RVTS model is available only to doctors who are working in an Aboriginal community controlled health service or already working in an isolated rural area with limited local medical support. The RVTS model is not available to Australian General Practice Training (AGPT) applicants.

Remote supervision models may accelerate professional development by promoting registrar resourcefulness, resilience and reflective practice. These advantages are counterbalanced by the reduced exposure to role-modelling and difficulty in learning procedural skills in the absence of onsite supervision.¹⁰

In 2005, a regional trainer obtained RACGP approval to extend the RVTS model to doctors who were completing their training in remote locations after a year of training under the traditional onsite supervision AGPT model.¹¹ Although reviewed positively, this hybrid model was not formally evaluated or widely implemented.

The team supervision model (Standard 1.2) was introduced in the

RACGP's 2013 *Vocational training standards* and continues in the 2015 *Standards for general practice training*.¹ A registrar is supervised not just by an individual supervisor but by a supervision team within the practice. This includes other doctors, nurses, allied health professionals and administration staff. To some extent this model was a recognition of current supervisory practice rather than a new model. Registrars have always sought support from sources other than their general practice supervisor. For registrars with less ready access to supervision, such as remotely supervised registrars, the cultivation of a network of local and remote supervisors and specialists colleagues is paramount.¹⁰

Blended supervision

In 2014, the regional trainer Beyond Medical Education (BME) developed a new supervision model. This was to enable registrars to be placed in practices that were considered likely to provide good training but were unable to meet all of the traditional supervision requirements. The new model was termed 'blended supervision' as it involved a blend of local and remote supervision. Although the model has utility in isolated rural practices, it was not exclusively designed for them and could be used in any training practice.

In the blended supervision model, local supervision resources that can provide the registrar with face-to-face support and insights into the local context are first identified and used. Examples include:

- onsite GPs who wish to contribute to supervision but do not want to be accredited teachers
- practice managers with knowledge of practice and healthcare systems
- Aboriginal health workers who are able to assist with cultural competence
- practice nurses and allied health professionals who are able to supervise within their scope of practice.

Offsite supervision and teaching is added to the identified and organised local supervision resources to ensure

the combined supervision meets the outcome standards of ensuring patient safety and facilitating registrar learning. As all practices are unique, with different local supervision resources available, the final model of blended supervision is different in each practice. An example of blended supervision is provided in Box 1.

Supervision and teaching framework

To better understand the supervision and teaching in all practices, a framework based on the RACGP's *Vocational training standards* and the Association for Medical Education in Europe¹² guide to supervision was developed (Box 2). The framework required each practice to document how clinical supervision and educational supervision would occur and how outcomes would be achieved.

The questions in the framework about clinical supervision consider, 'How is the supervisor making sure the registrar's patients are safe?' Activities that are primarily clinical supervision in purpose include:

- orientation of the registrar
- being available to respond to a registrar's clinical questions during consulting hours¹³
- conducting audits of registrar patient care, such as random case analysis¹⁴

- responding to critical incidents and complaints.

The supervisor ensures the level of supervision is matched to the registrar's competence.

The questions about educational supervision consider, 'How is the supervisor helping the registrar to learn?' Activities include:

- developing and reviewing the registrar's learning plan
- facilitating educational opportunities that evolve from clinical work
- providing registrar tutorials.

Most supervisors would identify educational supervision as 'teaching'.

Implementing blended supervision

BME required all current and proposed new practices to complete the supervision and teaching framework. This enabled the identification of gaps in clinical or educational supervision. When possible, these gaps were addressed using a blended supervision model, and this was reassessed against the supervision and teaching framework. Because remote supervision was included, particular attention was given to the communication plan between the supervision team. In 2015, three practices received RACGP approval and trained

Box 1. Case – An example of blended supervision

An Aboriginal community controlled health service had been unable to replace a leaving onsite supervisor and could not continue accepting registrars under the traditional supervision model. A review by the Regional Training Provider (RTP) of the practice identified continuing onsite supervision resources including the practice manager and Aboriginal health workers. Two accredited supervisors in a nearby practice were willing to commit to being available to attend the health service if a registrar requested emergency assistance.

To the local resources, the RTP added an offsite supervisor experienced in remote supervision and Aboriginal health who agreed to be the principal supervisor. The offsite supervisor was able to be contacted by telephone or, if necessary, videoconference during the day. The supervisor also provided regular evening teaching sessions by phone or videoconference using 'screen sharing' to review clinical notes.

Early in the registrar placement, the offsite supervisor attended the practice to establish a relationship with the registrar and to become more familiar with the practice. An RTP blended supervision project team that included senior medical educators, RTP staff and a representative of the state coordinating body for Aboriginal community controlled health services met monthly by teleconference to monitor and review the performance of the practice.

The registrar has remained in the practice after completion of training and has expressed an interest in progressing towards becoming a supervisor.

registrars under a blended supervision model. A further four practices have been accredited for 2016.

Evaluation of blended supervision

An internal evaluation of blended supervision that did not require approval from an ethics committee has been completed by BME in 2015. The evaluation consisted of written feedback from supervisors and registrars, supplemented by interviews with registrars, practice

managers and supervisors. To date, the feedback has been positive and registrars have been satisfied with the teaching and supervision provided.

BME was concerned that practices using blended supervision had less inbuilt reserve. If a key person in the supervision team left the practice, the viability of the training post could be jeopardised. A project group was established to proactively manage the impact of any changes in practice personnel on the delivery of supervision. As yet, there

have been no significant changes in the blended supervision teams.

It is known that selecting the right registrar for remote supervision is important.¹⁵ BME decided to only select registrars who had completed advanced life support training and demonstrated in previous general practice terms that they were able to practice under the 'gets reflective assistance' or 'gets mentoring' level of supervision as outlined by the *Standards for general practice training for blended supervision*.¹

Box 2. Components of the teaching and supervision framework

The supervision team

- Who is the principal supervisor?
- Who are the other accredited general practice supervisors?
- Who are the other members of the supervision team (eg non-accredited GPs, practice manager, Aboriginal health worker, allied health staff)?
- How are concerns about the registrar communicated between team members?
- How is information collated so the registrar can receive feedback?

Clinical supervision

- How do you orientate the registrar into your practice?
- What is the roster for in-hours and after-hours supervision?
- Is the supervisor able to attend onsite 100% of the time the registrar is consulting or on call?
- How is the supervisor to be contacted?
- What is the plan for when the supervisor is on leave?
- How is patient safety monitored?
- Does the practice have clinical meetings or other governance processes that the registrar will attend, and which will look at practice systems with a view to maximising safety?
- How are registrar critical incidents handled?

Educational supervision (teaching)

- What is the teaching and learning philosophy of your practice?
- How will you identify registrar learning needs?
- When will a learning plan be created and how often will it be reviewed?
- How often does a registrar receive face-to-face teaching and what is the duration of the teaching session?
- When does the teaching occur and who provides the teaching?
- What activities are typically undertaken during teaching sessions?
- Do you conduct teaching sessions concurrently with other learners such as medical students or other registrars?
- What educational opportunities are available in your practice?
- Will the registrar see a broad range of patients in your practice?
- What assessment activities will be undertaken during the registrar's term?

Supervisor education and professional development

- What training have members of your supervision team attended?
- How do you communicate knowledge and share skills gained from attending supervisor education among the team?
- How do you evaluate your supervision and teaching?
- Can you outline an example of how you have changed your teaching practice in response to either registrar or educator feedback, or attendance at an educational event?

Discussion

We have described the background and early implementation of a blended supervision model in general practice training. Although evaluation has been positive, only a small number of practices have used the model. Further review will be required to more completely determine the effectiveness and sustainability of the model.

We have not evaluated the cost-effectiveness of blended supervision, but it is expected to be more expensive than traditional supervision. We have identified the need for closer administrative support for practices using blended supervision. A workforce of GPs able to provide offsite supervision will be required if the model is used more extensively. General practice supervisors may be able to be recruited from experienced GPs wishing to reduce their clinical workload as they approach retirement.¹⁶

Concerns have been raised that the regionalisation of training is failing to deliver rural workforce,¹⁷ and the 2016 reduction in the number of regional trainers may further slow progress. The implementation of supervision models, such as blended supervision, could provide opportunities to deliver training in more rural practices and, arguably, assist redress of rural GP workforce shortage. When registrars choose to remain in the practice and become supervisors, blended supervision can act as a stepping-stone towards traditional onsite supervision (Box 1).

Blended supervision includes remote supervision. Regional trainers could benefit from the consideration of recent literature on remote supervision^{10,15} and RVTS experience in training supervisors for this skill. Increased use of videoconferencing and future innovations are likely to make the technical component of remote blended supervision easier.

Although the RACGP's *Standards for general practice training*¹ were designed to reflect current pedagogy, we have described how it can simultaneously be used to increase training capacity. The blended supervision model we developed allows a pragmatic response to the provision of supervision. The supervision and teaching framework provides useful insights into the supervision methods of all practices, not only those involved in blended supervision, and could be further developed, evaluated and more widely implemented.

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