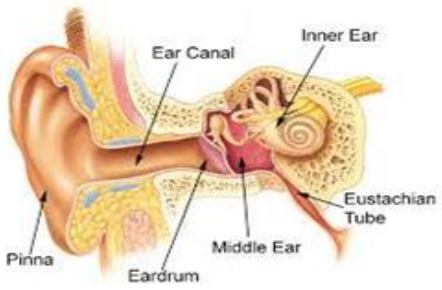
'Very well put together and thought provoking'

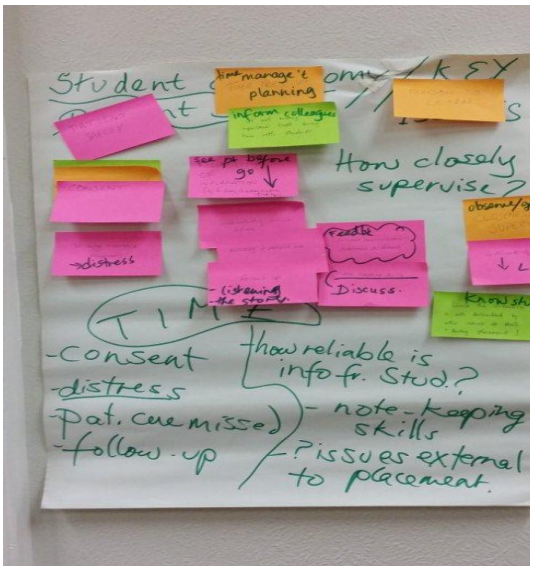
# Report

## Year 5 GP Teacher Workshop

2nd December 2014

**Workshop Organisers: Barbara Laue and Andrew Blythe**




# Contents

## Objectives

- Get update on the Primary Care attachment in Preparing for Professional Practice (Year 5)
- Share top tips and challenges with colleagues
- Explore pitfalls of consulting with patients who are health professionals
- Find out about opportunities for students to learn about the provision of care out of hours
- Develop skills for teaching ENT history and examination to medical students
- Enhance awareness of mental health and fitness to practice issues in medical students

## Teaching Competencies addressed in this Workshop

- Teaching complex skills (consultation skills, ENT history and examination)
- Effective feedback giving
- Providing pastoral care
- Supervision

## Speakers and Facilitators

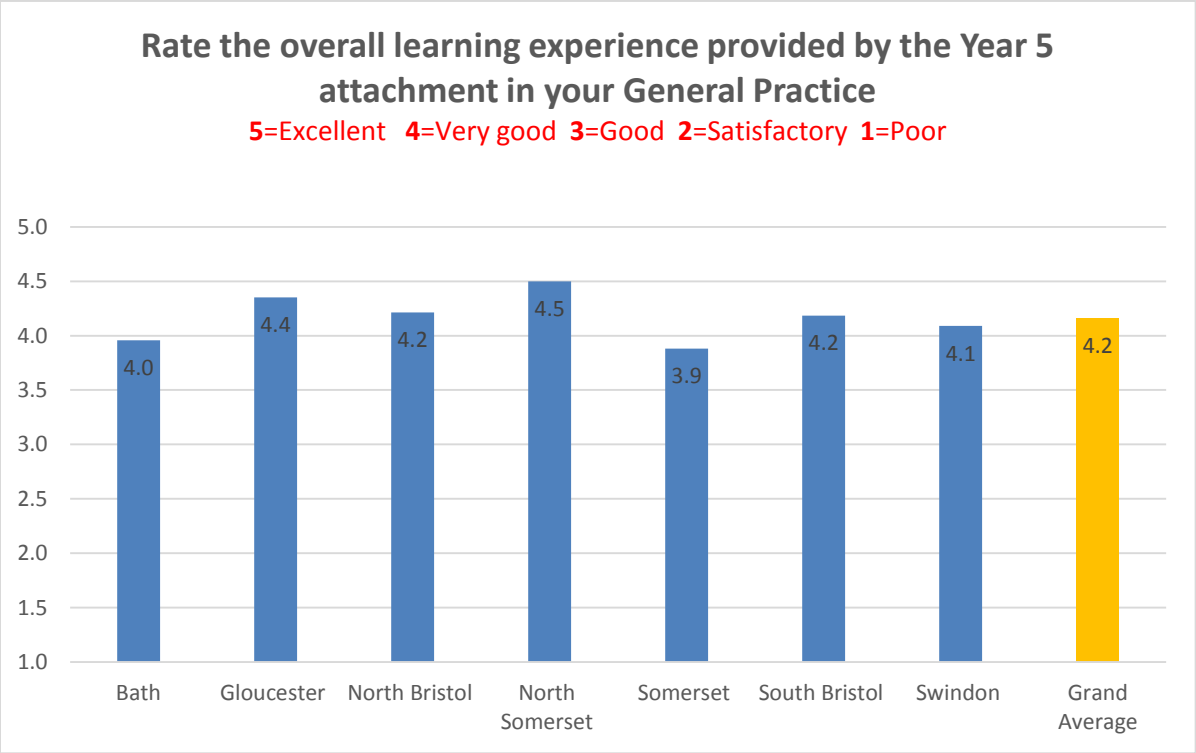
| | |
|---|---|
| Andrew Blythe | Head of teaching, Primary Care, Unit lead for COMP2 (Year 4) |
| Mel Butler | Primary Care Teaching Administration Manager |
| Andy Eaton | GP lead for Somerset, Taunton |
| Fiona Hayes | GP Principal, Student Health, University of Bristol |
| David Kessler | Senior Clinical Lecturer & Element Lead for Primary Care in Year 5 |
| Barbara Laue | Senior Teaching Fellow |
| Tricia Thorpe | Lecturer in Medical Education, University of Bristol |
| Angus Waddell | Consultant ENT Surgeon, Great Western Hospital, Swindon, ENT lead |

## Programme

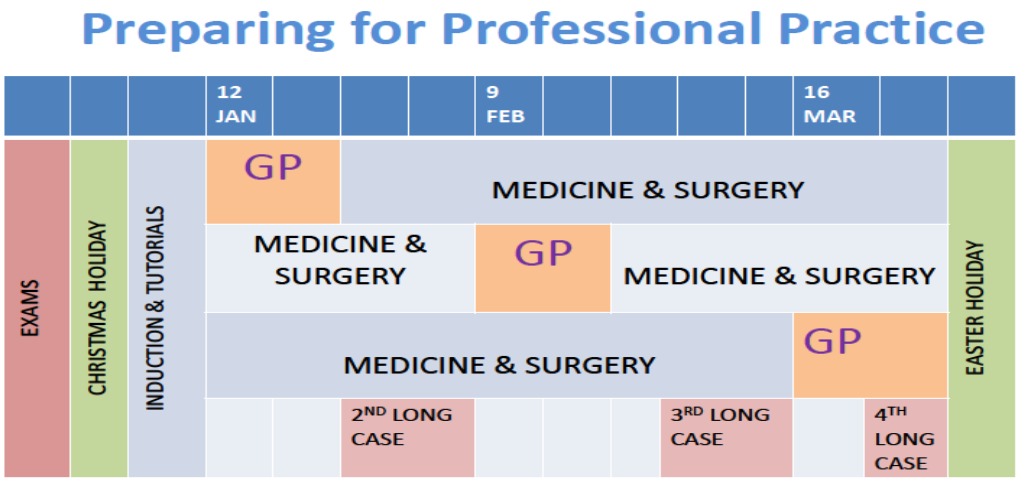
| | Morning | | |
|---|---|---|---|
| 09.00 | **Coffee and registration** | | Mel Butler |
| 09.30-10.00 | Welcome<br>Update for Year 5<br>Year 5 student feedback | | Andrew Blythe |
| 10.00 | Advanced consultation skills | Teaching ENT | Angus Waddel<br>Actors |
| 11.50 | **Coffee** | | |
| 11.20 | Teaching ENT | Advanced consultation skills | Angus Waddel<br>Actors |
| 12.10 | Is your student fit to practice? Mental illness,<br>fitness to practice and promoting mental well being | | Fiona Hayes |
| 13.00 | **Lunch** | | |
| | Afternoon | | |
| 14.00 | OOH experience | | Andy Eaton |
| 14.20 | Top Tips for Teaching PPP in Primary Care | | Small Groups |
| 15.20 | **Tea** | | |
| 15.40 | Supervision | | Tricia Thorpe |
| 16.20 | Conclusions and Q&A | | Andrew Blythe<br>Barbara Laue |
| 16.30 | Depart | | |

## Update on Year 5

The feedback from the students who went on their GP attachments last year was terrific. In a survey with a response rate of 62% the average rating of their learning experience was somewhere between very good and excellent. This is true across all the academies:




Students come to practices in pairs for 2 weeks. They enjoy working in pairs and they appreciate the welcoming and friendly atmosphere in the teaching practices. They like the fact that they see lots of patients with a wide variety of problems and feel that by consulting with patients their knowledge is affirmed and their confidence boosted. They come to the GP practices soon after sitting their final exams. The GP attachments are part of a unit called Preparing for Professional Practice.



The students like the supervision and one-to-one time that they have with a senior clinician. They like being given responsibility and doing student surgeries.

Some quotes from last year's students:

> "**Student surgeries** are a good way to **hone our skills** with patients without direct observation by a senior. It allows us to work to the end of a consultation, including management, and then discuss with the GP afterwards how our decisions compared to what they would have done in the same situation."

> "It is the only time in medical school that we are in the position to **determine management plans ourselves** and you can know the Oxford handbook inside out but when faced with that particular patient be completely unconfident on how to manage this".
>
> "More and more importance needs to be placed on encouraging us to make management decisions as it is the only way to learn effectively (and of course have it checked and confirmed by somebody else)."

Other benefits of this placement that students appreciate include:

- The opportunity to compare work in primary and secondary care
- The opportunity to re-consider general practice as a career
- The opportunity to learn about preventative medicine

Last year we asked the GP teachers to emphasise 5 themes during the attachment

- Prescribing
- Advanced Consultation Skills
- Complex Patients and Multi-morbidity
- *Unexplained Symptoms*
- *The Primary-Secondary Care Interface*

Students rated their teaching on all five themes highly. However, this year two themes (unexplained symptoms and the primary-secondary care interface) are being retired in order to make space for two new themes:

- **Urgent Care**
- **Consulting with Patients with Health Professionals**

The theme "Consulting with Patients who are Health Professionals" is an attempt to develop students' ability to care for themselves when they become doctors. Doctors are not always good at looking after their own health and sometimes take inappropriate short cuts when seeking help, such as prescribing for themselves. The main vehicle for teaching students about this will be a workshop in which they will participate in role play.

**News from the University**

Prof Hugh Brady has been appointed as the University's new **Vice-Chancellor** (the 13th). Like his predecessor he is a medic. The University is comprised of 6 Faculties. The MB ChB programme is delivered jointly by 2

Faculties: the Faculty of Medical and Veterinary Sciences and the Faculty of Medicine and Dentistry. The **Dean of the Faculty of Medicine and Dentistry** was Peter Mathieson (a renal physician); he moved to Hong Kong to be Vice-Chancellor there, and has been replaced by Prof Jonathan Sandy from the Dental School.

The outgoing Vice Chancellor launched a **Biomedical Review** – this involves re-organising the faculties and devising a brand new curriculum for our medical students. This curriculum will start in September 2017. In the new curriculum it's possible students will spend longer in primary care. At present they spend less than 10% of their time in years 3 to 5 in primary care.

Under the leadership of Prof Chris Salisbury the **Centre for Academic Primary Care** continues to thrive. It is one of a small number of academic units which collectively form the National Institute for Health Research School for Primary Care. Amongst its staff are 6 GP professors.

The student GP Society at Bristol is well established and has evening meetings to which GP are invited. It also organises an annual conference. The chief aim of the society is to promote primary care as a career.

Bristol Medical School's standing in the **National Student Survey** continues to rise – we are now in the middle of the NSS league table of the UK's 33 medical schools. If you look at the performance of doctors in post-graduate exams according to the medical school at which they qualified, Bristol graduates are up there with the very best.

The GMC's **4th Report on the State of Medical Education** was published last month; it showed that 31% of Bristol graduates entered the GP register and 19% were not on the GP or specialist register. Both figures are around the UK average. But these figures are for doctors who entered the provisional register from 1990-2001 and went onto the GP or specialist register by 2014. They do not include doctors from the new medical schools.

## Consulting with Patients who are Health Professionals

Delegates were divided into groups and were given the opportunity to role play the scenarios that will be given to the year 5 students in the workshop entitled "Caring for fellow health professionals and becoming the patient yourself". This session will explore the importance of self-care and building resilience throughout a doctor's career. Students will be invited to consider the difficulties doctors face when they become patients themselves, and how having a certain amount of knowledge can actually be unhelpful. During the session the students will do some role plays, using professional actors, to learn how to be a patient, accept advice from a colleague and manage colleagues who seek their advice and opinion. The session will focus on mental health issues, acknowledging them and addressing the stigma associated with them. Another part of the session will discuss being signed off work due to ill health and the impact this has on colleagues, and the difficult issue of presenteeism.

The scenarios rang very true and made us all think how the fact that we are doctors affects our behaviour when we become patients.

# Ten Top Tips for being a Patient (as a Physician) – Prof Aasland, Norway

1. Ask for help in time – don't wait too long.
2. Consult another doctor than yourself. AVOID self medicating
3. Ask the doctor to treat you as an ordinary patient.
4. Be sure that this is a normal consultation with proper records kept, etc.
5. Ask the doctor for all the information and advice that she/he usually gives patients with the same illness.
6. No shortcuts. No "corridor consultations". If you are hospitalized ask that ordinary routines and examinations be followed.
7. Do your best to follow the doctor's advice about sick-leave, diet, medication, etc. If you get little or no advice, be courageous and ask for it.
8. Inform your family and friends about your condition. (They will probably feel something is wrong.)
9. Inform your colleagues too, even if you are not on sick-leave. (Help destroy the myth that doctors can't get sick.)
10. Ask yourself why you got sick. Is there something in your lifestyle that should/can be changed?

# Top Ten Tips to doctors who have colleagues as patients (Prof Aasland)

1. The sick doctor is first and foremost a patient under your care. Treat the doctor-patient just like that.
2. Ensure open communication both ways between you and your doctor-patient, but remember he/she can be quite reduced by the illness.
3. Listen to the doctor-patient, but say clearly what you think is the best treatments, etc.
4. Do not leave it to the doctor-patient to make arrangements for examinations, tests, etc.
5. As with any other patient, write a case record, write prescriptions, and make an appointment for a return visit.
6. Do not hesitate to urge hospitalisation if you find it necessary. Follow your usual routine.
7. If the doctor-patient wants to be anonymous, not known as a doctor, respect this wish.
8. Give thorough information, not less than you usually give to your patients. Do not hesitate to repeat the information.
9. You are the one to make decisions as to when the doctor-patient should be discharged from the hospital, and when the sick-leave should end.
10. Remember: the doctor-patient is a person who is ill, (and no matter what his position may be in the medical hierarchy,) *you* are the doctor in charge.

## Supporting Students with Mental Health Conditions

Fiona Hayes gave a talk on her experience of caring for medical students at the University Student Health Service. She told us the mental health conditions are more common in medical students than they are in other students. She invited us to consider the warning signs of mental health problems amongst students. We came up with this list:

- Poor attendance
- Talking a lot about physical symptoms (hidden agenda) eg, IBS & insomnia
- General anxiety about scrutiny they are under
- "Not in gear"/ vacant
- Hung-over
- Unrealistic expectations
- Clues in de-brief after an emotionally charged consultation
- Excessive exam anxiety

Exam-related anxiety is very common. We learned that some students take beta-blockers before their long cases. Ritalin apparently is the new "smart drug".

Last year the GMC published guidance for medical schools on "Supporting Students with Mental Health Conditions" http://www.gmc-uk.org/education/undergraduate/23289.asp

Before the publication of this document Bristol was already doing a lot to support students with mental health problems. The University of Bristol is fortunate in having a Student Health Service that provides GP services to the entire student population within Bristol. For several years Fiona Hays and her colleagues were aware of the excess burden on mental health problems amongst the medical students, particularly in the later years of the programme. In order to meet the needs of these students the Director of the Student Health Service, Dominique Thompson, set up an eating disorder clinic, within the Student Health Service. Another innovative project that predated the GMC document was the provision of training in Mindfulness to students who were interested in learning about this.

Following the publication of this document Bristol Medical School set up a working party to see what more could be done to support students with mental health conditions. This working party grew over time to include the Director of Student Affairs and his deputy, a GP from the Student Health Service, two psychiatrists, two other GPs and the Student Support Advisor. The working group produced an action plan which has resulted in the following achievements over the last year

- All students have been issued with a handbook, based on the GMC document which aims to dispel common myths about mental health problems and tell students where they can seek help. Alongside this handbook all students have been issued with a credit-card sized document which contains the contact details of all the important sources of help including a GP practice in each of the academies outside Bristol.
- The training in Mindfulness has been rolled out to all students in year 2. This is just a taster but is sufficient to give them some basic skills.

- All students in year 3 have been invited to join Balint groups, led by psychiatrists, to support them during their first attachment in medicine and surgery.
- All staff (academic and administrative) were invited to half day training session on supporting students with mental health conditions. The event proved popular and may be repeated. The topics of the talks on this training session ranged from the neurobiology of adolescence to the practice of mindfulness. There were also small group sessions on exam stress, case studies and self-care.

## Teaching Out of Hours

The OOH ppt was attached to the email

8 GPs in the audience were doing regular out of hours (OOH) sessions – one only takes student with them.

**Barriers to teaching out of hours**

- A lot of us don't do it
- Paying providers
- Students have other things to do
- Is there much of a difference between nature of patients in and out of hours at treatment centre
- Is there more to be gained by going out with ambulance service?
- Complicated with different providers
- Safety concerns

**Teaching opportunities provided by OOH work**

- Supported home visits
- One- to-one time in car between visits, for teaching
- Working in an unfamiliar team
- Not having full set of patient's notes
- Telephone triage
- Giving emergency treatment
- Coping with chaos
- Deciding what needs to be done now (& what can wait)
- Building rapport from nothing
- Visits & telephone consultations are different

**OOH**

- Out of 30 GPs present, only 8 do or have done OOH within the last 3 years
- Only 1 (AE!) has taken a student with them
- In answer to "should OOH be compulsory for students" only 12 felt yes - I am unsure whether to broadcast this figure though as it transpired over coffee that some had obviously interpreted it as "if an OOH shift is compulsory for the student then THEY would have to take them and do the shift even if they didn't do OOH themselves. I will need to phrase this better next time

**OOH - Learning opportunities rarely encountered elsewhere**

- Giving emergency treatment
- Coping with chaos
- Deciding what actually needs to be done NOW (& what can wait)
- Building rapport with a new team and patient rapidly
- Supported visits (with 1 on 1 opportunity for debrief in the car) and telephone triage
- Coping without full set of patient records

**OOH - Barriers to providing students with OOH experience**

- A lot of us don't do it
- Paying providers
- Students have other things to do
- Is there much of a difference between nature of patients in and out of hours at treatment centre
- Is there more to be gained by going out with ambulance service?

- Complicated with different providers
- Safety concerns

## Teaching ENT

Ear examination from Year 3 to retirement from Angus Waddell ENT consultant, Swindon

See also separate PDF power point slides

**Introduction**

- Wash hands
- Introduce yourself
- Consent
- Ask patient which is worst ear

**Inspection**

- Inspect from the front – asymmetry
- Inspect both ears individually
- Scars, deformities, erythema, pinna lesions

**Otoscopy**

- Examine the better ear first
- Choose a 4mm otoscopy speculum. Hold the otoscope like a pen and not a hammer
- Pull pinna gently up and backwards when placing speculum in the ear. Get up close to the otoscope.
- Look at the external ear canal, the ear drum itself, and through the eardrum into the middle ear.

**Tuning fork tests** (if there is hearing loss, where is the problem?)

Use 512 or 256 Hz tuning fork

**Weber test**

- Tap the tuning fork on your elbow/leg to vibrate
  place it on the patient's forehead stabilising the head with your other hand
- Ask the patient which ear they hear it loudest in
- Weber localises towards a conductive loss and away from sensorineural loss

**Rinne test**

- This time, place the tuning fork alongside the ear canal
- Then place the base of the tuning fork on the mastoid tip, stabilising the head
- Ask the patient if it is loudest in front or behind
- Rinne test is loudest in front of the ear, a 'positive' test, if the hearing is normal or if there is sensorineural hearing loss. It is loudest behind the ear, 'negative', if there is conductive hearing loss

**Whisper test** (if there is hearing loss, then how bad is it?)

- To test the left ear, mask the right ear by pressing on the tragus
- Whisper two digit numbers into the unmasked ear, i.e. sixty three
- Whisper quieter and quieter until the patient can't hear you
- Repeat for the other ear
    - Loud shout is 110dB
    - Speaking voice approx. 60dB
    - Quietest whisper is approx 25 dB

# Tops Tips for Teaching Students in Year 5

**Notes from the group of GPs who are new to teaching students in year 5**

*What has motivated you to take on this teaching?*

I want to change my pattern of working week/ introduce variety to day
If fits well with post-graduate training
It will help to me keep up-to-date and in touch with education
Others in my practice have encouraged me to do this – in keeping with the practice teaching ethos
I want to pass on my skills and knowledge to the next generation

*What have you learned today that you want to put at the heart of you year 5 teaching?*

Looking after the health of students
Making my teaching fun
Getting students to see more patients/do more consultations
Offering the students exposure to out of hours care

**Planning the timetable for a pair of year 5 students**

Send them an e-mail. Introduce yourself. What would they like to get out of the attachment? Are there any practical procedures that they still need to practice and get signed off in their Consultation & Procedural Skills (CAPS) logbook?
Timetable will be dictated by doctors & rooms available each day
Lead GP should be doing about 1/3$^{rd}$ of the teaching
Learning needs analysis on first day
Each student must have a student surgery each week (other student can observe & give feedback -they can alternate)
Need debrief session on last day & set aside 15 min for students to sit in front of PC & complete feedback form

**Model for Student Surgery –** repeated every 70 minutes

| *Time* | *Student* | *GP Teacher* |
|---|---|---|
| 09.00 | Patient 1 | Patient 2 |
| 09.10 | | Patient 3 |
| 09.20 | Student & GP review patient 1 together | |
| 09.30 | Catch up time | |
| 09.35 | Patient 4 | Patient 5 |
| 09.45 | | Patient 6 |
| 09.55 | Student & GP review patient 4 together | |
| 10.05 | Catch up time | |
| 10.10 | | |

Or, GP might sit in & observe the whole student surgery

**Booking patients into student surgery**

Tell patients it is student surgery and that GP will review them with student at the end
If surgery is not filled, you can pick off patients from duty doctor's urgent surgery.

**Let them write in the patient notes**
Make sure they know how to access the computer notes & have a password
Let them practice writing the computer notes after each consultation.

**Authentic tasks**
Get students to do authentic tasks & help them prepare for their long case examinations
Ask them to do full history & examination of new patients in nursing homes
Ask them to do full review of patients with long term conditions (eg COPD & diabetes)

**Ensuring that the 5 themes are addressed:**

**1. Prescribing**
Ask them to look at prescriptions which need review – gives them practice at looking things up in BNF - they have to do this for their Prescribing Safety Assessment

**2. Complex patients & multimorbidity**
Ask them to visit patients at home who need review
Let them practice doing long cases

**3. Urgent Care**
Pick out the reports from Out of Hours service. Ask student to review one or two of these cases

**4. Advanced consultation skills**
Let them experience telephone consultation. Buy a dual headset

**5. Consulting with patients as health professionals**
Flag this up within the whole primary care team and ask them to tell student about a patient they have seen when it became apparent that the fact they were a health professional . How did this affect the consultation?

**Notes from the experienced Year 5 GP teacher groups**

**Year 5 teaching highlights**

- They are focused and really engaged and thinking about the future
- Watching them consult
- Watching them develop confidence
- Being there when they 'discover that 'they are doctors' (using their mobiles to find out whether they have passed finals)
- Seeing 5th years in control of their learning

**Year 5 'negatives'**

- Students can be very variable
- Get rid of CAPS logbook

**Authentic tasks**

- Send out the student when you receive an 'urgent' visit request. Vet the call – how urgent is the problem. Sending the student out means the patient gets attention sooner and the students gets experience of front line responsibility. You need to know your students – could they cope with it?
- Patient in surgery wanting to be seen immediately – get your student to see them first
- 'Long case' experience – could see patients who need sorting out or patients where you need more information. New patients in NH for example
- Students to see patients we don't know
- Students to see patients from urgent surgery
- Carry out a learning needs analysis – what skills do they need to be an effective F1?

**Teaching prescribing**

- Medication reviews with and without patients
- Review medication for NH patients
- In consultations, ask them to write the prescription
- Use polypharmacy lists and ask students to work out what is wrong with the patient
- Organise is session in the pharmacy for students – to make up prescriptions, Dossette boxes under supervision of pharmacist

**Keeping up to date with changes in curriculum / what do you like most**

- Handbook
- Ask the students what's new!
- Attachments are good when they are keen, knowledge generally good
- Working in pairs allows a degree of autonomy

**What's expected during their attachment?**

- Themed surgeries - very difficult to execute - keep a list in your head of the key themes and be on the lookout for opportunities, ticking off as you go. review at one week and engineer some patients if one theme likely to be overlooked
- Tailor the themes to their interests
- Prescribing teaching - spend time with community pharmacist and prescribing advisor
- Consult in pairs - can be crowded, read the handbook, ensure patients are aware when they check in, consent issues
- Establish email contact beforehand - any requests, special considerations
- OOH / urgent care teaching - read the OOH / 111 reports on patients they have seen by day, use local resources / services e.g. SWINDOC daytime visiting service
- Primary secondary care interface - use discharge summaries, referrals - get them to dictate a referral

**Motivation pre elective**

- Good that they are in pairs so can motivate each other
- If one doesn't know something use them both to find it out
- If they want to be neurosurgeons and are disinterested in GP stuff - play to their strengths and find them some GP neurosurgery - that way they will leave feeling that there was something interesting in GP
- Give them more responsibility (safely), more surgeries on their own with you checking after each patient
- Even better if you can find a long case related to their interest to let them present to you

- Take every opportunity to fill out their CAPS logbook, tailor opportunities
- Take them on home visits, once established the situation is stable / safe can leave them there to do a longer
- Clerking" and collect them later but keep in mobile contact

**Long case practice**

- Do visits
- NH patients
- Frequent attenders
- Patients with complex problems
- Lonely patients

**Keeping the practice engaged with teaching (esp. when doctors away / off sick / not replaced)**

- If rooms / space is an issue stagger surgeries all the way through the day
- Use trainees as teachers
- Maximise opportunities to involve them in learning opportunities which tick boxes for the practice - QOF points, patients with multi-morbidity
- No major risks reported

**Student welfare**

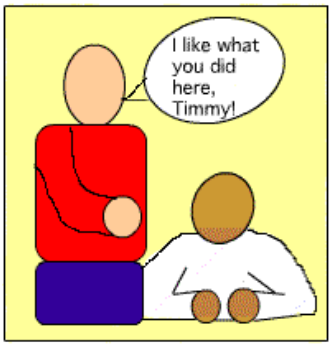
- Get to know your students
- Check student is not distracted by other issues at the start of the placement
- Role model work – life balance
- Don't have to be perfect
- Ok to look things up
- Students love it if the receptionists make them tea (and vice versa)

## Supervision of Year 5 students

- Create an atmosphere where it is ok not to know everything
- Initial assessment of your students is important
    - Assess their history taking, consultation, examination and note keeping skills
    - Consider reliability of information gathered by the students (history and examination findings). What do you need to repeat?
    - Have the students missed any cues? Have they listened carefully to the story?
- Tailor teaching, involvement in consultations to the students ability and personality
- Freedom to learn versus close supervision that keeps things safe for patients
    - Always consider patient safety
- Consider how you gain patient consent for student consultations and involvement
- How to handle distress inadvertently caused by the student
- Think about time management – teaching and consulting
- Make sure your colleagues and staff know that you are teaching

## Educational Hints & Tips

## Giving oral feedback




**Feedback should be**

- **Timely** (as soon after the event as possible)
- **Constructive** (identify strengths as well as making recommendations for improvement) i.e. support but also challenge
- **Specific** (NOT "That was quite good" BUT 'It was good that you gave the patient time to answer that question …"etc.)
- **Descriptive & objective** ('the lens was upside down' NOT 'you bungled the last bit')
- **Address *behaviour* not person** (NOT "You were unsympathetic there", BUT "You went straight into the 'bad news' without a warning…")
- **Normalise difficulties** (That procedure is tricky … when I first did it I felt … and I…)

**Try, too to help improve the student's ability to self-assess and to take responsibility for their learning:**

- "What did you think was good? … What might you do/say differently next time?"
- "How are you thinking of working on this aspect/skill?"
- "What process do you go through when trying to learn …?" "Can you think of other ways that might be useful? I like to … "
- What type of learner are you? More reflective and theoretical or an activist or pragmatist? How might that affect how you study?
- Do you like reading or viewing as a learning medium or do you like discussion? Have you tried discussing with fellow students?

**The 'Chicago approach'. General principles for providing effective feedback.**

- Review your goals and expectations of the student (refer to learning objectives set)
- Give interim feedback in light of these.
- Ask the student to evaluate his/her performance before giving your feedback.
- Focus feedback on the student's behaviour, not on their personality.
- Give specific examples to illustrate your observations.
- Suggest specific strategies by which the student might improve his/her performance
- Review your goals and expectations of the student

.

Adapted from: Brukner et al (1999*)*

**Various other feedback formats** are discussed in: Chowdury & Kalu (2004*):Learning to give feedback in medical education* The Obstetrician & Gynaecologist, 6: 243-247

**Some further useful ideas** can be found in: Brukner et al (1999) *Giving Effective Feedback to medical students: a workshop for faculty and house staff,* Medical Teacher, 21:2, 161-165 See the following example from this paper.

***The Student Who Disputes Feedback***

*Key observations*

The student is very confident in his clinical abilities. However, fund of knowledge is spotty and he demonstrates trouble synthesizing data. He has been argumentative with others during rounds, and seems to undercut fellow students and house staff.

The student's write-ups and presentations can be disorganized. He has told others he expects `Honors'.

*Suggested feedback strategies*

- Acknowledge achievements, but note relative lack of clinical experience.
- Point out observations about areas for improvement with specific examples of performance deficits
- Be assertive in your critique; stand behind your judgment
- Point out that teamwork is essential to the achievement of student's goals
-

**Post-script**

If you are required to write down feedback for an observed session, try to make it concise but do be aware that it will not be accompanied by any mitigating facial expressions on your part or added explanations – so read it back to yourself as if you were the student.

A meta analysis … investigating what made a difference to student achievement found feedback to be the most powerful single influence (Hattie 1987) and in Australia, work by Ramsden (Ramsden 1991 and Ramsden 1992) has shown that "whether or not higher education teachers provide helpful feedback" correlates more closely with student performance than anything else they do.

**Hattie JA** (1987) Identifying the salient facets of a model of student learning: a synthesis of meta-analysis. International Journal of Educational Research, **11**, p187-212

**Ramsden P** (1991)A performance indicator of teaching quality in higher education: the course experience questionnaire. Studies in Higher Education, **16**, 129-150

**Ramsden P** (1992) Learning to teach in higher education. London: Routledge.

# Workshop evaluation (15 replies)

## Section 1: Your practice

| **1.** Which Academy is your practice attached to? | | | |
|---|---|---|---|
| Bath: | | 6.7% | 1 |
| Gloucester: | | 13.3% | 2 |
| North Bristol: | | 33.3% | 5 |
| South Bristol: | | 13.3% | 2 |
| North Somerset: | | 0.0% | 0 |
| Somerset: | | 13.3% | 2 |
| Swindon: | | 20.0% | 3 |

| **2.** Which year do you teach in? | | | |
|---|---|---|---|
| Year 4: | | n/a | 11 |
| Year 5: | | n/a | 13 |
| Starting to teach Year 5 after xmas: | | n/a | 1 |
| Not teaching students but planning to start: | | n/a | 1 |
| Other *(please specify)*: | | n/a | 2 |

## Section 2: Please rate the following workshop sessions

| **3.** Welcome, update and student feedback | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 6.7% | 1 |
| Good: | | 86.7% | 13 |
| Excellent: | | 6.7% | 1 |

| **4.** Advanced consultation skills | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 6.7% | 1 |
| Satisfactory: | | 0.0% | 0 |
| Good: | | 66.7% | 10 |
| Excellent: | | 26.7% | 4 |

**'Great to try out these scenarios, actors brilliant as usual'**

| **5.** Teaching ENT (Angus Waddell) | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 0.0% | 0 |
| Good: | | 20.0% | 3 |
| Excellent: | | 80.0% | 12 |

**'Great concise explanations of conditions and engaging teaching style'**

| **6.** Mental illness and fitness to practice (Fiona Hayes) | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 33.3% | 5 |
| Good: | | 46.7% | 7 |
| Excellent: | | 20.0% | 3 |

**'Interesting, good speaker'**

| **7.** Out of hours experience (Andy Eaton) | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 26.7% | 4 |
| Good: | | 66.7% | 10 |
| Excellent: | | 6.7% | 1 |

**'Very engaged enthusiastic speaker'**

| **8.** Top tips for teaching PPP | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 20.0% | 3 |
| Good: | | 80.0% | 12 |
| Excellent: | | 0.0% | 0 |

| **9.** Supervision (Tricia Thorpe, TLHP) | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 20.0% | 3 |
| Good: | | 60.0% | 9 |
| Excellent: | | 20.0% | 3 |

**'Energetic and good as ever - great choice to finish off a long day and keep everyone's energy levels up'**

| **10.** The workshop overall | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: |  | 13.3% | 2 |
| Good: |  | 60.0% | 9 |
| Excellent: |  | 26.7% | 4 |

**'Thank you for another great day, very worthwhile and great to meet colleagues new and old who share a common interest'**