

# Senior Fellow Applicant Resubmission Template

Thank you for your application for HEA Senior Fellowship. The Review Panel has asked you to revise elements of your application and to submit a revised version for their consideration. Please use this template to draft your revised application.

Within [MyAdvanceHE](https://my.advance-he.ac.uk), you will be able to:

* download a copy of your original application submission, for reference.
* generate a resubmission form. All details and information will be copied from your original application into the resubmission form ready for you to revise as needed.

Please use the available tools within the resubmission form to highlight any additional text and amendments to your original application so that the Panel is clearly signposted to your revisions. You must submit text only; i.e. no appendices, hyperlinks, diagrams, photographs, etc. can be included.

The Panel has provided you with feedback to support you in strengthening your application to meet the requirements of Descriptor 3. We hope that you will find the Panel feedback clear to follow but if you would like to discuss this with a member of the Fellowship team then please contact us at [Fellowship@advance-he.ac.uk](mailto:Fellowship@advance-he.ac.uk)

In working on your resubmission, please do continue to refer to Descriptor 3 of the [UK Professional Standards Framework](https://www.advance-he.ac.uk/knowledge-hub/uk-professional-standards-framework-ukpsf) (p6) and the guidance for Senior Fellow applicants:

* [Guidance for Senior Fellow applicants](https://www.advance-he.ac.uk/knowledge-hub/guidance-documents-senior-fellowship-applicants)
* [Dimensions of the Framework guidance](https://www.advance-he.ac.uk/knowledge-hub/dimensions-framework)

The Panel feedback will guide you about areas of your application to revise and you will need to edit your application to remain within the word limit (6,500 word limit for Reflective Account of Practice and Case Studies). Citations and references have a separate word limit of 500.

When you have finalised your draft resubmission below, please copy and paste the text into the online resubmission form and submit. You will not be charged for this resubmission.

## Reflective Account of Practice (RAP)

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| Insert your reflective commentary here, **highlighting any additional text and amendments** to your original application. Revisions to your references and citations are to be listed in a dedicated field below:  **CONTEXT STATEMENT (max 300 words)**  I am the Academic Lead for Phase 1 (P1; Years 1 and 2) Medicine in the Rural Clinical School (RCS) at the University of New South Wales (UNSW) campus in Port Macquarie (PMQ), Australia, where I lead a team of more than 30 academic, sessional and professional staff.  UNSW is one of Australia’s top Universities (ranked 44th, 2021 QS World University Rankings). Approximately 30% of the Australian population live in regional, remote and very remote areas (RRR), and RRR students consistently underperform educationally compared with metropolitan students [1]. Rural Clinical Schools help address the gap between these groups by providing an equal opportunity to progress from school to further training for RRR students. Access to healthcare also presents a challenge to RRR peoples in Australia, and rural medical schools were first established to provide medical teaching facilities outside metropolitan areas of Australia, recognising that those who train rurally are more likely to practice rurally [2].  The RCS is therefore strategically important for UNSW, which has provided rural medical education at 5 rural/regional sites for Years 3-6 of the undergraduate course for almost two decades. In 2017 rural access to the course was expanded to include access to the full 6-year medical degree in a rural setting at UNSW at the PMQ campus, situated in regional Australia, 450km from Sydney. At PMQ RCS we have approximately 100 students across all 6 years of the Medicine undergraduate program, 50 of whom are in P1. All students are part of the larger UNSW cohort, which in P1 is around 500 students, and the role therefore requires extensive liaison with Sydney-based colleagues, as the accredited course must be delivered identically at both sites to ensure equity for all students.  **Reflective Account of Practice**  During my BSc (Hons) in Health Sciences (1997-2001) and my PhD in neuroscience (2001-2004) at Queen Margaret University (QMU), Edinburgh I had several inspirational teachers and mentors (K1). Spending a decade working in Scotland’s top universities, including Edinburgh and Glasgow Universities, I became acutely aware of the lack of opportunities for those from deprived backgrounds. In 2014, motivated by a desire to widen participation and access to education (V2), I became a Lecturer at QMU, an institution well-known for its Widening Participation and Outreach program. This opportunity saw me embark on a new, extremely challenging career. The student body at QMU encompassed adult learners from diverse cultural backgrounds and different socioeconomic groups (V1, V2)—diversity that impacts on learning styles and motivation to learn (K3; Biggs, 2003). Recognising my lack of a formal teaching qualification, in 2015 I enrolled in the QMU Postgraduate Certificate (PGCert) of Higher and Professional Education (K2, A5), completed online (2017), with Fellowship of the Higher Education Academy (FHEA) awarded (2018).  My experience and PGCert studies brought wide-reaching changes into my teaching practice, and hence into the practice of my colleagues as they recognised my success in engaging my students. I reflected on different learning theories and teaching styles and used the skills I was learning during my PGCert modules to evolve in my teaching style (K3, D3.vi). I learned to encourage students to develop as independent thinkers and engage more deeply with the content and ideas. For example, I found myself drawn to Constructivist learning theory, which suggests that students learn most effectively when they can relate a new concept to appropriate existing knowledge or experiences on which to build, and also to retain information [3]. Yet without background knowledge in cell biology and human physiology, my students were unable to build on their own knowledge by connecting the new information to existing understanding [4]. I therefore developed more effective learning activities by using evidence-based tools, introducing a semi-flipped classroom to my teaching, giving students access to material to engage with before class with interactive participation in class [5], such as incomplete handouts/diagrams [6], interactive quizzes, and class discussions (A1). These interactive learning modalities enabled students to work collaboratively and interactively (V1), reducing the passive transfer of information from me to the students, and helping them develop as independent thinkers [7]. My students responded very positively to these innovations, and course evaluation scores for my courses improved (K5).  From 2015-2017 I focused on introducing tools to support lectures, devising ways to make them more interactive, and to encourage students to participate as active learners (A1, A2). In 2016 I developed a series of optional online quizzes that linked to each weekly lecture. Like Johnson and Kiviniemi [8], I think students often do not re-visit their lecture notes until close to the exam, and I hypothesised that linking a quiz to this material might encourage them to revise the material at least soon after the lecture (A4). Although like Dobson [9] I would ideally have liked to encourage participation by assigning some of the overall course marks to the online quizzes (A3), this was not possible at the time, so, to encourage my students’ participation, I shared the evidence that online formative quizzing can improve performance in summative exams [8, 9]. Following Dobson [9], I designed multiple-choice quizzes to simulate the summative exam questions, except that my quizzes time-stamped each question, showing how long students spent on each question, enabling me to evaluate the effectiveness of my teaching (K5) and to revisit difficult topics (those which had taken students longer to answer) in the lecture the following week (A4). The quizzes were also available to students to use as a revision tool at exam time.  My toolbox of techniques for engaging students with different learning styles and learning disabilities (V1) expanded and I introduced incomplete handouts which students completed as the lecture progressed, and think-pair-share activities to encourage interaction and discussion (shown to facilitate learning of difficult concepts; [10]. I also embraced technology in the classroom, using clickers to assess student learning and comprehension [11], which enabled me to address misconceptions in real time and facilitated classroom discussion. Like Smith et al., (2009) my students responded positively:  *“Using the clickers is really useful and would be really good for revision lectures”.*  I used clickers to evaluate the effectiveness of my teaching and gain feedback from students on my modules, which increased the completion of formal course evaluations, giving me better insight into the student’s opinions of the course (K5). I thoroughly enjoyed introducing innovative teaching methods to my students, with significant positive feedback. This was the first time that these educational initiatives had been used in my Department, which was heavily didactic in style and somewhat outdated in practice. I became a leader influencing change in teaching and learning perspectives: senior colleagues asked me for advice and changed their own teaching (D3.VII).  During 2015-2017 I co-ordinated a third-year undergraduate module on Determinants of Health, which had long-term negative feedback: students routinely failed to see its relevance to their other studies and found the assessment unrelated to module content. I completely re-developed the program by engaging with external specialists (D3.VII). I re-designed the entire 12-week module (D3.VI, A1) and sought out colleagues in Physical Activity, Health and Wellbeing (PAWS) to design interactive activities relating to course material (A1,D3.VI). Re-designing this module led me to really engage with curriculum design. I organised my new course using learning outcomes in a constructive alignment paradigm [12], putting a new emphasis on collaborative learning using interactive activities and debate to draw out students’ knowledge (A1,V1). I tabulated the course objectives using the Blumberg (2009) method and determined where changes were required—in the learning objects, the teaching and learning activities, and the formative/summative assessments (A1,A3). I embraced a social constructivist theory of learning emphasising the collaborative, social nature of learning, as I too believe learning is more than simply acquiring and integrating new knowledge [13]. To me, learning is a social process—understanding develops from communication and connections between learners—so my new curriculum subscribed to a learner-centred ideology (Schiro, 2013). My students interacted not only with each other and with me, but also with ideas and artefacts. I crafted the environment to stimulate such interactions and enabled the students to create meaning through their activities (A4). I encouraged students to take responsibility for their learning and to actively participate, which the class clearly enjoyed, becoming actively involved in the groupwork, with group presentations leading to classroom debates, and much greater student engagement (A4). My collaborative leadership in this program influenced my PAWS colleagues to build more interactivity into their teaching, and include activities I designed into their undergraduate program (D3.VII). Even though I have left QMU, this module still follows my design.  **Taking on Leadership in RCS**  In 2017 I was appointed as P1 Academic Lead with UNSW at the PMQ RCS (see Context), fully responsible for leading/directing a team of academic and technical staff in the education of all 50 P1 Medicine students. I also oversee the learning/wellbeing of the additional 50 PMQ students in Medicine P2 and P3. As well as supporting all Year 1-6 students, I lead/direct/mentor all the staff within my academic team—5 direct reports (2 Lecturers, 1 Associate Lecturer, 2 conjoint Lecturers) and my team of senior sessional tutors (n=28) who support P1 at both PMQ and Sydney campuses (D3.VII).  Crucially, the Medicine program must be delivered identically at both Sydney and PMQ to meet national accreditation requirements (K6) and to ensure equity for all students (V2). This is why the inauguration of P1 outside Sydney was not initially widely supported within the Faculty: some believed students attending PMQ would be disadvantaged. I found this initially very challenging from a leadership perspective, as it was the first time Sydney staff had needed to consider rural colleagues in their planning. I concentrated on what was needed for success. As Academic Lead, I could see RCS was routinely overlooked, so central to my leadership strategy was my proactive building of effective relationships with colleagues across the Faculty and University, and externally.  In liaising regularly with Sydney-based colleagues, I have influenced their approach and that of the Faculty to ensure that RCS-PMQ students receive high quality teaching commensurate with their Sydney counterparts (D3.VII,V2). Though naturally a quiet and collaborative leader, I have become bold in putting forward opinions, never afraid to speak up and advocate for my staff and students, and influencing my academic and professional colleagues and senior educational leaders in Medicine in Sydney to this end (D3.VII).  My inspirational leadership and teaching across all P1 scientific disciplines, and my mentoring of my teaching team towards many innovations (D3.VII, Case Study 1), has resulted in four years of PMQ cohorts achieving at the same level as their rural counterparts attending in Sydney (K6). Collaborating with Medical Education Professor Boaz Shulruf, my preliminary evaluation of performance outcomes of the first two years of UNSW Medicine predicts that PMQ students’ Weighted Average Mark will be some 6 points higher than that of students studying in Sydney (K6).  **Leadership in Teaching and Supporting Learners**  At RCS, my leadership position includes an active, innovative role in teaching, assessment, and curriculum development. I showed high-level leadership by changing the status quo and introducing anatomy teaching using cadaveric specimens onsite. PMQ students were travelling to Sydney by coach (12 hours return) to undertake semi-intensive blocks of anatomy teaching using prosected cadaveric specimens (3 or 4 two-hour anatomy teaching sessions over 1.5 days), while their city-based peers had sessions carefully/constructively spread through their 8-week teaching block. This approach was generally very tiring and detrimental to their anatomy learning. Despite opposition from some Sydney colleagues, I advocated strongly and influenced the decision-makers (D3.VII)—including leaders from Charles Sturt University (CSU), which shares our PMQ learning space—to allow our students to attend anatomy classes in PMQ using CSU’s cadavers/specimen and Sydney-based academics travelling to PMQ to teach (A4,II,V4). After my cross-institutional success in convincing senior staff, in 2019 we trialled this new approach:  *“Having our anatomy pracs in Port was very beneficial as it meant that they were a lot more spaced out and we were fresh and ready for them, rather than being exhausted from being on a bus … The anatomy tutors here are really great and its good to look at different specimens.”*  While COVID-19 interrupted 2020 plans, from 2021 all anatomy teaching is being delivered on-site at PMQ.  **Designing curriculum and assessment**  The UNSW Medicine Program has a modular structure; in P1 this comprises eight 8-week teaching periods over 4 years. The curriculum is scenario-based: each 8-week teaching period (TP) is divided into 3 over-arching scenarios with content taught in lectures, tutorials, practicals and small group collaborative teaching sessions in which students learn independently and in small groups.  Each TP has a Course Convenor and Design Implementation Group (DIG): the latter updates/revises the curriculum with each iteration, responding to student/staff feedback from the previous course; designs/plans new learning activities; develops new assessments, and updates teaching materials for both staff and students (A1, A4). I am a key member of most DIGs, leading discussion and decision-making about program changes based on student/staff feedback. I guide/influence the relevant course convenors to review/update their teaching material, and design new content/assessments (D3.VII).  For example, like Reddy and Andrade [14], I define a marking rubric as a document that clearly describes what the student is expected to include, and how to differentiate between possible grades. In teaching across all 8 courses in P1 Medicine, I noted the assessment rubrics provided to facilitators varied considerably—often no more than task instructions. I found this problematic, particularly for inexperienced markers. My concern, reinforced by anecdotal student feedback, was the scope for inconsistency from multiple assessors marking without guidelines (K6). I used my influence in DIGs to lead change (D3.VII). In 2020 I guided Course Convenors to design comprehensive, clear marking guides with fair grading. My leadership has greatly improved this aspect of teaching quality (D3.VII): experienced facilitator Dongni Lily Guo reported “*the marking scheme is easy-to-follow … the flow charts … are logically structured and easy to navigate while cross-checking the core message…”*  Formal feedback on assignments is one of several different opportunities I have for giving feedback to learners (A3). I also give regular oral feedback in class, informal feedback on draft assignments, written feedback on interactions and performance in small group settings, and written and face-to-face feedback on effective communication with simulated patients.  *“[Linda] knows how to extend students slightly out of comfort zone to develop skills but not so much that they are uncomfortable.”* (MyExperience, Nov 2020).  I am also involved in assessment at all levels of the program. Phase 1 students are required to write a portfolio, reflecting on their first two years of study: I am the Portfolio Advisor for rural students (A2,A4), and am also involved in their assessment. I am examiner for Year 4 Independent Learning Program projects and for the Year 5 Biomedical Science viva voce barrier examination, which assesses student’s understanding of the biomedical sciences in the context of clinical scenarios (A3). These roles contribute to my broader understanding of the Medicine program, allow me to collaborate with colleagues in terms of cross-Program standards (K6,D3.VII) and add to my overall learning and teaching knowledge base thus contributing to my professional development (K2,D3.VI).  After each 8-week course students can give feedback on the course, on individual lecturers and on me as a facilitator of small-group teaching, via university-standardised anonymous online surveys (MyExperience, maximum 6). My individual ratings are routinely high (e.g. 5.92 for T3/2020), frequently above Faculty averages (5.47 for T3/2020). Written comments are generally very positive:  *“very engaging and very kind! I usually don't like participating in class but towards the end of the term, I became much more comfortable since she was very encouraging. and a very interactive class as well, so I looked forward to these classes*” (MyExperience, Nov 2020)  While MyExperience data is very useful to staff and DIGs, allowing us to reflect on the course and implement changes, the whole student cohort rarely contributes. To ensure more student voices were heard (V2), in 2019 as Academic Lead I introduced face-to-face response sessions after each term’s MyExperience data. I lead the whole P1 academic team and student cohort in detailed discussion of students’ feedback, and then support/guide colleagues in addressing any concerns, or explain why change is inappropriate (e.g .accreditation requirements, K6). Like Könings, Seidel [15], I find integrating students’/teachers’ perspectives and ‘closing the feedback loop’ (K5) creates a stronger collaborative group (A4,V1). Since implementing this approach, I have seen more students submit MyExperience surveys (K5,K6).  Through the Medicine Program Evaluation and Improvement Group, I influence the quality of UNSW Medicine’s programs, learning environments and student support (K6). For example, when Faculty introduced Peer Assisted Student Support (PASS) for P1 students during COVID-19—free, weekly out-of-class study sessions led by senior students—I realised the potential benefits (Bennet, 2018) and sought volunteers from our local student cohort to run online small-group teaching sessions for our rural P1 students to develop their clinical competency in history-taking (A4), as the COVID-19 lockdown meant students were missing regular clinical exposure. They greatly appreciated these extra opportunities to practice skills learned in class. My proactive leadership in PASS has seen me additionally appointed Academic Lead of PASS for all the Faculty’s P1 students—leading PASS as a strategic initiative of the Faculty’s Health25 Education Strategy. This involves guiding/directing/influencing colleagues and ‘students as partners’ to coordinate Senior Student Tutors (SSTs) and P1 tutees in developing PASS teaching (D3.VII). I was the natural person for this position/role due to my proven leadership in the Rural Tutoring Program (supporting struggling rural students; V2). As mentor for SSTs—emerging educators often in their first teaching role—I influence their teaching approach (D3.VII).  Year 4 students (P2) undertake a year-long independent learning project (ILP) with a major research component. Traditionally, most rural campus students returned to Sydney for this year (a costly exercise) due to a perceived lack of suitable local research projects. In 2017 when our first Y1 cohort commenced, there was no ILP program at PMQ. Realising this gap in the educational provision, and the wellbeing implications of a year’s move to Sydney for RMC students, I became determined to establish a local ILP program (V2). I influenced local GPs, hospital colleagues and PMQ Health Promotion Teams to become ILP supervisors for our students (D3.VII). Under my precise guidance and instruction, these professionals—some with no experience of researcher education or research as teaching—learned how to support/mentor PMQ students to fulfill their research requirements. I led these colleagues’ capability development around all aspects of research e.g. designing appropriate research studies, writing successful ethics applications (D3.VII). Several of these rural clinicians now supervise students annually, demonstrating the positive impact of my supportive influence on their practice becoming more research-based, enhancing career prospects and building UNSW’s reputation for quality rurally-situated research (D3.VII).  My development of the PMQ ILP program has laid the roots of a regional research culture built on strong partnerships with sister institutions and Local Health Districts, another key goal in the Faculty’s Health 25 Strategy (A1,V4,D3.V). My pioneering efforts meant the entire first cohort of P1 RCS students successfully completed their research year in PMQ in 2020. Needing at least 12 projects annually, I recruited an additional part-time team member (Dr Emma Schofield) to help me build this program. I have directed/mentored/supported her to build solid links with our Coffs Harbour campus to develop joint research capacity (D3.VII). As lead and liaison for both campuses, I have forged links with the Local Health District’s Director of Research (D3.V). Already PMQ students are creating a reputation for high quality ILP projects, with national impact—three presentations at national research conferences and a feature on ABC Radio (D3.V,V4).  The leadership I showed in supporting and improving student ILP achievement has contributed significantly to my reputation for excellent and research-led teaching leadership among my colleagues. As an active member of the Faculty Research Committee and the Medicine Higher Degree Research Committee (D3.VII), I contribute directly to decision-making around the administration of research degrees, and actioning all matters relating to the candidature of HDR students (V1). In recognition of this leadership and influence, in 2019 I was appointed PMQ ILP Co-ordinator and awarded RCS Researcher of the Year , and have become a strong and confident advocate for rural ILP/Honours students on the Year 4 Medicine Committee.  **Leadership in Scholarly Practice**  As leader of the Faculty’s Medical Education Interest Group (MedEd), I am directly involved in leading and influencing scholarly practice, encouraging educational research, and developing new networks across Medicine and Health, and linking up with other education groups across the University (D3.VII). I lead the multiple MedED outputs—monthly Faculty-wide seminar series and newsletter; annual Faculty Learning and Teaching Forum; a Moodle support module; and a MedEd group Twitter feed.  My MedEd leadership sees me engage and influence colleagues across all the many disciplines in UNSW Medicine & Health. For example, I select the monthly seminar topics by identifying areas for improvement, promoting Faculty educational research findings, and seeking colleagues’ ideas (K5, D3.VII). When I noticed learning outcomes are often poorly written in our Faculty (probably because of limited training for clinical and conjoint staff who teach infrequently), I arranged a Learning Outcomes Workshop by Educational Developer Dr Annie Luo (UNSW Medicine Education Development Unit) in April 2021. One immediate impact was seeing colleagues now incorporating learning outcomes in their small-group teaching sessions. Given my concern with marking guides (see above), I also arranged for innovative UNSW scholar in this field Dr Lidija Krebs-Lazendic (Psychology Deputy Program Director and Program Authority) to deliver a MedEd seminar to inspire academics to adopt key changes (A3,D3.VII).  As MedED leader, I also have responsibility for the Induction Day for new staff in Medicine & Health (D3.VII, K4), crucial for them to feel supported and informed (D3.VII). I am the Faculty’s main contact and support for these new staff, for whom I organise and deliver the Induction Day teaching professional development. For my first Induction Day (February 2021) I received very positive feedback—my own teaching sessions were rated 4.8/5 and 4.5/5. Through MedEd, my leadership and influence across the whole Faculty and all campuses is significant and increasing, while and my community of practice approach means I constantly seek colleagues’ feedback on MedED outcomes.  **Scholarship, research, and professional practice**  In 2018, I transferred to UNSW’s Education Focused academic career pathway, using my strong research background to shift to leadership in educationally targeted research. I forged a still-flourishing collaboration with colleagues from the Local Health District Health Promotion team. Guided by my leadership and research expertise, we successfully applied for a small translational research grant which enabled me to embed my research with my educational activities. Researching Medical Students’ knowledge and understanding of childhood obesity simultaneously allows us to improve the curriculum content for students in this area (A1, D3.V). I recently presented this work at the virtual conference ‘The Austral-Asia Obesity Research Update 2020’. I extended this research by developing an ILP project under my supervision (D3.V), inviting my colleague Dr Macer-Wright to co-supervise so she could develop her supervisory experience (D3.VII). On examination our student received 86% (High Distinction) and presented his data at ‘The Austral-Asia Obesity Research Update 2020’ and the ‘7th Rural and Remote Health Scientific Symposium 2020’ (A2,D3.V). Recognition of my research led to an invitation as facilitator for the Obesity Sub-group of the Contact, Help, Advice and Information network, an online support network for people working in health and social care. With the confidence of my mentorship (D3.VII), Dr Macer-Wright, has since supervised further ILP projects.  I was primary supervisor for a second ILP student in 2020 (A2), inviting Dr Susan Heaney (University of Newcastle) to co-design a project on the impact of COVID-19 induced lockdown on eating behaviours and nutritional intake in Australian adults. Again, the student achieved High Distinction (88%), with the study reported by Australia’s national radio station. We have submitted this for presentation (‘Dieticians Australia 2021’ conference) and are preparing a manuscript for publication (D3.V). In pedagogical research I collaborated with colleagues to evaluate the performance of our rural students and explore factors affecting this in comparison with metropolitan students. We presented this data to two very different audiences; at the Association for Medical Education in Europe Conference (AMEE) 2019 and at the 8th Rural Health and Research Congress.  With colleagues and a Year 5 Student Partner I developed new pathology resources for our rural students (A4,K2) after realising PMQ’s own collection of pathology specimens was in disrepair, without no clinical notes and unavailable for teaching, so PMQ students were missing out on vital learning available to their Sydney peers. I convinced part-time RCS academics to pool their professional development funds and led a successful Special Funding application (AUD$61,000) for a collaborative project to develop a Pathology Museum on PMQ campus (D3.VII). I led this significant project (presented at AMEE 2019) to create a bookable-by-students facility with high quality specimens supported by relevant clinical scenarios (A4). This facility is also benefitting local junior doctors and local high schools, and I am leading development of a full teaching plan (A1,D3.V).  I have developed links with the wider professional State and local community. I am a member of the Translational Research Grants Scheme Grant Review Panel for NSW Government Health, and I actively contribute to the local Healthy Communities Advisory Committee (HCAC) and Human Research Ethics Committee. These roles maintain/enhance my professional standing, contribute to building UNSW-community research links and capabilities, support ethical oversight of local research, and provide me with broad professional development around leadership and mediating locally-relevant student research (D3.VI,D3.VII,V4).  **Broadening my leadership capabilities**  In 2019, I completed the international [ESMELead](https://www.esmecourses.org/enrol/index.php?id=21) (Essential Skills in Educational Leadership & Management) course which considered key aspects of leadership and management in the context of medical education. Specifically, this course gave me insight into my own leadership style and a deeper understanding of teamwork and leadership, all of which helped me to become a more effective leader (D3.VI,D3.VII). In 2020 I successfully applied for UNSW’s highly regarded Academic Women in Leadership (AWIL) program which empowers women towards career progression and more confident, effective leadership within the University (D3.VI). COVID-19 restrictions postponed the program till 2021, but guided by the program leaders I instead undertook a comprehensive LinkedIn Learning module, Women in Leadership. This CPD added to my knowledge of formal leadership development which complemented my on-the-job leadership experience (D3.VI). One direct impact was that I looked for new ways to nurture/develop the talent in my team. I now consciously step back, delegate, and enable other team members to lead, while consciously motivating/inspiring them. For example, I delegated more decision-making tasks to my administrative support assistant (Cara Elvidge; see Case-Study 1; D3.VII).  My cross-campus reputation for influencing high quality teaching also led to my recent invitation to join the selective multi-disciplinary UNSW EF team newly collaborating with [Aga Khan University](https://www.aku.edu/Pages/home.aspx) (AKU; Pakistan, East Africa—strong in Medicine) for peer engagement in professional recognition of university educators. I have already presented to members of AKU’s prestigious Teachers’ Academy as a panel member on reflective writing in teaching (D3.VII) and am currently planning cross-institutional staff and student peer learning initiatives (V2,V4). |

## Case Study One

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| Insert your first case study here, **highlighting any additional text and amendments** to your original application. Revisions to your references and citations are to be listed in a dedicated field below:  :  **Leadership through Supervision, Management and Peer Influence**  As Phase 1 Academic Lead, I must ensure RCS designs/delivers engaging, challenging learning experiences for adult learners within a tertiary environment, aligned with the program delivered in Sydney but adapted for the regional environment. My leadership goals are increasing student recruitment, engagement, success and retention (D3.VII, V4)—by all measures I have fulfilled that leadership role very actively and successfully. Given my success in RCS P1 leadership, I have been tasked with many additional leadership responsibilities. I am thus also ILP Co-ordinator for P2 (Year 4); Examiner of the Year 5 Biomed and Year 6 Portfolio in P3; RSC Postgraduate Degrees Coordinator; Director of Research; and Faculty Lead of the MedEd Interest Group (see above).  Beyond the P1 Committee, required by my position, I have also proactively and enthusiastically embraced other governance roles in the School, Faculty and University. For example, through the Program Evaluation & Improvement Committee I provide high level guidance for Medicine program development, while on the Clinical Learning and Assessment Committee I influence colleagues in ensuring clinical teaching is effectively integrated across all Phases (D3.VII,A2,A4). These roles are building my understanding of organisational policies and strategies (D3.VI).  Cultural safety is paramount to UNSWs strategic priorities (V4). On the Indigenous Health Education Working Group I am influencing the journey of staff and students towards more effective cultural competency, especially important in the rural context where I am developing a new supportive pathway to help Indigenous staff/students succeed (D3.VII). As a member of the ALLY@UNSW network (staff trained as allies to UNSW’s LGBTIQ+ community), I lead/cultivate a strong inclusive culture at PMQ, providing confidential support to the LGBTIQ+ community (V2,D3.VII).  In 2019 I was invited by Faculty leaders Professors Tony O’Sullivan and Gary Velan to provide leadership on the inaugural implementation of P1 at Wagga Wagga (NSW, 450 km southwest of Sydney, 830 km from PMQ). I was fundamentally involved at all leadership levels, from the building design to the recruitment of the local P1 Academic Co-ordinator and the final Australian Medical Council accreditation. I can honestly say my leadership has underpinned Wagga’s successful rollout. I remain a key member of Wagga’s P1 Steering Committee, providing ongoing support/mentorship to Wagga’s new P1 team.  I am influencing UNSW’s modernised Medical curriculum in an active Working Group reviewing/updating/simplifying the UNSW Medicine Graduate Capabilities to make them more relevant to our program. Specifically, I am leading colleagues in reviewing the Teamwork Capability, to make its assessment more relevant/direct, and to increase opportunities for students to engage with allied health professionals (D3.VII,K6). I am trialling the latter by partnering with University of Newcastle colleagues (co-located on the PMQ campus) to deliver interdisciplinary learning modules giving P1 students opportunities to interact with Allied Health students. Understanding the practices/assumptions of each discipline will enable our Medical students to gain important insights into multidisciplinary teams. My strengths in listening to colleagues’ views are essential (D3.VII): all learning activities and assessments in the Medicine program are related to Graduate Capabilities, so my work is influencing colleagues across the entire Medicine program.    My leadership position includes developing and mentoring a small team of academic and administrative staff. Over my 4 years in this role, my team has evolved from two staff to a close-knit team of four full-time staff and three part-time academics. I have built an inclusive environment where my staff a feel encouraged and comfortable to voice their opinions and where, guided by Sinclair [16], I listen actively and mindfully to their concerns and ideas. I have especially focused on developing my relatively inexperienced academic team, actively assisting them in their teaching and support of students, supporting them to achieve their career goals.  Capability development in research and leadership is crucial for career trajectories in a research-intensive university like UNSW, so I support my team’s scholarship and research potential. As an experienced biomedical researcher, I model/guide research skills by including my team in my own research projects, and mentor them as ILP supervisors. Supportive of distributed leadership frameworks [17] I also involve them in decision-making where appropriate (D3.VII).  I actively look for, and recognise, existing strengths and future potential in my team, and support professional recognition. For example, in 2017 Dr Jessica Macer-Wright applied for an administrative position with RCS but on seeing her CV I recognised her potential in a more senior role, and then recommended her for a Lecturer role. She recently achieved FHEA (D3.VII). Similarly, Ms Karan Bland was employed for her expertise in microbiology laboratory work, but I realised her ability to create engaging lab/learning environments in which students feel supported. With my mentoring, Karan has gained confidence as an educator and receives excellent student feedback (100% satisfaction) on the quality of her teaching and student support.  I set a high bar for my team. I have actively encouraged Jess and Karan to completed the Foundations of University Learning and Teaching course, ESME training, and FHEA, extending this towards the Master in Education program and the Graduate Certificate of University Learning and Teaching respectively. I give them practical support by providing academic assistance and ‘protected hours’ towards their assignments, while also reducing their marking load and enabling flexible working patterns (D3.VII).  Communication is key in leadership. My approach is to be open, approachable, and honest, and to value everyone’s input: my team works well with virtually no conflict. We have regular meetings, face to face or online via MS Teams, and also communicate via email, Teams and What’s App (K4). I believe in giving appropriate recognition; my staff know that they matter. I ensure our meetings haves space for everyone to raise views for open discussion and changes if required (D3.VII).  I developed Administrator Mrs Cara Elvidge’s role by delegating more complex tasks to her and empowering her to manage the Clinical Skills timetable. Confident in her knowledge and skills after mentoring, I now delegate Cara to manage this fully (D3.VII).  To become more involved in the quality assurance and enhancement of P1 Medicine, I am also an active member of the UNSW Medicine Inspired Learning Initiative Committee and the Technology Enhanced Learning and Teaching Committee. These two Committees have especially enabled me to keep updated with technology matters across the Faculty (K4), to influence the use of technology by my colleagues in the Medicine program, and to share experiences of innovations in eLearning and emerging IT (D3.VII). This allowed me to organise a 2-day blended learning workshop with UNSW Educational Developer Amanda Yeung for my PMQ team (K4). We used our training on preparing quizzes using the Moodle platform, and using knowledge maps, to create new and individualised learning experiences for our students, vital during the COVID19 shift online (V1).  In 2019 I recognised my extended team and colleagues at PMQ needed support on conducting/writing systematic reviews. I facilitated Dr Sandra Matheson to deliver a 2-day workshop, attended by PMQ academic staff, conjoint staff, University of Newcastle colleagues, and Year 3 students (who commence ILPs in Year 4). This prepared staff well for career performance reviews and proved useful when COVID-19 meant some student research changed to systematic reviews; staff were in an excellent position to assist those projects (D3.VII). |

## Case Study Two

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| Insert your second case study here, **highlighting any additional text and amendments** to your original application. Revisions to your references and citations are to be listed in a dedicated field below:  I am the official Co-Lead of the UNSW-wide Student Wellbeing Community of Practice (CoP). Through this I am collaborating with colleagues (especially Dr Gavin Mount, Honorary Assoc/Professor Jacquelyn Cranney, Dr Leesa Sidhu) across multiple disciplines and Sydney, Canberra and PMQ campuses (D3.VII). We focus on creative ways to monitor/enhance wellbeing for students at different stages of learning (V1) across diverse disciplines/environments (Psychology, Humanities, Science, Medicine). I influence CoP members by recommending resources/tools and ways of incorporating these into courses. I am leading the active documentation of case studies and evaluations of 2020 interventions to improve student wellbeing (A4,D3.V)  Early in 2020 we held discussions in the Student Wellbeing CoP and formed a sub-group to determine students’ needs. I jumped at the chance to lead this since I had concerns about RCS students’ wellbeing and was actively working to improve this. Our RCS learning environment is usually a blend of face-to-face in small groups and some sessions taught online (A4). All face-to-face lectures in Medicine are livestreamed from the Sydney campus: many of ours students watch in the PMQ lecture theatre. Some other teaching sessions are conducted online in dedicated sessions where our students can interact with tutors by asking/answering questions. For all other teaching—small group tutorials and practical classes—students are taught face-to-face by my academic team and other discipline-specific local academics (A4). In this environment where students feel supported and are happy to talk to staff and peers alike; it is a very socially connected environment (V1). Our student-centred educational philosophy is underpinned by this social connectedness.  The COVID-19 pandemic resulted in the rapid transition of all Medicine program face-to-face learning activities to online teaching midway through Term 1 2020. My academic team quickly reported to me that they felt the loss of our usual social connectedness with our cohort, so I led them to introduce strategies to support development and maintenance of social relationships. Social connectedness is positively associated with mental and physical health [18] and we felt maintaining this was as important as supporting our students’ educational and academic experience (A4). The second half of Term 1 (4 weeks from March 2020) was largely spent getting through the teaching and transitioning to online teaching and there was little time to focus on how students were coping. But early in Term 2 I led a survey of our students to find out how they were coping: unsurprisingly, we found the majority (64%) were struggling to some extent.  I led my team and colleagues in the School of Psychology to devise a wellbeing intervention using self-determination theory (SDT; Cranney, Morris [19], [20] as our theoretical framework (D3.V). As educators we create the curriculum environment and this shapes human behaviour, including students’ engagement with learning. In normal circumstances, we can easily create learning environments in which we design and deliver curricula that support the three basic psychological needs posited by SDT (relatedness, competence and autonomy). I wanted us to enhance student wellbeing in our cohort, but we knew that achieving this online would be a challenge. I led an engagement strategy from design to implementation, and convinced all my staff and colleagues to participate. We included virtual coffee catch-ups and other informal activities organised by teaching staff to bring students into a connected learning community (relatedness); live-streamed science practicals to support students’ academic success (competence); and used ice-breakers in small group teaching sessions to help students interact more (relatedness). I ensured this was all done within environments where students felt supported and comfortable to approach staff for individualised assistance (competence, relatedness; A4).  I led the evaluation of our new initiatives (K5). Surveying the students at the end of term, we found all strategies were rated positively (they wanted all activities to continue). Student wellbeing and the overall satisfaction with the program remained healthy despite the pandemic disruption. I led presentation of this work at the UNSW Medicine and Health Forum 2020, and via an online webinar organised by the Pro Vice-Chancellor Education and Student Experience, who wanted me to “support program and course convenors who are seeking practical curricular tools and approaches to support student academic success and thus wellbeing”.  My wellbeing strategies have been recognised as beneficial for learning communities and have already had impact on local and national colleagues. My success in influencing others was evidenced by my appointment in 2021 by the RCS Head of School to the UNSW Medicine and Health Education Academy (MHEA), which works directly to achieve the UNSW 2025 strategies of Educational Excellence and Student Experience (V4). This appointment recognises especially my leadership in improving student wellbeing. I thus became Co-Lead of the MHEA’s Enhancing Student Success and Wellbeing subgroup, influencing Faculty staff to adopt and support strategies to support our students.  After I presented at the EF Forum 2020, several colleagues successfully adopted my ideas into their teaching (e.g to support international students unable to return to Australia, who remain online). Following another presentation at the Medicine & Health Faculty Education Forum (Dec 2020), I was asked to deliver a ‘Prestigious Oral Presentation’ at the Association for the Study of Medical Education (ASME) Annual Scholarship Meeting 2021 (theme ‘Disrupted Medical Education’), and to colleagues at the 2021 Student Transitions Achievement Retention and Success Conference (D3.VII). |

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