



Joint Statement on Clinical Supervision in General Practice

Clinical supervision keeps patients safe and builds Australia’s future general practice workforce, yet current policy and funding do not consistently recognise, resource, or support it across training and settings. The National Council of Primary Care Doctors (NCPCD), a coalition of Australia’s leading general practice organisations, calls for the following measures to appropriately support and sustain high-quality and accessible primary care for patients across the country.

- Formally recognise and appropriately resource clinical supervision (which is distinct from the educational supervision function) across general practice and rural generalist training, including primary care placements for medical students and prevocational doctors, and broadly clinical supervision occurring in all primary care settings.
- Align supervision expectations with clinical governance requirements, including the National Safety and Quality Health Service (NSQHS) Clinical Governance Standard Action 1.26, supported by clear escalation pathways, access to senior advice, and protected time.
- Address payment and infrastructure gaps so supervision is not financially penalised compared with direct patient care, including time spent on case review, documentation, and real-time oversight.
- Invest in supervisor capability and sustainability through structured training, peer support, and evaluation, with a focus on rural, regional and remote contexts where onsite and remote supervision models are both essential.

Setting the context

Most registrar learning in general practice and rural generalist training occurs in practices and training sites where supervision combines structured educational supervision (planned teaching and reflective learning) with clinical supervision (real-time oversight, mentoring, and accountability for safe patient care).

Clinical supervision is highly skilled work. It relies on trusted relationships, frequent communication, and timely feedback that supports safe, independent decision-making. These relational and professional elements take time and resources, and they work best when practices can provide both robust educational supervision and clinical supervision.

Despite its centrality, the system does not consistently recognise or support the full scope of clinical supervision. Supervisors often absorb opportunity costs and administrative burden, and practices face infrastructure constraints (space, technology, and workflow design) that can limit supervision quality, particularly when service demand is high. For rural generalists, supervising time and resources are further constrained by the need to provide clinical care across multiple settings, including primary care and emergency services.



Governance and standards

Australia's National Safety and Quality Health Service (NSQHS) Standards set expectations for safe, high-quality care across health service organisations. The [Clinical Governance Standard](#) makes supervision a practical safety requirement that must be matched to capability, embedded in governance systems, and supported by structured feedback and access to advice.

In general practice and rural generalist training settings, this reasonably includes the senior supervising doctors as well as the multiple tiers of doctors providing care under supervision. Translating standards into consistent, workable supervision arrangements requires time, systems, and resourcing. Without that support, supervision quality can become variable and harder to sustain.

Evidence and impact

Evidence consistently links effective clinical supervision with safer, higher-quality care. A [systematic review](#) found clinical supervision is associated with improved patient safety and effectiveness of care, including better adherence to evidence-based processes that support better outcomes.

Organisational conditions matter, with research highlighting that [effective supervision](#) depends on practical enablers such as protected time, structured frameworks and leadership commitment. Where these are present, staff report benefits including improved job satisfaction, better retention, improved wellbeing, and a higher-quality working environment that supports quality care delivery.

Clinical supervision also shapes professional formation and capability. The [supervisor's role](#) underpin safe care in developing professionalism, ethics, communication and other core skills. Recent [general practice research](#) describes supervision as occurring within competing service, training and personal demands. It also identifies sustained support, time allocation, administrative and programme-level backing, and opportunities for peer interaction, as key to preventing supervisor attrition and sustaining [meaningful learning](#).

The challenge we face

Supervisors carry responsibility for patient safety, trainee development and workplace culture. They model professionalism, support interprofessional collaboration, provide pastoral support, and help trainees progress to independent practice.

However, rising service pressures, especially in rural, regional and remote settings, mean supervision often competes with direct patient care, including urgent presentations. Physical constraints (consulting rooms, IT and telehealth capacity), inconsistent protected time, and the opportunity cost of real-time oversight can undermine supervision quality.

If supervision becomes inconsistent, the risks are predictable: weaker learning experiences, reduced training quality, higher professional risk, and avoidable patient safety issues. These pressures also



threaten the future supervisor workforce by making supervision less feasible and less attractive over time.

What needs to change

Clinical supervision is not 'extra' oversight, it is a core safety function and a strategic investment in workforce capability and system sustainability. Governments, colleges, training organisations and funders should strengthen supervision by recognising the full scope of supervisory work and ensuring it is viable for practices to deliver. With additional Government investment in practices and training places, maximising impact may require a stronger focus on the people who are currently, or will in future be, responsible for providing supervision.

This includes policy and funding settings that support protected time, workable supervision models (including remote supervision where necessary), supervisor development and peer support, and payment arrangements that do not disadvantage supervision compared with direct service delivery. Aligning these settings with [NSQHS Action 1.26](#) (National Safety and Quality Health Service Standard) will help ensure supervision is consistently embedded within clinical governance systems.

Clinical supervision remains central to safe patient care and to developing Australia's next generation of general practitioners and rural generalists. Recognising and resourcing it properly will strengthen the training pipeline, support supervisor sustainability, and protect patients across all regions.

The National Council of Primary Care Doctors (NCPCD) represents the interests of general practice and primary care in Australia, comprising leaders from the Australian Medical Association (AMA), Royal Australian College of General Practitioners (RACGP), Rural Doctors Association of Australia (RDAA), Australian College of Rural and Remote Medicine (ACRRM), General Practice Supervisors Australia (GPSA), General Practice Registrars Australia (GPRA) and Australian Indigenous Doctors Association (AIDA).