Education Research Grants 2017-2018
Final Admin, Research Findings & Financial Reconciliation report (main)

Application ERG009 From General Practice Training Tasmania Inc.

Instructions for ERG Grantees

* indicates a required field

This form is due by **COB 17th August 2018**. It has four parts:

Part 1: Project information

Part 2: Final project administration report

This is designed to help us understand the challenges, triumphs and insights you experienced and gained while running your funded project/program.

Part 3: Research findings

Tell us what you discovered from your research and how your findings may contribute to General Practice.

Part 4: Financial report and reconciliation

The financial reconciliation form is required to reconcile grant funding against actual expenditure. This process enables RACGP to calculate the amount of the final payment to RTOs, or if necessary, to recoup funds from RTOs.

Part 5: Certification

This section must be completed by an appropriately authorised person on behalf of the RTO.

The information in this report will enable racgp to report back to the Department of Health as well as understand the support activities that may assist future ERG grantees.

Part 1: Project information

Name of RTO *
General Practice Training Tasmania Inc

RTO project leader name *
Michael Bentley

Name of project member completing this form *
Marisa Sampson

Email of project member completing this form *
marisa.sampson@gpsupervisorsaustralia.org.au

Part 2: Final administration report

* indicates a required field

Project team variations

Were there any project team variations during the funding period? *
○ Yes ◉ No

Education Research Grants 2017-2018
Final Admin, Research Findings & Financial Reconciliation report (main)

Application ERG009 From General Practice Training Tasmania Inc.

Project outcomes

Report on project plan and milestones as recorded in Part 3 of your application.

Project stage	Project activity	Deliverable/ output	Status	If outstanding, provide reason and impact on project success
Advice of success	Signed funding contract in place	Funding agreement was signed within the planned timeframe	Completed	
Advice of success	Complete ethics approval application for the qualitative arm of the project	Ethics approval application lodged and outcome was received	Completed	
Project Initiation	MABEL data used to define study population, conduct cross tabulation and univariate analysis by geographic location. Multivariate analysis reported and discussed	Quantitative analysis finalised and reported on, MABEL results tabled at Steering Committee Meeting, sub-groups for interviews defined	Completed	
Project Initiation	First communique has been finalised	Communique was distributed and made available on the GPSA, GPTT and Monash University websites	Completed	
Project Initiation	Steering Committee established	The first meeting of the Steering Committee was held and a meeting schedule for future meetings was confirmed	Completed	

Application ERG009 From General Practice Training Tasmania Inc.

Progress Report 1	Submit Progress Report 1	Progress Report 1 submit by the due date	Completed	
Implementation/ data collection	Letters sent to GPs to recruit for interviews	Invitation to participate sent to Tasmanian GPs working in areas classified as District of Workforce Shortage.	Completed	
Implementation/ data collection	Additional targeted recruitment for interviews	Interviews scheduled and completed	Completed	
Implementation/ data collection	Qualitative data collection complete (transcribed) and entered into N-Vivo	Final participation rate achieved and data collection and entry complete	Completed	
Data Analysis	Final analysis of quantitative analysis and reanalysis of qualitative data	Results of analysis complete	Completed	
Data Analysis	Attend RACGP Annual Conference (presentations and workshops)	Attendance at the RACGP Annual Conference cannot be marked as completed as it will take place after ERG009 has been concluded	Outstanding	Abstract accepted for GP18 conference. Dr Belinda O'Sullivan is scheduled to present and presenter registration has been completed and paid for. Flights and accommodation for the GP18 conference have also been booked and paid for
Write-up	Drafting of research report	Research results drafted in academic report	Completed	

Application ERG009 From General Practice Training Tasmania Inc.

Progress Report 3	Submit Progress Report 3	Progress report 3 submit by the due date	Completed	
Dissemination	Conference abstracts prepared for dissemination of project findings	Abstracts have been accepted for conference presentation	Completed	
Dissemination	Seek presentations to GPTT and GPSA Boards	Dates set for presentation to GPTT and GPSA Boards	Completed	
Dissemination	Prepare manuscript(s) for publication	Draft manuscript(s) and journals selected	Completed	
Dissemination	Prepare final project report for disseminating via GPTT and GPSA websites	Final project report submitted to Steering Committee for approval. Final report available on GPTT and GPSA websites	Completed	
Final Report	Final research report completed and made available for download from GPTT and GPSA	Final Report submitted	Completed	
Final Report	Final Reconciliation report	Final Reconciliation report submitted	Completed	
Final Report	Presentations to GPTT and GPSA Boards	Presentations minuted	Outstanding	Presentations on Final report scheduled to take place at GPSA board meeting on 25 October 2018 and GPTT on 4 October 2018

Report on project objectives

Education Research Grants 2017-2018
Final Admin, Research Findings & Financial Reconciliation report (main)

Application ERG009 From General Practice Training Tasmania Inc.

For each objective listed in your ERG application form, list Key Performance Indicators, measure of success and report on acheivement

Objective	Key Performance Indicator	Measure	Report on achievement of this objective
Attended orientation webinar.	Orientation webinar attendance.	Webinar was attended.	Glen Wallace of General Practice Supervisors Australia attended the orientation webinar.
Initiated project - Established Steering group and held the first Steering Group meeting.	Steering group established and met.	Steering group established and first meeting has taken place.	The Steering group met on 13 October 2018 and a meeting schedule for the project duration was set. Minutes of the meeting were taken and approved by the Steering Group Committee chair.
Released a communique about the study.	Communique released.	Communique about the study released and featured on GPSA, GPTT and Monash websites.	Communique was released and posted to GPSA, GPTT and Monash websites on 20 October 2017.
Completed ethics for the qualitative arm (ethics already approved for using MABEL data) and completed the first stage of analysis of the MABEL data.	Ethics Committee application submitted. Early analysis of MABEL data has taken place.	Ethics approval received and draft quantitative results available.	Ethics approval was received on 14 September 2018 and draft quantitative results were tabled at the Steering Group meeting on 13 October 2018. The study was approved by The University of Melbourne Faculty of Business and Economics Human Ethics Advisory Group (Ref. 0709559) and the Monash University Standing Committee on Ethics in Research Involving Humans (Ref. CF07/1102 – 2007000291).

Developed draft qualitative in-depth interview schedule.	Draft qualitative in-depth interview schedule set.	Draft qualitative in-depth interview schedule set.	The draft questions went to the Expert Supervisor Group for their feedback
Convened the Expert Supervisor Group.	The Expert Supervisor Group meeting took place.	The Expert Supervisor Group was convened on 30 October 2017.	The Expert Supervisor Group convened on 30 October 2017.
Proposed a recruitment strategy for qualitative interviews.	Feedback on the recruitment strategy for the qualitative arm.	Qualitative recruitment strategy developed.	Qualitative recruitment strategy developed for interviews.
Attended ERG meeting in Melbourne.	Attended workshop.	Attended workshop.	Glen Wallace attended workshop in Melbourne.
Completed analysis of the MABEL data.	Conducted second analysis of MABEL data.	Second draft quantitative results.	Second draft quantitative results circulated to Steering Group.
Decided with which GP sub-groups to target the qualitative interviews.Got feedback from the Expert Supervisor Group about the MABEL findings and the focus of the qualitative arm of the study.	The Expert Supervisor Group provided feedback on sub-groups.	Responses of the Expert Supervisor Group were received.	Post-pilot qualitative in-depth interview schedule could be set.
Revised and piloted the interview questions.	Discussion by Expert Supervisor Group feedback on qualitative interview questions.	From the responses of the Expert Supervisor group the post-pilot qualitative in-depth interview schedule was set.	Post-pilot qualitative in-depth interview schedule set.
Finalised the recruitment strategy for interviews.	Discussion about recruitment strategy.	Qualitative recruitment strategy finalised.	Qualitative recruitment strategy finalised.

Revised the ethics for the qualitative arm of the study.	Amended (low risk) Ethics Committee application submitted.	Ethics amended.	Amended Ethics approval was received. The study was approved by The University of Melbourne Faculty of Business and Economics Human Ethics Advisory Group (Ref. 0709559) and the Monash University Standing Committee on Ethics in Research Involving Humans (Ref. CF07/1102 – 2007000291).
Held the second Steering Group Meeting.	Second meeting of the Steering Group held.	Second meeting of the Steering Group has taken place.	The Steering group met for the second time on 30 January 2018. Minutes of the meeting were taken and approved by the Steering Group Committee chair.
Submitted Progress report 1.	Progress report 1 submitted.	First progress report completed.	Progress report 1 was completed and submit by the due date 3 November 2017.
Distributed the letters of invitation to Tasmanian GPs (in DWS) via GPTT.	Invitation to participate sent to Tasmanian GPs.	GPs receiving invitations to participate were in contact to take part.	Invitations to participate were distributed to Tasmanian GPs.
Contacted respondents and commenced interviews.	Interviews commenced.	Qualitative interview responses received and transcribed.	Qualitative interviews took place and were transcribed.
Conducted final interviews.	Interviews transcribed and entered into N-Vivo.	Transcription completed, interviews entered into N-Vivo.	Entry of interviews into N-Vivo and all interviews transcribed.
Submitted progress report 2 (mid-term report).	Progress report 2 (mid-term report) submitted.	Second progress report (mid-term report) completed.	Progress report 2 (mid-term report) was completed and submit by the due date 2 February 2018.

Develop 2nd communique.	Communique released.	2nd Communique released and featured on GPSA, GPTT and Monash websites.	2nd Communique developed.
Held third Steering Group meeting.	The third meeting of the steering group was held	Third meeting of the Steering Group has taken place.	The Steering group met for the third time on 29 March 2018. Minutes of the meeting were taken and approved by the Steering Group Committee chair.
Finalised the analysis of both quantitative and qualitative data.	Any final data analysis conducted.	Results of the project written in an academic reports.	Two reports have been finalised on both the quantitative and qualitative data.
Presented initial findings at the RACGP Conference.	Presentation at RACGP Conference.	Presentation.	Abstract has been accepted and presenter registration has been completed and paid for. Flights and accommodation for the GP18 conference have also been booked and paid for so that presentation can take place at GP18 11-13 October 2018.
Completed final progress report.	Final progress report developed.	Final progress report.	Final progress report was completed and submit by the due date 17 August 2018.
Prepared a final communique of results.	Final communique, thanking for participation.	Final communique released and featured on GPSA, GPTT and Monash websites.	Final communique developed.
Drafted a research report.	Draft research report developed for Steering Group	Draft research report submitted/received by Steering group.	Draft research report submitted to the Steering Group at the meeting held on 25 June 2018.

Application ERG009 From General Practice Training Tasmania Inc.

Convened final Steering Group meeting.	The final meeting of the steering group was held.	Final meeting of the Steering Group has taken place.	The Steering group met for the last time on 25 June 2018. Minutes of the meeting were taken and approved by the Steering Group Committee chair.
Sought dates to present findings at GPTT and GPSA boards.	Dates sought for presentation to Boards.	Presentation dates set.	Findings of ERG009 will be presented to the GPSA Board on 25 October 2018 and to the GPTT Board on 4 October 2018
Finalised a project report to put on GPTT and GPSA webpages.	Desseminated report via GPTT and GPSA webpages.	Disseminated report on web pages.	Project report finalised and featured on GPSA, GPTT and Monash websites.
Submitted abstracts to present at conference/s and to GPSA and GPTT Boards.	Abstracts submitted. Board presentations prepared.	Abstracts submitted. Board presentations delivered.	Abstracts have been submitted and accepted for GPTEC and GP18. Dates have been set to present project findings to GPSA and GPTT boards.
Submitted final conciliation reports.	Conciliation reports completed.	Conciliation reports completed.	Final conciliation reports completed and submitted by the due date.
Prepared final drafts of manuscript/s to submit to high impact/open access journals:Medical Education and Health.	Paper(s) drafted for submission.	Paper(s) submitted.	Manuscript(s) have been submitted to journals in the area of Medical Education and Health.
			Explain the impact of any incomplete objectives

Project governance

Report on project governance against the project plan.

What are the lessons learnt in managing project governance throughout this project?

Respond and explain *

Managing project governance demonstrated the need for clear communication between the members of the Steering group and for forward planning to take place to manage the busy and varying schedules of the members. The commitment shown by the members of the

Application ERG009 From General Practice Training Tasmania Inc.

Steering group to attend scheduled meetings contributed to the project plan being delivered as proposed, with all members knowing what was expected of them.

Project communication plan

Was the communication plan delivered in accordance with the project plan?

What are the lessons learnt in managing communication throughout this project?

Respond and explain *

There were no delays in meeting communication objectives as outlined in the communication plan. The communication plan was delivered in accordance with the project plan.

Lessons learnt were the need for clear and specific dates and times to be communicated to the entire team, ensuring all project members were kept informed of requirements.

Project risk register - foreseen risks

Review the risk assessment submitted in your ERG application. List each risk, the alevel of risk at commencement likelihood that have been identified and any that could eventuate in the future.

Complete the assessment and mitigation actions.

Risk	Level at commencement	Mitigation actions required - if any	Residual risk level
Failure or delay to secure research ethics approval.	Low	The Lead Researcher, Dr Belinda O'Sullivan is experienced in obtaining university human research ethics approval. The ethics application falls into the low risk category. Low-risk applications are subject to an expedited review process.	Low

Low response rates to the interviews.	Medium	The recruitment to interviews will involve a broad mail out and then a targeted email recruitment to ensure representation of subgroups of interest. The incentive, and flexibility of phone surveys will increase participation. The aim is to sample enough GPs in Districts of Workforce Shortage, supervising and not, who meet key sub-group criteria and fulfil thematic saturation, so up to 25 interviews are required.	Low
Loss of key members of research team.	Low	Timely recruitment of replacement staff with appropriate handover. The inclusion of three Monash researchers boosts capacity to mitigate research staff loss.	Low
Loss of data.	Low	Analysis of data takes place at Monash University facilities with secure servers and back-ups. Recorded interviews will be backed up on computer with separately stored paper and electronic transcriptions.	Low
Loss of or inability to recruit Expert Supervisors.	Low	GPTT CEO and Director of Training are on Project Steering Committee and can assist with identifying additional supervisors if required.	Low

Failure to manage project within budget.	Low	CEO and Research Team are very experienced at managing projects within budget. The budget indicated is realistic. Costs outside of Research Team salaries are very low.	Low
Failure to complete project within timeframe.	Low	The project is simple and straightforward logistically. the research team is very experienced at managing projects to tight deadlines. The research team includes experts with quantitative and qualitative research skills. The lead researcher has strong project management and academic experience based on involvement in the MABEL Centre for Research Excellence, including strong skills in achieving publication and clearly presenting to academic and policy audiences.	Low
List each risk	Assessed level	Did you need to take action?	

Project risk register - issues log

Describe any unforseen problems or issues that arose during the project.
How were they were managed? Have they been resolved or what is the plan for resolution?

Problem or Issue	**Issue resolved?**	**Resolution - undertaken or planned**
Qualitative analysis was delayed due to change in Monash employment	Yes	New qualitative researcher recruited but with limited availability

Application ERG009 From General Practice Training Tasmania Inc.

Lessons learned

Consider your project successes and shortcomings for future projects

Successes - which activities and processes worked well? *
The communication between the Steering group and project team was excellent and contributed to the project objectives being met.

The recruitment of GPs went very well, with more interest than expected.

This interest allowed for the interviews to take place during the planned interview period, preventing any delays in getting the interview data to the research team. It also meant that participants from the sub-groups identified to target were part of the project.

We know this is a particularly hard question to answer as there may be many different contributors to any particular outcome but if you have some insights to share, we'd love to hear them.

Shortcomings - which activities and processes could have been improved and how? *
The budget and time frame for the project allowed for 25 interviews but more GPs contacted the project team wanting to take part in the Project.

However, we achieved data saturation with 25 interviews, and within the budget for a 12 month project.

Provide details on the overall status of the project Include any points of reporting you wish to identify that were not covered in the body of this report. *
A one page lessons learnt document titled 'More supervisors for teaching the next generation of rural GPs' was developed to provide information to Registered Training Organisations and Colleges to increase participation in training GP registrars was compiled from the interviews conducted.

This document will be shared with all Registered Training Organisations and Colleges, as well as handouts being made available at conferences and the information being featured on the websites of the project participants.

Part 3: Research findings report

* indicates a required field

Research outcomes

Purpose *

The purpose of the project was to produce reliable information about GP supervisors in Australia and to better understand the factor that relate to GPs supervising in underserved areas.

The aims as stated in the original application were:

1. to identify the factors related to participation in GP registrar supervision related to the GP’s characteristics, those of their practice and their geographic location of work.

This aim was refined during the research project to specifically explore rural GPs' participation in supervision and the extent to which supervision related to the location where the GP's practice (for example different Modified Monash Model levels), compared with other factors like GP and practice characteristics or practice workload. Refining the aim of the study enabled the research to focus on building rural GP supervision capacity and to specifically inform the qualitative area of the study which was focused on GPs in rural underserved areas.

2. To interview GPs in Tasmanian Districts of Workforce Shortage about why they choose to participate in supervision or not and whether the perceived barriers and enablers to participating in registrar supervision affect different sub-groups of GPs in different ways.

This aim was refined to enable the exploration of GPs' perceptions of these factors, amongst those in underserved areas in Tasmanian locations which were geographically dispersed (outside of Hobart and Launceston) though not specifically defined as Districts of Workforce Shortage. The reason for making this broader than Districts of Workforce Shortage was that these areas are under review, and our research interest was broader than this definition to encompass communities outside of regional centres within a jurisdiction where every location is considered "rural".

State the purpose as recorded in your application form. If this changed during the course of the project explain why.

Methodology *

The quantitative study included clinically active GPs working in rural Australia who self-reported whether they were currently teaching or supervising registrars on the MABEL 2016 survey (www.mabel.org.au). The study excluded registrars as well as GPs who were not currently in the paid workforce, or permanently retired. The MABEL study cohort is reasonably representative of GPs nationally, and includes a range of covariates relevant to this study. It has extensively informed general practice workforce policy for over a decade.

Non-response weightings were used for all calculations. Multivariate logistic regression modelling explored factors associated with supervision for rural GPs. Statistical significance was set at $p<0.05$. The location of each rural GP's main practice was geocoded to the Modified Monash Model (MMM) categories of geographical remoteness and population size: MMM 2 >50,000; MMM 3 15-50,000; MMM 4 5-15,000; MMM5 <5,000; MMM 6-7 remote and very remote. Covariates were progressively added for GP factors (gender, age, Australian-trained), practice-employment factors (number of doctors and business-relationship in practice, total work hours) and specific activity factors (medical student or prevocational

teaching/supervision and working in either public hospital or aged care settings).

The qualitative study recruited a range of GPs working in different types of practices in underserved areas in Tasmania. These GPs were recruited in writing via letters sent to the GP's work address, after excluding GPs based in Hobart and Launceston. GPs were enrolled in the study by contacting Marisa Sampson at GPSA, who used a screening questionnaire to determine eligibility, ensuring we had a range of GPs in different geographic locations, and who then arrange a mutually agreeable interview time with the researchers. Eligible GPs participated in audio-recorded virtual interviews with researchers. Researchers conducted these interviews from a quiet office where confidentiality could be assured. The interviews were transcribed, de-identified and analysed by the research team using N-vivo software. The interviews explored the barriers and enablers underpinning their decision to participate or not in registrar supervision capacity. There was regular team discussion after each iteration about emerging themes and new findings to ensure the interviewers had a shared understanding of the emerging factors within the study that needed to be further explored.

State the methodology as recorded in your application form. If this changed during the course of the project explain why.

Results *

The quantitative study included 941 rural GPs of median age 49 (95% CI 47.0-50.0), 62.8% male and 93.2% in accredited practices. Of these, 528 (57.8%, 95%CI 54.3-61.0) were currently supervising registrars. In univariate analysis, GPs working in rural communities <15,000 (MMM 4-5), in larger practices (3+ doctors) and for longer hours (40 or more weekly hours) were more likely to be supervising. Additional significant factors included being Australian-trained, male, aged 41-55 years, practice principal or associate, working in public hospitals and aged care settings and supervising medical students, interns and pre-vocational trainees.

The first multivariate model which included GP characteristics, showed the relationship between practice location and supervising registrars was similar to the univariate results. In the second model which included practice factors, the practice factors, rather than location, had the strongest associations with supervision. In the final model which also included practice teaching activity, the strongest associations with supervision were working in a practice with more GPs (ORs 4.7-15.1 - from 3 to 5 up to 11+ doctors) and supervising medical students (OR 8.3) and interns/prevocational doctors (OR 6.0). Additionally, GPs in later career (OR 1.9), Australian-trained (OR 2.4) and working moderate extra hours in other community

settings (aged care OR 1.7- public hospitals OR 2.2), along with GPs based in remote towns (MMM6-7) (OR 2.4) were significantly more likely to supervise registrars.

The qualitative study included 25 interviews with GPs either supervising or not in underserved areas of Tasmania at which saturation of themes was largely achieved. The data identified that the GPs chose to supervise because their practice offered rich learning opportunities in general practice and they strongly enjoyed seeing the next generation, whether Australian-trained or overseas-trained, and to support this group to come through the system with high quality learning and mentorship support. Their motivations stemmed from a strong need for more doctors to serve the needs of their local community, meet the practice demand and ensure feasible workload to keep themselves going as a rural GP in an underserved area.

“I think… [we offer]… good experience for the GP registrars to be busy, and to be very much valued as they are, and to be part of the team”

“…seeing them grow and seeing them become good GPs that are able to care for all of the patient’s needs”

“…we’re a small practice that needs to be working at full capacity to stay viable basically, and so they, that, there is that positive benefit to the practice as well as the positive benefits of watching someone learn and grow in general practice…”

“[having registrars] gives us more doctors to see patients”

Having registrars in the practice, with fresh ideas and their currency of learning, boosted the morale of the practice and served to remind the rural GPs why they work in rural primary care. This was important given a number of rural GPs in underserved areas had trouble getting away from the practice to do other types of continuing professional development. Registrars were almost unanimously considered to bring energy and enthusiasm that reinvigorated the GP’s enjoyment of rural general practice.

They hoped that they could attract GPRs to work in their practice longer-term once qualified but they realised this was not realistic in most cases.

“…hopefully if we did have a registrar come they may want to stay on for longer or they may encourage other people to come because they have had such a great experience…”

The GPs were keen to supervise more often, though noted that the current policy settings made it difficult to lure GPRs to leave Hobart and Launceston.

The quality of registrars was considered high with very few negative experiences related to supervising. More experienced GPs mentioned that the ability for early identification of trainees in difficulty was important and they were now good at this.

“the registrars we’ve had…have been very pleasant…”

For GPs not supervising, the main reasons were lack of autonomy over the decision, not feeling confident, recently becoming a Fellow, being overseas-trained, having too many other commitment would preclude them doing a good job as a supervisor, juggling part time work and having additional family commitments or other professional roles. There was also a sense for some that the policy environment and paperwork involved were negative factors. Others reported simply being happy to supervise if they were asked to do so, or encouraged and mentored through any personal barriers. For some they thought more information about how to become a supervisor would be helpful, that is, they couldn’t identify any other barriers

“just the start of this year my practice principal talked to me about would you like to supervise a registrar and I told him I am not confident…because of some reassurances from him…we actually did discuss it…so I might”

“My colleague who’s the lead supervisor, he feels that I have useful experience to give the registrars, and very much encourage me to do it. I probably wouldn’t have volunteers to do it but I do very much enjoy doing it…”

“I think the fact that I wasn’t trained here as a general practitioner that’s the one thing that’s holding me back”

“It’s just a matter of supervisors meeting other GPs and suggesting it often…I was speaking to someone on the weekend about it. I asked if she would consider being a supervisor and she said oh I feel like the registrars would know a lot more than I do, and I said that’s often the way for me and I think that’s all part of it and that’s fine to acknowledge”

Provide a summary of your results

Discussion - what do your findings add/ contribute to the body of knowledge in the field? *

The quantitative study provides the first national empirical evidence quantifying the factors associated with the current rural GP supervisor workforce, showing that more than half of rural GPs supervise registrars. A number of factors related to the rural GPs characteristics and their practice were found to be significantly associated with supervising registrars. In the final multivariate analysis, the strongest associations were not with the geographic location of practice, but rather, with working in practices with more doctors, supervising medical students and prevocational trainees, and being Australian-trained.

A career orientation to teaching has been described in other literature as a factor motivating GPs become involved in medical education (14). Additionally, it may be easier for rural GPs to supervise if teaching is expected within their practice employment and relevant infrastructure exists for supporting multi-cohort learners (2). Larger rural practices with more learners may provide more options for team-based supervision and peer to peer learning, reducing the individual supervisor responsibility and mitigating increased practice workload (27). Supervising registrars may also be economically more viable if the practice also teaches medical students. Practices receive similar reimbursements for teaching medical students per day (up to $400) as for supervising registrars per week ($520-$560 - GPT1, $260-$280 - GPT2) (with additional teaching subsidies for GPT1 and GPT2 $120-$140) (28, 29), although registrars contribute to the clinical workload of the practice. Rural GPs may otherwise supervise medical students and prevocational doctors to promote the uptake of general practice career paths by the next generation. Finally, it is possible that GPs with experience of supervising medical students or prevocational doctors feel more confident to supervise registrars (or vice versa), compared with those who are not supervising these other groups, whereby engaging rural GPs in any teaching activities may be an important motivator.

Developing more Australian-trained doctors working as rural GPs and increasing the number of international medical graduates (IMGs) qualified and pursuing supervision roles in rural areas will also enhance rural supervision capacity. IMGs may face structural barriers to supervision including accessing or completing the required vocational training standards for formal fellowship themselves. Atop of a range of existing options for IMGs to pursue pathways for vocational-registration, new programs in the current federal budget are expected to enhance options to achieve GP fellowship, important for building a rural GP workforce with the qualifications and confidence for supervising registrars (30, 31). Some IMGs who are already fellowed may participate in supervision with encouragement and support by peers. This is particularly so if they are still learning to navigate the Australian system themselves. Encouraging more IMGs to supervise is a substantial issue for rural GP supervising capacity given that they constitute around 40% of all rural GPs, and many rural general practices continue to depend on these doctors in areas of workforce shortages (24). In towns where un-fellowed IMGs are heavily used and which have only a small number of fellowed GPs, the available supervisor pool is likely to be small and difficult to increase.

More continuity of rural training pathways for Australian-trained students could increase the uptake of rural general

practice and build the overall rural registrar supervision capacity (31). Some of these initiatives include increased investment in rural end-to-end medical programs, initiatives for more prevocational doctors to train and work in rural general practice, and the development of a National Rural Generalist Training Pathway and pathways via the Regional Training Hubs.

The quantitative study had some limitations. It was a cross-sectional so only associations rather than causality, can be attributed. The focus was targeted on rural GPs to specifically inform rural training capacity so the results cannot be generalised to metropolitan GPs. The study involved a subset of GPs responding to MABEL though this is known to be a reasonably representative cohort of respondents, evenly spread by jurisdiction, town size and remoteness(23). When explored, there were no signs that missing values systematically biased the results. Our data could not easily demarcate whether IMGs were vocationally-fellowed.

The qualitative study of rural GPs in underserved Tasmanian areas highlighted for the first time that rural GPs based in underserved areas have a different context around the issue of supervision such that the event was “more than just supervision”. Their need for more workforce and their scope of practice and community orientation placed them in an ideal position to support registrar learning but their immediate conditions did not guarantee them a registrar. Their working in an underserved area with high primary healthcare needs predisposed them to two predicaments: whether to pursue registrars who may not be attracted to the location or whether to attempt recruitment of IMGs who may require supervision themselves, but who at least offered support for the workload on a more regular basis than typical registrar rotations could achieve.

The data revealed the richness of the supervision experience for rural GPs with some links with job satisfaction and intrinsic professional reward. This is an important finding given that rural GPs in underserved areas have extensive challenges related to managing extra on-call and practice workload to meet community needs.

The qualitative study had some limitations - it was limited to 25 interviews and the study was over-subscribed. This may have meant that GPs with particular interests in promoting supervision were the ones who enrolled in the study. Nevertheless saturation of the themes was broadly achieved due to careful screening prior to enrolling GPs, to ensure a balanced sample. The findings being based on underserved areas, however, provide important insights for other rural underserved areas and the importance

of accessing registrars for teaching and learning in this context.

Implications - what is the wider impact of your research and what are the implications of your findings for policy and practice? *

From the quantitative study, participation in supervising registrars is related to rural practice activity, rather than where the practice is located or the characteristics of the GP. Those supervising registrars were mainly also supervising medical students and prevocational trainees and working in an increased practice size. Supporting GPs in smaller practices to engage in supervision and maintaining the strong involvement of larger practices will build more capacity for rural supervision. Enabling rural GPs to supervise medical students and prevocational trainees is likely to foster registrar supervision as well. More Australian-trained doctors in rural general practice and support for IMGs to undertake vocational training and become supervisors will also enhance rural general practice supervision capacity.

From the qualitative study, more policy support is needed for general practices in underserved areas in conditions where there are nearby (also rural according to MMM classification) regional centres. This includes those outside of Hobart and Launceston) where practices wish to attract registrars, to build essential critical mass and enable their high energy in their immediate environment, to help rural GPs maintaining a passion for their work in delivering rural primary care services. Rural general practices offer a strong breadth of clinical learning experiences and registrars bring important energy to these practices, reinvigorating supervisors' interest in rural general practice and allowing the exchange of ideas and practises, with the next generation.

The implications of the quantitative and qualitative research are summarised in a one page communique flyer to be provided to all RTOS and the RACGP – attachment 1. Additionally, this flyer will be made available on relevant websites and at GP-related conferences.

Future research - outline areas for future research that your work identified. *

Further research should test interventions to facilitate rural GPs to supervise registrars. This includes the influence of:

- interventions to promote supervision by GPs in small rural practices.

- Interventions to support fellowed OTDs to supervise.

- the effect of rural supervisors asking other GPs they know (that are

currently not supervising) to supervise.

- continuity of registrar supply on the practice and the GP's supervision

experience.

Application ERG009 From General Practice Training Tasmania Inc.

Academic contribution

List any peer-reviewed publications that have been, or are likely to be, produced as a result of this research. We ask that you attach a copy of any draft papers.

Manuscript title	Status
A national cross-sectional study of the factors related to rural GPs supervising GP registrars in Australia	Submitted
Qualitative manuscript to Health and Place	In preparation

Upload manuscript file:

Filename: Draft qualitative manuscript for ERG009.pdf
File size: 321.1 kB

Filename: Manuscript - A national cross-sectional study of the factors related to rural GPs supervising GP registrars in Australia.pdf
File size: 222.3 kB

Filename: One Page Document - More supervisors for teaching the next generation of rural GPs.pdf
File size: 110.5 kB

Did you provide acknowledgement of funding body as stipulated in funding agreement? *
◉ Yes ○ No

Other avenues where your findings will or are likely to be disseminated

Describe the event and actual or anticipated date.

Workshops *

Education Research Grant 2017-2018 cohort - Workshop 1 (22 November 2017) Attended by Glen Wallace (GPSA)

Education Research Grant 2017-2018 cohort - Workshop 2 (2 August 2018) Attended by Marisa Sampson (GPSA) and Michael Bentley (GPTT)

Conferences *

GPTEC - Presenting September 12 2018 11:30am - 1pm Attended by Marisa Sampson (GPSA), Michael Bentley (GPTT), Glen Wallace (GPSA) and Belinda O'Sullivan (Monash University)

GP18 - Presenting 11-12 October 2018 Attended by Belinda O'Sullivan (Monash University) and Glen Wallace (GPSA)

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Online forums, blogs, websites etc.	Three communiques advising of the progress of ERG009 were featured on the GPSA, GPTT and Monash University websites. A copy of the final report is available for download from the GPSA, GPTT and Monash University websites also. The summary findings will also be available on the RACGP website
Policy frameworks, educational materials	Produced one page lessons learnt document from project findings circulated to the Rural Health Commissioner, all RTOs, RACGP and ACRRM - More supervisors for teaching the next generation of rural GPs (attached)
Other (explain)	One page document to be circulated to all Registered Training Organisations.
Confirm that you have or will provide acknowledgement of funding body as stipulated in funding agreement? *	◉ Yes ○ No ○ N/A

Capacity building - how has or will your project contribute to capacity building in the following areas of General Practice research?

Providing opportunities for other practice members to gain research experience *
Exposure that GPSA, GPTT and Monash University staff have received working on a practical research problem has built capacity in all our research skills. Marisa Sampson attended the workshop, was involved in recruiting with Allyson Warrington and research staff buddied up with practice staff to gain the ethics approval, recruit participants and manage data, analyse findings, prepare abstracts, present at conferences and develop a one page project summary flyer.

These findings will assist RTOs by providing 1) a national understanding of the demography of rural GP supervisors and 2) findings on the barriers and enablers which to lead to prospective supervisors making a decision to supervise registrars in general practice.

Contributing to the knowledge and skills of your research team *
Marisa Sampson attending PHCRC 1-3 August 2018 and the Education Research Grant 2017-2018 cohort Workshop 2 Thursday 2 August 2018.

This is also the first time Marisa has worked on an Education Research Grant and the experience has assisted in broadening her knowledge of General Practice research. It also gave Marisa the experience of working with an RTO.

Danielle Couch is a new health sociologist and the Education Research Grant exposed her to primary care research for first time.

Providing training and research support to early career researchers *

Application ERG009 From General Practice Training Tasmania Inc.

Danielle Couch had not worked on an Education Research Grant before, this is her first project after completing her Phd. The Education Research Grant has given her exposure to primary care research and how the Education Research Grant system works.

Inspiring your research team members to continue to pursue research *
The opportunity to work on an Education Research Grant has been a positive experience for the entire research time.

The team continued to apply for Education Research Grants throughout the year, submitting 3 collaborative projects with the same team, with all of the team members keen to continue.

Providing collaborative research links with GPs and local services *
The findings from ERG009 identify barriers and enablers to taking up supervision and can support RTOs with the goal of attracting more supervisors for teaching in rural general practices.

Local supervisors throughout Tasmania have contributed to this research that will have a national application.

The communique and the findings from ERG009 are available via websites, communique and the one-pager will be sent to RACGP, ACRRM and all RTOs, as well as available to the GPs involved in the study.

Initiating/strengthening internal collaborations *
GPSA CEO working on the governance committee, communicating with the finance manager to ensure the expenditure of funds and collaborating with the lead researcher from Monash University, Belinda O'Sullivan and the Project Lead Michael Bentley of GPTT.

Initiating/strengthening external collaborations *
The project was conducted with employees from GPTT, GPSA and Monash University. The project team worked well to organise the interviews and the sharing of data to compile the report and disseminate findings.

Contributing to research culture *
Three applications for Education Research Grants were submitted throughout the twelve months that ERG009 was funded for.

These were collaborative projects with the same team, all of which wanted to continue to work on research.

Other - specify

Other comments

Do you have any other comments about your research findings? *
The interest in further research (identified on page 21) is strong considering there were more GPs wanting to take part in the project than could be accepted.

Part 4: Financial report and reconciliation

* indicates a required field

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Project income and expenditure

The financial reconciliation form is required to reconcile grant funding against actual expenditure. This process enables RACGP to calculate the amount of the final payment to RTOs, or if necessary, to recoup funds from RTOs. RACGP will distribute the financial acquittal form by email to each ERG team. The form must be completed and signed by the ERG project manager and RTO finance representative, then uploaded within this form.

*** Actual expenditure refers to expenses that have been incurred at the time of reconciliation (receipts to be available on request), or where there is a legal obligation for the RTO to pay the expense in the future.**

RACGP recognises that due to the constraints on the Funding Agreement period, it is difficult for RTOs to use funding to cover the cost of presentation of findings at conferences. Therefore we would like to encourage RTOs to consider prepaying for a member of their team to attend up to two Australian conferences with the intention to present findings. Conference expenses prepaid may include economy airfare, accommodation and registration, and is not dependent on the acceptance of a conference abstract. The RACGP's expectation is that every effort will be made to ensure an abstract is accepted however in the case where it is not, the ERG representative would be expected to attend the conference as a participant to support the program aims of building research capacity.

Costs associated with International conferences are excluded.

If full expenditure of the grant has not occurred, the value of the unspent funds will be deducted from the final funding payment. If the funds already received exceed the final actual expenditure, a reimbursement to the RACGP will be required.

Note, the final funding payment will not exceed the total contract amount regardless of actual expenditure. A comparison of actual versus budget is also required, with commentary to explain any variation.

*** Financial reports not completed according to these guidelines may result in a processing delay and a request to re-submit.**

If you have any queries about this please contact our team using the gpedresearch@racgp.org.au email.

Reconciliation form

The reconciliation form has been sent via email to RTO finance managers, the Smarty Grants user and RTO project leader. If you have misplaced this, email gpedresearch@racgp.org.au

Upload a completed and signed copy of your reconciliation form below. *

Filename: FinalFinancialReconciliationERG009.pdf
File size: 867.3 kB

Part 5: Certification and feedback

* indicates a required field

Certification

Education Research Grants 2017-2018
Final Admin, Research Findings & Financial Reconciliation report (main)

Application ERG009 From General Practice Training Tasmania Inc.

Once this form has been completed, generate a pdf version so that the appropriately authorised person can complete the declaration on behalf of the RTO. This should be the person who signed the funding agreement, or their delegate.

I certify that to the best of my knowledge the statements made within this application are true and correct.

Signature	
Name of authorised person	Dr Michael Bentley
Position	Research Officer Position held in RTO
Contact Phone Number	(02) 6215 5000
Contact Email	Michael.Bentley@gptt.com.au Must be an email address.
Date	17/08/2018 Must be a date
Upload a copy of this report that has been signed by the authorised person and initialed on each page.	Filename: Education Research Grants 2017-2018 ERG009-signed report.pdf File size: 10.6 MB

Feedback

You are now nearing the end of this form. Before you review your application and click the **SUBMIT** button please take a few moments to provide some feedback.

Did you find the reporting process okay? *
◉ Yes ○ No

Provide us with your comments or suggestions about any improvements on the reporting process. *
Some of the sections are repetitive and the process could be streamlined.