



# **SEEDLINGS....**

## **A Guide to Self- directed learning groups**

by  
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# **Self directed learning groups: A Guide to making them successful**

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*June 2011*

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## **A personal introduction.**

I first started facilitating the creation of SDLGs in 2005 in my role as GP tutor for sessional GPs for the Northern deanery. Like many activities I had undertaken as a tutor it required a degree of experimentation and a leap of faith. After picking the brains of my colleague Rebecca Viney in London I decided to hold an event for people to meet and find out about groups. I encouraged them to identify themselves by geographical area and sent them off with what I felt was a not very well defined “task” into (geographically determined) break out groups to talk more about SDLGs. The year that followed everything went quiet and it was only through my informal “grapevine” and carrying out appraisals that I found out, that despite failing to reply to my follow up emails, attendees had in fact gone on to form SDLGs.

I was so encouraged by this that I carried out a second round of electronic facilitation and further networking events. I use our local sessional GP group as a mail base to send out an expression of interest form where GPs could record their location, working status, and aspirations from a group and contact details. I compiled the responses and sent a single document back round to the respondents. I also encouraged individuals who contacted me through the sessional GP group to use its internal email group to find others willing to form groups.

Another round of positive feedback came when we ran a project funded by the Royal Medical benevolent Fund where SDLG group members came to share their experiences in focus groups regarding the benefits the groups offered and the role my initiative had had in their formation. Having been in Newcastle for a long time I am fortunate to have an extensive professional network and my subjective impression is that 100% of retainers and appraisees I see are in SDLGs and probably 90% of the sessional GPs I meet outside this are also now in groups. It was exciting to see the impact of my efforts. The ripple effects of this growing wave of group formation has continued to stimulate further group activity.

From my own perspective, my own group has been crucial to my own CPD, but to say more would be to betray confidentiality...

I took our initial findings to a national conference for educators involved in sessional GP CPD a few years ago and there was lots of interest. Our recent RMBF funded project (“Support for Sessional GPs”) indicates that tutors across the country have some involvement in facilitating the creation of these groups and now the RCGP as part of its First5 initiative is also promoting what it calls “First5 CPD groups” though I have my reservations about groups with a narrow range of experience as I feel diversity enriches these groups. The VTS however continues to generate important groups, which form nubs for new groups to grow as their members move away, have children, go on maternity leave, etc.

I remain extremely grateful to the person who first set me on this journey- Rebecca Viney, from London Deanery.

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## **What are self directed learning groups (SDLGs)?**

These are groups of GPs **who meet regularly to address their shared needs for education and peer support, without paid or unpaid external facilitation.** They follow a long tradition of group learning in general practice, which has over the years been referred to as “young practitioners groups”, “MRCGP study groups”, Balint groups and mentoring groups the latter two having a more specific focus on communication (former) and support (latter). **The self-directed element** refers to the fact that the learning content and methods are both determined and delivered by group members.

Recently, **appraisal** has also become a driver for the creation of SDLGs, as a forum in which isolated GPs can discuss significant events and formalise their education. This has come about on the back of increasing evidence that sessional GPs struggle more than practice based GPs with the processes of evidence collection for appraisal<sup>i ii</sup>.

There is an increasing body of evidence that sessional GPs are deeply affected by professional **isolation**. Practitioners may feel isolated at work either because there are infrequent opportunities for meeting with others during working time, because they work as a locum, or they are not at work when practice meetings occur, or they are the only salaried doctor in their practice. Maslow said that according to a “hierarchy of needs” individual performance is improved when people have a sense of “belonging” to a social network. To read more about the effects of isolation please have a look at the RMBF funded report “*Support for Sessional GPs*”.

Typically these groups also have the following features:

1. Non hierarchical with no appointed leader, though some may sometimes have an individual who may take more initiative with organisation.
2. Autonomous- so only accountable to itself and its members.
3. Non- funded
4. Clarity about membership and who belongs, as opposed to functioning on a drop in basis.
5. Rotational division of educational content- for example preparation of topics or presentation of cases.

## **What are the benefits of SDLGs ?**

1. Better retention of CPD- as discussion around topics and their relevance and implications for day to day practice significantly increases the connections between new facts and existing knowledge structures thereby improving retention.
2. Efficiency- rotational allocation of content preparation means that each member benefits from many hours of preparation and reading done by other group members, not just by themselves. Everyone benefits from the collective efforts of the group rather than each practitioner having to be totally self reliant to keep up to date and feeling overwhelmed by the volume of new publication guidelines and directives published.

*Self directed learning groups : a Guide to making them successful.*

3. Benchmarking- Many areas of our day to day practice cannot be encompassed by evidence and in a court of law it is how we compare to peers which may be the ultimate test of our professional competence (Bolam's law). For this and other reasons, comparing what we do with colleagues has many benefits.
4. Motivation- The regularity and rotational responsibility for content creates external motivators for educational work which for some people (driven more by external than internal motivators) helps keep them focused.
5. A forum for discussing significant events, complaints and difficult professional issues including employment issues.
6. Supporting evidence collection processes for revalidation by producing either minutes, or Significant event reports or topic summaries. They can also be used for peer feedback.
7. Tricky subjects are better dealt with by talking: There are particular topics which are difficult to get to grips with without discussion and exploration e.g. policy changes in the NHS such as practice based commissioning, ethical problems, end of life care, do not resuscitate orders
8. Peer support in discussing personal professional dilemmas such as interpersonal difficulties, employment issues, complaints, and issue relating to getting work life balance for example.
9. Retention. There is some evidence from London that small group learning aids retention in areas which struggle to recruit.





## Comparing different types of practitioners groups

	<b>Task-</b> <b>what</b> the groups wants to achieve	<b>Group maintenance:</b> <b>How</b> the group needs to work to achieve its task
<b>MRCGP study group</b>	<p>The aim is to pass the exam by sharing out the “research work” of finding out the latest developments in various “hot topics”.</p> <p>The focus is education / fact based rather than personal/experiential.</p> <p>Time scales and “syllabus” are externally imposed.</p> <p>The idea is that the group benefits from collective academic knowledge.</p>	<p>Ground-rules are simple and focus mainly on ensuring each member delivers their part of the syllabus so that all benefit equally.</p> <p>Confidentiality not a strong feature nor is constancy of membership as long as the work is covered. Building up trust is not a high priority as the task is largely “impersonal”.</p>
<b>Self directed learning group</b>	<p>The task is broadly educational but is defined by the members not external organisations. It needs to be defined through sensitive discussion and consensus building to ensure that it meets the needs of all members.</p> <p>Education in its wider sense may include not just new developments but reflecting on learning from personal experience (e.g. problem patients, significant events, cases, and even complaints or interpersonal professional issues) - hence trust and ground-rules more important.</p> <p>The “task” (individuals and group priorities) may change over time- hence evaluation is important.</p>	<p>Ground-rules are more important including trust, confidentiality, commitment to the group over time, contribution (equity of). Membership stays relatively constant and new additions require the agreement of the group.</p> <p>Communication skills and emotional intelligence are more important both to help reach consensus about the aims (task) and to help reflect collectively (evaluation and feedback) on whether the group is meeting everyone’s aims.</p>
<b>Action learning sets</b>	<p>Action Learning Sets (ALS). ALS are groups which attempt to learn from tackling real work (and life) issues using a series of problem solving techniques. By establishing firm ground rules and working together in a small closed group, high levels of trust are built over a period of time.</p>	<p>Ground rules are extremely important and more explicitly defined and these work best with around 5 members. Investment is needed in building trust for the Set to work well. Members commit to the set over a period of time and membership remains constant.</p>

		Both of these aspects benefits from the input of an external facilitator initially to establish a safe and supportive learning environment. Effective listening, empathy and resort to problem solving models are key ingredients.
<b>Co-mentoring group</b>	Co-mentoring is a form of mentoring based on a model similar to co-counselling, where two or sometimes three people meet together on a regular basis and use protected time to 'mentor' one another. As occurs for SDLGs and ALS the agenda is set by members who take it in turns to be mentored and co-mentored and topics include clarifying and exploring difficulties at work; looking at ways of solving problems; discussing patients in depth; complaints; practice relationships; keeping the home/work balance .	Members meet in pairs or threes approximately once a month for a couple of hours, taking turns to be mentor and mentee. This involves providing good active listening, facilitatory questioning, support and challenge. An advantage of co-mentoring is that it is a reciprocal, non-hierarchical model.

## Features of successful groups:

There are a range of factors which have been identified as being important to the success and sustainability of learning groups. This is based on the RMBF report "Support for sessional GPs".

### **SEEDLINGS:**

**Size**

**Evaluation (=review)**

**Education**

**Date,**

**Local**

**Infrastructure (=planning)**

**Networking = support**

**Ground Rules**

**Shared (aims, role, commitment)**

### **Key ones:**

1. **Size:** thought to be ideal between 6 and 8 members. This is because scheduling dates becomes harder with smaller groups. In larger groups it is possible to fix a set date of the month and as long as members attend 2/3 of meetings the group will have its own momentum and no-one need feel bad if they can't attend occasionally. It rare that meetings have to be cancelled due to non attendance in larger groups. The down side to larger groups it is harder to develop trust and rapport.
2. **Geographical spread:** As most groups meet in rotation round members houses, and most meet after work, travelling time is important and therefore members need to be close to each other such that the commute time is not excessive (<15min).

3. Shared aims amongst members for the group. There needs to be consensus about the purpose of the group and the preferred activities or method and balance of education to social activities and peer support.
4. Explicit ground rules (of which more below).
5. Planning of activities.
6. Review of satisfaction with and efficacy of activities.
7. Set monthly date to reduce time spent on coordinating diaries.
8. Supportive ethos, with where there is trust and confidentiality.
9. Commitment to the group (time, attendance, preparation of content).

### **Pause for thought...**

It is important to remember how “life” (by which I mean work, travel, parenthood, leisure) can get in the way of attending evening meetings for CPD. This is why having a group with enough numbers to allow you to miss the odd month because life is just too busy is important. With low numbers there is a risk that your inability to attend may mean cancelling the meeting for everyone else and commencing diary discussions all over...

### **Additional factors:**

1. Similarity of working status (.e.g. newly qualified or all sessional).
2. Willingness to share.
3. Motivation.
4. Flexibility to run the group according to members’ needs and preferences.
5. Autonomy from other organisations.
6. Non-hierarchical, democratic.

Here are some of the things group members said as part of the recent focus groups which were held in the northern deanery as part of the RMBF project:

*"I think it's important as well to have people who you do like...to be honest, that will otherwise deter you from attending. So I think it probably important to have people that you do like and you can have a chat with and you can speak openly with. And that you can trust...I think that **if you have trust and commitment within the group then the rest of the learning just happens** by the by really"*

*"...apart from the clinical stuff, it's nice to have some...a support network. A co-mentoring network, I suppose, where if there's been an issue at the practice or if there's been an issue with a patient or a complaint or a worry, then we can share that with our colleagues and peers and just make ourselves feel better"*

*"I think the balance, it's getting the **balance right** between **having the support** and mentor type thing and **actually doing** kind of quite perhaps a bit more formal about **topics** and making sure they're learning stuff" (ID 27)*

*"I mean our group works well and I think I wouldn't want it formalised in any way because then I'd feel you were doing it for somebody else. Whereas what drives us is that we're doing it ourselves" (ID 21)*

*"I don't think you can have a blanket, sort of, 'This is how a group should run and this is what you should do'. I mean it's **sort of up to the individuals how their group runs and what works for all of us isn't going to work for somebody else**" (focus group 4)*

*"... it [review] can be very structured or it might be not so structured. I just think the main thing is that you have a general **time to talk about what people feel is working and what isn't, because we've definitely sort of modified things as we've gone along as a result of those**"*

## **What are Ground rules?**

These are rules members agree to abide by as a condition of membership of the group. Usually they need unanimity and are agreed at meeting where all are present, usually the first (founding meeting) or at subsequent review meetings.

Smaller groups often need less explicit ground rule as they can be more cohesive and tend only to meet when all are present so there are no issues around decisions being taken in the absence of certain members.

- Minimum number of meetings members must attend
- How new members are recruited, and how this is agreed
- How dates of meetings are set
- Behaviour:
  - punctuality, listening , not interrupting,
  - not changing the agreed agenda without consensus,
  - confidentiality,
  - acceptable sources of information when preparing a topic
  - expected contribution into “content” rota

## **What sort of activities or aims do Self Directed Learning Groups report?**

- a) topics prepared in advance by group members
- b) discussing PUNS and DENS
- c) discussing complaints or SEAs
- d) audits
- e) journal papers/articles
- f) clinical and non-clinical dilemmas
- g) sharing learning points from courses attended by members
- h) case discussions
- i) employment and workload issues
- j) invited speakers
- k) “turn up and share”- no pre-agreed topic, each members just bring something along to discuss and share, with varying amounts of preparation needed.

There is clearly a spectrum in terms of the amount of planning which goes into individual meetings, Most groups seem to either

operate some form of rota for preparing content so that the responsibility for presenting is shared out and not too onerous, or alternatively have all members bringing something along but with much less preparation required (“turn up and share”). There was a suggestion in the RMBF report that less structured groups, where there was a less clear commitment, were at greater risk of losing momentum and ceasing to function. There is clearly a balance to be had between the SDLG becoming yet another burden and pressure on time, and it actually being a reinvigorating way to gain support and lighten the load of keeping up to date.

### ***Journal Rotas***

Many GPs feel overwhelmed by the burden of keeping up to date with essential developments like NICE guidelines, local guidelines, prescribing changes and learning needs arising from difficult, unusual or new (for them) cases. One group reported dedicating meetings in alternative months to presenting any items of relevance to General practice appearing in the BMJ. The BMJ issues were allocated to all 8 members for 6-8 months at a time and at “BMJ” meeting each attendee would have around 8mins to present the keys points in their issue (occasionally they might have 2 issues) of the BMJ. Summary handouts were presented. Members were encouraged to find that when they attended Hot topics or GP update courses they had significant knowledge of most update topics being presented at the course- a very affirming experience for them. Some groups are doing this and including also the BJGP and other publications like DTB, CMO alerts etc. This approach has the benefit that:

1. There is comprehensive coverage of most of what is new for General practice
2. Each member is only required to read in depth a fraction of all that is published
3. The group discussion provides more memory reinforcement than simply skim reading everything yourself
4. Summaries provided by members contribute to the appraisal folder
5. The relevance and impact of new guidelines can be discussed and placed in context of day to day practice

Members who do not have much experience of reading journals, possibly due to being older and not having sat the MRCGP with its

hot topics evidence based paper, may find the prospect of reading and summarising journals daunting and may need encouragement, support and guidance from other members who are more experienced in this.

**Pause for thought:**

Members will have varying skills in researching topics- the group has a vital role in supporting those who feel less skilled and confident at this.



## **Do SDLGs need a leader ?**

The experience of the RMBF focus groups is that most groups are non-hierarchical, however many recognise that there is often one person who is more pro-active at making meetings happen specially in groups where there isn't a set day of the month for meeting.

Individual meetings need a chair simply to facilitate time keeping specially when there are multiple components to a meeting (e.g. social, educational, planning and or reviewing).

Chairing skills are particularly important at the founding meeting and review meetings. This is because these address fundamental aspects of the aims of the group, ground-rules and planning of activities. In a badly chaired meeting more vocal members, including a non-neutral chair can end up exerting too much influence and determining an apparent "conclusion" for which there is not sufficient support. As the success of the groups relies on continuing input and commitment from all members, if some members don't feel represented by the conclusions of the meeting they are less likely to contribute towards the achievement of stated aims. The chair plays a crucial role in ensuring everyone makes their views heard, that discussions are balanced and that where possible outcomes have the support of all members not just the majority. Where there are significant differences in expectations or preferred style, groups may have to consider the difficult decision to split.

## **First meeting of an SDLG: “Setting up”.**

- 1) One person needs to be facilitator to call the group to order, manage time and tasks, summarise discussions, and bring the group to a close.
- 2) Start by introductions to find out what attendees reasons are for joining a group: what their background is and what they want out of the group. The following exercise can achieve this as well as initiate important ice breaking and listening skills. Pair off and one person explains to their pair what their professional circumstances are and what they would like out of the group. This is repeated with reversal of roles. Each person introduces their pair to the group by reporting back what they have been told.
- 3) Aims of the group: Initially with a “brainstorming” style, attendees make suggestions about what they would like the purpose of the group to be with specific suggestions. At this stage none of the suggestions are evaluated by anyone- this is to encourage free flow of ideas and overcome inhibitions. (See list above). After this everyone is invited to comment on which of the suggestions made they would like to pursue.
- 4) Ground rules (see section above) specially expected commitment of members, how new members are recruited and agreed (not drop in), whether group is “closed” to new members; how decision making is done (at each meeting, or planning meetings which all attend).
- 5) Methods of groups (cases, journal papers, pre-prepared or “turn up and share”).
- 6) Housekeeping: what are the preferred time for meetings and setting dates for the next 4 meetings? It is worth being aware that setting dates by consensus can be extremely time consuming and soul destroying! Having a set monthly date removes this task and though it may mean more meetings a year than members want to attend if the group is large enough it allows extra flexibility for members not to attend when they feel it would be difficult to fit in. In contrast working by ad hoc dates means someone needs to be responsible for getting dates and taking decisions sometimes regarding dates which are not convenient for all.
- 7) Planned topics for next 6 months and date of next review or social meeting.

## **Topic based meeting: example format for 2 hour meeting.**

- 1) Nominate someone to keep time
- 2) Allow 15-20mins for warm up- usually this is for getting teas and coffees and allows latecomers to arrive.
- 3) Education time : 60-90minutes including discussion and questions. The number of topics and presenters will vary.
- 4) Review of how the meeting went using rules of feedback.. Personal evaluation for the meeting using descriptive non judgemental statements e.g. I found David's presentation really clear and the discussion really helped me understand the topic better.
- 5) Plan topics and contents of next meeting (s) (where this hasn't been done on a six monthly cycle).

## **SDLG review meetings.**

The review meeting is key to maintaining the health of the group. An honest and sensitive exploration of members' feelings and experiences about the group will ensure active ongoing commitment from all members to the activities of the group.

Unlike normal SDLG meetings, the review meetings does require careful facilitation (not just time keeping) to ensure that all have the opportunity to speak openly, and decisions taken have wherever possible unanimous support. A brain storming approach of generating lots of ideas first without evaluation, can help to avoid the discussion become narrowed down too early on (see also section on "groupthink").

The facilitator needs to remain impartial/neutral and resist the temptation to steer the outcomes of the discussion. The role of the facilitator is to help set a structure to the discussion, encourage participation by all present, summarise the discussion in its component stages and try and capture suggested outcomes for action ideally where appropriate with nominated individuals taking on responsibility for delivery.

In order to encourage and facilitate participation by *all* members in the feedback and evaluation process it may be helpful initially to get people to work in pairs. This may help the more reticent members to express their thoughts.

1. Ask what is going well?
2. Frequency, date, timing of meetings
3. Venue
4. Attendance : does the group have problems with attendance, if so what are the reasons and what can be done. Are some less satisfied and see the meetings as less useful; are some members only able to commit to 6 meetings a year; does the group need to be larger to ensure sufficient attendance.
5. Range of activities- what methods have worked well and what has worked less well. What new methods do members want to try (perhaps on recommendation from other groups)
6. How topics and activities are selected
7. Sharing of workload
8. Handouts- are these useful; which ones have been most useful
9. Balance of education to social
10. Other organisational stuff: named roles
11. Group membership: is the group large enough. Does the group need more members, How will the group decide who to invite.

## **What is “groupthink” and why should we avoid it ?**

Groupthink is a form of group behaviour which can lead to closed-mindedness, jumping to conclusions, and failure to rethink strategy when the group is failing or failure to look at alternatives.

*“Groupthink, a term coined by social psychologist Irving Janis (1972), occurs when a group makes faulty decisions because group pressures lead to a deterioration of “mental efficiency, reality testing, and moral judgment” (p. 9). Groups affected by groupthink ignore alternatives and tend to take irrational actions that dehumanize other groups. A group is especially vulnerable to groupthink when its members are similar in background, when the group is insulated from outside opinions, and when there are no*

*clear rules for decision making.” Taken from Janis, Irving L. (1972). Victims of Groupthink. New York: Houghton Mifflin.*

A number of “symptoms are described

1. Illusion of invulnerability –Creates excessive optimism that encourages taking extreme risks.
2. Collective rationalization – Members discount warnings and do not reconsider their assumptions.
3. Belief in inherent morality – Members believe in the rightness of their cause and therefore ignore the ethical or moral consequences of their decisions.
4. Stereotyped views of out-groups – Negative views of “enemy” make effective responses to conflict seem unnecessary.
5. Direct pressure on dissenters – Members are under pressure not to express arguments against any of the group’s views.
6. Self-censorship – Doubts and deviations from the perceived group consensus are not expressed.
7. Illusion of unanimity – The majority view and judgments are assumed to be unanimous.
8. Self-appointed ‘mind guards’ – Members protect the group and the leader from information that is problematic or contradictory to the group’s cohesiveness, view, and/or decisions.

Some initiatives which can counteract groupthink include:

- 1) The leader assigning the role of critical evaluator to each member.
- 2) The leader should avoid stating preferences and expectations at the outset.
- 3) Each member of the group should routinely discuss the groups' deliberations with a trusted associate and report back to the group on the associate's reactions.
- 4) One or more experts should be invited to each meeting on a staggered basis. The outside experts should be encouraged to challenge views of the members.
- 5) At least one articulate and knowledgeable member should be given the role of devil's advocate (to question assumptions and plans).
- 6) The leader should make sure that a sizeable block of time is set aside to survey warning signals from rivals; leader and group construct alternative scenarios of rivals' intentions.

## **New Members**

As meetings often occur at members houses it is important that all members are in agreement about taking on a new member. Ideally a new member should:

1. Be discussed as a possible new member by the whole group before joining.
2. Not be working at the same practice as other members.
3. Not be a specially close friend of another member as they may be perceived to cause an imbalance in allegiances.
4. Join at a review meeting where planning and review of ground-rules is taking place to ensure that they have an opportunity to influence these and are therefore fully committed to them.
5. Be given a clear trial period in which to decide whether to commit to the group or not , for example 3 or 6 months. This is so that the educational rota for content is not disrupted by last minute non-attendance and so that group members are clear about whether the person is as committed as they are to the group.

## **Why do groups fail?**

Here is a useful list from “Groups: A guide to small group work in healthcare management, education and research.” By Ewlyn, Greenhalgh and McFarlane.

- 1) Failure to state or clarify the groups’ goals and secure agreement on the task
- 2) Failure to signal which individuals are members
- 3) Failure to chose suitable team tasks
- 4) Avoiding team building and working solely on the task
- 5) Meeting too infrequently
- 6) Meetings being too long
- 7) Failure to share materials, papers and experiences
- 8) Preferring social activities to work activities
- 9) Playing political games

## The ingredients of good feedback

Feedback is an important skill in many professional settings, particularly in group work.

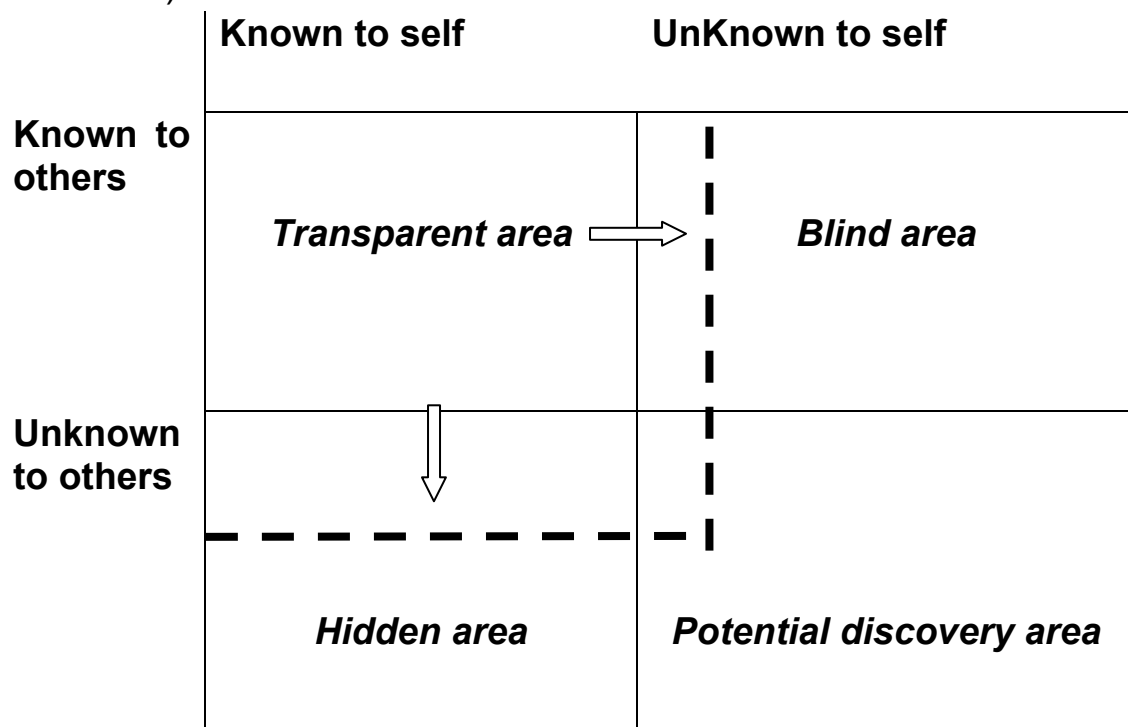
It can help one reduce one's "blind spot" and also those of others.

Being able to give feedback is an essential skill. Here are some tips.

1. Choose the right time and place.
2. Be descriptive rather than evaluative: e.g. describe a behaviour or action not an intention or personal attribute
3. Be specific rather than general
4. Focus on what's *missing* rather than on what is *wrong*
5. Direct feedback about behaviour the receiver can do something about
6. Ensure it is communicated clearly

## Johari window

(arrows indicate potential benefits of giving and receiving feedback)



## Evaluating meetings

- 1) Did it reach its stated objectives?
- 2) Was everyone able to participate?
- 3) Was decision making shared by participants?
- 4) Was time managed well?
- 5) Were conclusions articulated by the chair and checked against those present
- 6) Were actions assigned to individuals with deadlines
- 7) Is there someone nominated to write up the minutes.



## Example of SDLG planning schedule

	DR A	DR B	DR C	DR D	DRE	DR F
JAN VENUE	x					
JAN CONTENT		X				
FEB VENUE		x				
FEB CONTENT			x			
MAR VENUE			x			
MAR CONTENT				x		
APR VENUE				x		
APR CONTENT					X	
MAY VENUE					x	
MAY CONTENT						X
JUNE VENUE						X
JUNE CONTENT	X					
JULY VENUE		x				
JULY CONTENT		X				
AUG VENUE			x			
AUG CONTENT			X			
SEP VENUE				x		
SEP CONTENT				X		
OCT VENUE					X	
OCT CONTENT					X	
NOV VENUE						x
NOV CONTENT						X
DEC VENUE	X					
DEC CONTENT		x				



## Summary of points agreed at setting up meeting

Capture what you have agreed in you meeting:

Dates and timing of meetings e.g 1 <sup>st</sup> Thursday of month	
How Will content be decided	
Venue (?by rotation)	
General priorities for content	
General priorities for methods/ learning styles	
Any points about preparation of topics or handouts	

Is the Group open or closed to new members ?	
Is there a minimum attendance expected of members ?	
Decisions which require unanimity ?	

## Reflection and Evaluation tool for SDLG meeting

Date	
Attendees	
Topic/ Content	
Methods	
References/ resources	
Chair	

Key learning points for me	
Other learning points for group	

### **EVALUATION OF MEETING**

features/methods which worked well	areas to improve

### **PLANNING NOTES**

DATES	Venue/ presenter

## MEMBERS OF GROUP

Name	email	address and telephones

## Useful references:

Marion Haynes (1988) *Effective meetings skills*. Kogan Page.

Glyn Lewyn, Trisha Greenhalgh, Fraser McFarlane (2001) *Groups: a guide to small group work in healthcare, management, education and research*. Radcliffe.

Robert Bolton (1979) *People Skills: How to assert yourself, Listen to others and resolve conflicts*. Touchstone

Induja Bandara (2005) *Personal support—the ins and outs of small self-directed learning groups for doctors*. BMJ Career Focus. October 2005

Morrow G, Kergon C and Wright P (May 2010) *Support for Sessional GPs* Report to the Royal Medical Benevolent Fund. (on RBMF website)

Wright P, Viney R (2007) Drinking from the Stream: self directed learning groups for Sessional GPs. *Education for Primary Care*, **Vol 18 (2)**, p291-295

Wright P (2005) How to set up and run a group for Sessional GPs. *BMJ Careers*. **Vol 330 (no 7504)** P238-239.

Bandara I. Personal support-the ins and outs of small self-directed learning groups for doctors. *BMJ Careers*. Oct2005

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Continuing professional Development in Small groups. Part of the RCGP's First Five initiative. Clare Taylor, Nigel Sparrow. RCGP.

Guide to setting up SDLGs. Support4doctors.  
[http://www.support4doctors.org/category.php?category\\_id=14&sub\\_category\\_id=492&category\\_id=14](http://www.support4doctors.org/category.php?category_id=14&sub_category_id=492&category_id=14)



Self directed learning groups for sessional GPs. Michael Baber, Joanna Quayle. <http://www.rmbf.org/pages/rmbf-research-into-self-directed-learning-groups-for-sessional-gps-.html>

At time of writing the author has submitted a paper jointly with Gill Morrow and Charlotte Rothwell to the BJGP about SDLGs based on the RMBF project.

***Comments about this Booklet are gratefully received !***

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<sup>i</sup> Martin D, Harrison P, Joesbury H *Extending Appraisal to all GPs*. Schools of Health and Related Research (SchARR), University of Sheffield 2003.

<sup>ii</sup> Jelley D, Morrow G, Kergon C, Burford B, Wright P, Illing J. Revalidation processes for sessional GPs: A feasibility study to pilot current proposals. Report to the Royal College of General Practitioners. April 2010.  
<http://www.rcgp.org.uk/revalidation/pilots.aspx>