



LEAP

FRAMEWORK

Learning, Education, and Professionalism

A Framework for Continuing Professional Development for Medical Practitioners

Report on Validation Project

A Project conducted by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists on behalf of the Committee of Presidents of Medical Colleges with funding provided by the Commonwealth Department of Health and Ageing

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EXECUTIVE SUMMARY

College: The Royal Australian and New Zealand College of Obstetricians and Gynaecologists on behalf of the Committee of Presidents of Medical Colleges

Project title: Project to trial a Framework for Continuing Professional Development for Medical Practitioners (known as the LEAP Framework)

INTRODUCTION

The Framework for continuing professional development (CPD) known as LEAP (Learning, Education and Professionalism) has been developed for medical practitioners who are Fellows of Australasian specialist Colleges. Designed to be applicable to a wide range of disciplines and practice settings, the Framework uses the concept of *medical professionalism* as its basis, with the concept deconstructed to three separate, yet overlapping, 'strands' and further to ten 'components'. Three 'levels' of CPD activities are described, differentiated according to their capacity to increase knowledge or facilitate and/or evaluate change in professional practice. The ten components of medical professionalism and the three levels of activities describe a two-dimensional matrix that can guide a practitioner's CPD. Combined with some basic guidelines that can be defined by individual colleges to suit their fellowship, the Framework is believed to possess the flexibility, breadth and rigour needed to facilitate relevant and effective CPD for today's medical specialists.

This project, conducted on behalf of the Committee of Presidents of Medical Colleges (CPMC) and funded by the Commonwealth Department of Health and Ageing (DHA), aimed to test the utility and validity of the Framework in practice, using a representative sample of Fellows from a range of specialist medical colleges and/or their faculties.

The scope of the project involved:

- testing the validity of the conceptualisation of 'medical professionalism' used as the theoretical platform of the Framework;
- conducting learning need assessments for medical specialists;
- developing and administering an on-line program that encompassed college-specific CPD programs and activities, as well as the broader range suggested by the LEAP Framework; in particular, CPD activities and events that reflected aspects of practice from different strands and levels and had applicability and relevance to practitioners from a range of specialties, work settings and practice locations.

Evaluation of the project involved a mixture of both quantitative and qualitative methodologies, and was conducted in collaboration with the Hunter Institute for Mental Health. A number of evaluation tools and approaches were used to ensure triangulation and reliability of data obtained, including: questionnaires, focus groups, telephone interviews and analysis of participant learning logs, as well as an evaluation of CPD activities and workshops conducted for the concurrent, *LEAP in a Rural Context* project.

OBJECTIVES

The objectives of this project were to:

1. Test the validity of the conceptualisation of 'medical professionalism' used as the theoretical platform of the Framework with a representative sample of Fellows from a range of specialist medical colleges and/or their faculties.
2. Develop methods for conducting learning needs assessments for medical specialists.

3. Develop, administer and evaluate CPD programs based on the Framework at both the College and Fellowship level.
4. Evaluate specific CPD activities that will enable the Framework to operate successfully in practice.
5. Evaluate the effectiveness of the Framework in terms of satisfaction of participants and where possible, the ability of programs based on the Framework to effect change in specialist practice.

RESULTS

A total of 126 specialists from 8 medical colleges completed a pilot of the Framework via an on-line program over a 12 month period from November 2004 to October 2005. Participating specialists came from a variety of practice settings, sub-specialities and locations. A range of age, gender, full/part-time and years of practice were represented.

On-line versions of eight individual college CPD programs based on the Framework were developed. These consisted of college-specific activities, of which the vast majority were from Strand One, as well as the generic, non-clinical activities that attempt to address the wider range of skills, knowledge and attributes now considered to be part of professional practice.

Participants used these to devise an on-line personal learning plan, outlining their CPD needs for the 12 month pilot period, choosing activities from those already listed under each of the strands and components, or entering their own activities.

Individuals were encouraged to refer to their learning plan on a regular basis and meet three criteria in piloting the Framework:

- undertake CPD activities in each of the three strands (any components)of the Framework;
- obtain 50 hours or 'credits' of CPD in the 12 month pilot period; and
- complete 10 hours or credits in a Level Three activity (any strand, any component).

The nature (type, number, percentage, amount) of CPD to be undertaken in each of the different components was not stipulated or quantified, nor was it intended that participants should undertake CPD activities in all ten components.

Feedback from questionnaires at the end of the 12 month period indicated that there was general agreement that the three strands and ten components of the Framework comprehensively cover the roles and responsibilities expected of medical professionals and provide a helpful structure to the medical profession of the variety of CPD that is expected today.

The theoretical platform of the Framework was considered sufficiently relevant, applicable and flexible, albeit with some slight modifications, to encompass a wide range of specialist practice.

A high percentage of participants agreed that using the Framework to prepare a learning plan helped identify needs and encouraged identification and sourcing of CPD activities to meet those needs, particularly in areas other than traditional medical and clinical expertise.

Collation of the initial and final learning plans indicated that most participants planned and then completed professional development activities in areas additional to those directly related to their clinical area. Eighty-eight percent (88%) of participants completed CPD in each of the three strands and a further 10% completed activities in at least two of the three strands, giving validation to the broader roles and responsibilities suggested by the Framework.

Ninety-seven percent (97%) of participants obtained a minimum of 50 hours or credits during the twelve month pilot, with many completing well in excess of this number.

Despite some colleges not having Level Three activities in their current CPD programs, participants from all colleges managed to undertake Level Three activities. Over half (54%) of the participants completed a minimum of one Level Three activity, documenting the facilitation and implementation of changes to their practice. Twenty-one percent (21%) reported completing more than one Level Three activity.

A range of Level Three activities was undertaken by participants, including Quality Assurance/Practice Improvement activities and risk assessment activities encouraged by individual Medical Defence Organisations. For those who completed a Level Three activity, it was seen as a challenging, yet satisfying and positive learning experience. For those who did not manage to undertake one during the pilot, a lack of time, college-specific guidance and support were seen as hurdles.

Participants agreed that undertaking Level Two and Three activities encourages and promotes reflection and evaluation of practice. Fourteen percent (14%) of participants indicated that they had undertaken more Level Two activities and 20% more Level Three activities during the pilot, than they would have done previously.

Non-clinical activities and areas identified by participants in learning plans provided information for a concurrent project run to test the validity in practice of the Framework. The project, *LEAP in a Rural Context*, was funded by the DHA to source and deliver activities that reflect aspects of practice from Strands Two and Three (*Risk Management* and *Professional Values & Responsibilities*) of the LEAP Framework matrix and in particular, in those components where little if any professional development activities were being offered by colleges or providers.

A total of twenty-seven CPD events were delivered under the *LEAP in a Rural Context* project, using eight core workshop activities contracted from third party providers, from November 2004 to August 2005. In total, 384 specialists from eight medical colleges, participated in CPD activities that were based on the following themes: Introduction to Evidence Base Medicine; Expert Witness Training; Computer Based Literacy; Difficult Doctor Patient Relationships; Mentoring in the Workplace Environment; Work Life Balance; Teaching on the Run; and Medical Responses to Adults who have Experienced Sexual Assault.

Feedback from these events was generally very positive, with many participants citing that the workshop not only increased knowledge and awareness of the areas covered, but that the activities chosen had actually led to a change in aspects of professional practice. Given that the activities provided were non-clinical and all from Strands Two and Three, the concept of offering these types of learning opportunities and activities gives further validation to the broader roles and responsibilities suggested by the Framework.

Thus, participation in activities that form part of the Framework appears to offer the capacity to effect change in professional practice. In addition, the Framework and participation in the pilot encouraged participants to think more broadly about the competencies and responsibilities involved in being a medical professional and to incorporate a wider range of activities into their CPD, many of which address the needs and expectations of the broader community.

There was general agreement that in principle, a CPD program based on the LEAP Framework or a similar framework, would:

- allow a more consistent approach to CPD across colleges than currently exists;
- serve to refocus the profession on the practice of medicine in a wider context;
- encourage the sharing of relevant CPD activities between colleges; and
- with simplification and modification, be a reasonable model for colleges to adapt and adopt for their Fellowship.

BACKGROUND

History

During 2002–2003, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) completed a project to develop a Framework for Continuing Professional Development (CPD) for medical practitioners. The project was conducted on behalf of the Committee of Presidents of Medical Colleges (CPMC), and was funded by the Commonwealth Department of Health and Ageing (DHA).

The resulting Framework, now known as the LEAP (Learning, Education and Professionalism) Framework, uses the concept of *medical professionalism* as the central underlying concept to describe the diverse roles and the wide range of, skills, knowledge and attitudes that are considered to be part of being a medical professional today, along with three ‘Levels’ of CPD activities. It was developed through a review of the literature relating to medical professionalism, consultations with practising specialists and other relevant groups, and reflects their views on what it means to be a medical professional in Australia today. The Framework was developed to be applicable to all medical specialties and practice profiles, and to be adaptable for use by all Australian specialist medical colleges.

Through the CPMC member colleges and DHA, RANZCOG has undertaken the task of validating the LEAP Framework in practice with samples of Fellows from eight Australasian specialist medical colleges. This report outlines the activities undertaken to contribute to the overall validation of the Framework in practice, and presents the results of the validation trial.

Conceptual Structure of the LEAP Framework

The LEAP Framework offers a description of professional medical practice, independent of the specialty or practice setting. The Framework recognises that being a medical practitioner today involves more than just the possession of technical knowledge and clinical expertise. As such, it outlines the diverse roles and the wide range of responsibilities and attributes that are now considered necessary for being a medical professional.

The Framework identifies three main ‘Strands’, or areas, of practice: *Clinical Expertise*; *Risk Management*; and *Professional Values and Responsibilities*. These three strands can be further unpacked into a series of ten ‘Components’ or ‘Domains’ of professionalism.

The three strands and their components are described briefly below.

Clinical Expertise

This Strand acknowledges the need for an up to date requisite body of knowledge and skills. The Strand encompasses three components.

- *Medical Expertise*: The possession and maintenance of the knowledge and procedural skills necessary to conduct the clinical aspects of professional practice.
- *Clinical Judgement*: The ability to apply knowledge and procedural skills to make an informed, accurate diagnosis and provide appropriate treatment from the range of options available.
- *Medical Informatics (Clinical)*: An awareness of and ability to use the range of technologies available to assist in the maintenance and extension of the previous two components; both as a user and a provider of information to other professionals and stakeholders.

Risk Management

This Strand acknowledges the need to be cognisant of those aspects of practice outside of medical expertise that may impact on patient outcomes. The Strand encompasses four components.

- *Communication*: The ability to ensure honest and open communication with patients and their families, demonstrating empathy and the ability to appreciate and accommodate cultural and other factors that contribute to the individuality of specific patients and their needs.
- *Practice Management*: An awareness of the factors that contribute to effective practice management and a commitment to best practice in this area.
- *Medical Informatics (Practice)*: An awareness of the range of technologies available to assist in the attainment of best practice in a practitioner's environment.
- *Personal Management and Insight*: The capacity to reflect on all aspects of professional practice, including an awareness of their own suitability for practice and a monitoring of self, in order to optimise patient outcomes.

Professional Values and Responsibilities

This Strand acknowledges the need for an awareness of medical practitioners regarding beliefs and behaviours that reflect the expectations of others with whom they interact during their practice. There is a need to be aware of and sensitive to cultural and linguistic diversity, and responsive to the cultural needs of patients and their families. Additionally, the implications of working with other practitioners and healthcare professionals is also acknowledged. Three components are involved.

- *Relationships and Accountability*: An acknowledgement of the expectation on medical professionals to work within the ethical and legal Framework of the profession and to understand and exhibit appropriate interpersonal, including interprofessional, behaviours. An appreciation of the possible pressures that can arise from competing interests in the modern practice of medicine, an awareness of the responsibility for assisting with the creation and implementation of continuous improvement initiatives, and an acknowledgement of the responsibility for ensuring the existence and effective functioning of mechanisms for identifying and dealing with incompetent/unprofessional practitioners.
- *Advocacy and Equity*: The desire to work actively at promoting equity and justice in the healthcare system, including a commitment to improving access for disadvantaged groups and the circumstances of fellow health professionals; a recognition of the fine balancing act that can be involved.
- *Education*: A commitment to on-going learning for all in the profession. Acting as role models and taking a formal involvement in the training of medical students, early postgraduates, new specialists and other health professionals in ways that demonstrate an understanding of appropriate teaching and learning theories and practices. An involvement in credible scientific research and an acknowledgement of the responsibility to ensure new knowledge is appropriately used.

The Framework also advocates the recognition of a wide range of activities as valid for CPD and proposes three 'Levels' of CPD activities. The three levels of activity – Level One, Level Two, and Level Three - are intended to reflect a 'hierarchy' of CPD activities that are based on the ability of the activity to effect and demonstrate change in practitioner behaviour and patient outcomes. It is possible for activities that a practitioner undertakes in Level One to lead to a Level Two activity, and then to a Level Three activity. The three Levels of activities are described below.

- *Level One activities* are considered to be those activities that provide the participant with information to improve their practice. The level of demand on the participant is considered to be relatively low. Generally, these learning activities focus on increasing knowledge and skills and include the more traditional, passive activities such as lectures, conferences and journal reading.

- *Level Two activities* are those that impose a higher demand on the participant. Generally, it is expected that involvement in these activities will ensure that the participant can demonstrate the maintenance of best practice standards and/or that they have implemented a particular activity or facilitated changes in practice and health outcomes. Level Two activities include things such as preparation for and taking part in a practice review or clinical audit, critical incident monitoring, or trying a new approach or technique.
- *Level Three activities* are those that have the highest demand on the participant. Generally, these will involve change and evaluation activities where the practitioner evaluates the impact of an activity or intervention, perhaps resulting from involvement in a Level Two activity, makes adjustment in order to address the problem or issue, and measures the effect. Level Three activities include things such as trying out a new approach/technique and evaluating the outcomes; peer reviews and audits – implementation of recommendations and evaluation of the improvements made; and completion of a quality cycle where an action plan has been developed, implemented and evaluated.

It is these three levels of activities, coupled with the ten components of professionalism, that comprise the crux of the Framework in the form of a 30 cell matrix as shown in Figure 1 below.

It is not intended that individual practitioners undertake CPD activities from all 10 components or 30 cells of the Framework. It is intended that practitioners analyse their learning needs and undertake CPD in those areas that they identify as being of need or interest to them, thus widening the scope of their CPD.

Strand	Component	Level One	Level Two	Level Three
Clinical Expertise	Medical Expertise			
	Clinical Judgement			
	Medical Informatics (Clinical)			
Risk Management	Communication			
	Practice Management			
	Medical Informatics (Practice)			
	Insight & Personal Management			
Professional Values & Responsibilities	Relationships & Accountability			
	Advocacy & Equity			
	Education			

Figure 1: Matrix of the strands, components and levels upon which the LEAP CPD Framework is based.

Project Aim

The aim of this project was to test the utility and validity of the LEAP CPD Framework in practice.

Project Objectives

The objectives of this project were to:

- Test the validity of the conceptualisation of ‘medical professionalism’ used as the theoretical platform for the Framework;
- Develop methods for conducting learning needs assessments for medical specialists;
- Develop, administer and evaluate CPD programs based on the Framework at both the College and Fellowship Level ;
- Evaluate specific CPD activities that will enable the Framework to operate successfully in practice.
- Evaluate the effectiveness of the Framework in terms of satisfaction of participants and where possible, the ability of programs based on the Framework to effect change in specialist practice.

Project Scope

The scope of this project involved testing the validity of the conceptualisation of *medical professionalism* used as the theoretical platform of the Framework with a representative sample of Fellows from a range of specialist medical colleges and/or their faculties.

This involved developing an on-line program that encompassed college-specific CPD programs and activities, as well as the broader range suggested by the LEAP Framework; in particular, CPD activities and events that reflected aspects of practice from different strands and levels and had applicability and relevance to practitioners from a range of specialties, work settings and practice locations. Practitioners were then asked to trial the above program over a 12 month pilot, (during the project), period.

PROJECT METHODOLOGY

Background

Participation in CPD activities is an aspect of medical practice that is increasingly being recognised as a basic professional expectation. In light of this, the project methodology was designed to provide a structure for participants to identify their areas of need and take responsibility for planning and undertaking professional development across a broad range of areas; in particular, by engaging in activities that are more likely to effect change in practice and patient outcomes.

The project methodology was designed to be broad ranging and flexible in its application and operation. It was developed on the premise that identification of needs and participation by Fellows in a range of CPD activities can assist to maintain and increase the knowledge, attitudes and skills required to keep abreast of the changing nature of specialist medical practice, and assist to develop an ability to practice in a manner that is considered ‘professional’.

It does not, however, claim to make a causal link between participation in CPD activities and the guarantee of professional competence. Participation in CPD is seen as a means to help the profession to self-regulate, and to maintain and improve standards of care.

The project methodology paid attention to several key areas: understanding the LEAP Framework, the type and nature of CPD activities undertaken and the relevancy, usefulness and applicability of the Framework to a range of practices and specialities. This ensured that the project addressed the following needs:

- Served as the impetus to promote the importance of moving medical specialists away from the current ad-hoc trends of CPD programs and activities, to more planned, ongoing and beneficial approaches to CPD development and delivery;
- Emphasised that the traditional focus in maintenance of clinical/technical skills is now considered insufficient for ongoing professional and personal development. Evidence now suggests that, due to the nature and complexity of consumer health care, a stronger need for medical practitioners to develop a wider range of skills, knowledge and attributes in order to manage this intricate consumer health care balance, is required;
- Recognised that participating in CPD activities was not only about increasing technical knowledge and skill, but about facilitating and implementing changes in clinical practice in the wider context and promoting the advancement of primary health outcomes;
- Enabled specialist medical colleges to share and develop the expertise to offer a broader range of CPD activities to their Fellowship, while developing and/or improving relationships between external providers and the colleges.
- Encouraged the attendance of medical specialists in CPD that can facilitate change in their practise (Level Two activities that can lead to Level Three), rather than attendance at passive activities (Level One).

Methodology used

Project Reference Group

A project reference group was convened to advise and support the direction and delivery of the project in its various stages. The group included representatives from CPMC, the NSW Medical Board, the Australian Medical Council (AMC), the Australian Medical Association (AMA), the DHA, the Australian Council for Safety and Quality in Health Care, a Medical Defence Organisation, the Tertiary Medical Education sector and RANZCOG. For a list of the members see Appendix A.

Invitation to participate

The project schedule outlined the recruitment of three to four specialist medical colleges who were willing to be involved in a trialing of the Framework. Invitations were sent to all colleges under the auspices of the CPMC .

An information and consensus workshop was held in Melbourne for colleges interested in participating in the project. Representatives from eight medical colleges, the Department of Health and Ageing and the Committee of Presidents of Medical Colleges, attended, with a facilitator employed to lead discussions. The background behind the development of the Framework was presented and the aims, objectives and time lines of the project clarified. A detailed explanation of the strands, components and levels of the Framework matrix was given and the expectations and responsibilities of participants, colleges and the Project Office, outlined.

Information about the types of CPD activities currently undertaken by specialists was shared. It was evident that individual colleges regarded similar CPD activities differently, not only in their terminology and the allowance given, (generally called ‘credits’ or ‘points’ and often allocated on a ‘per hour’ basis) [for undertaking an activity], but also in terms of their placement in the strands and components (even the levels) of the Framework, to which they should be assigned. For example, publication of a book chapter was given 5 credits by one college and 20 by another. For being an examiner, one college allowed 7 credits per day, another allowed 20. Research activities were considered to be Level One, Two and/or Three by different colleges.

As a result of discussions:

- The definition of Level Two activities was revised to include CPD activities where demonstration of best practice standards can be shown, as well as those activities that can facilitate changes in practice and health outcomes;
- Lists of clinical and non-clinical examples of CPD activities for each level were expanded and the original lists modified;
- The more traditional and generic activities were given the same credits, levels and caps; A cap being the maximum number of credits that could be claimed for a particular activity during the twelve month pilot;
- Minimum guidelines to be met by participants during the pilot were set; and
- Given the number of colleges involved, it was confirmed that the project would be conducted on-line.

It was agreed that, whilst individual CPD college programs varied significantly, commonalities existed and, subsequently, any program developed to test the Framework needed to be generic, but inclusive of individual college-specific activities where known.

It was also agreed that those colleges wishing to participate in the project, were responsible for recruiting volunteers and supplying their contact details, including email addresses, to the Project Office. Volunteer participants would then be involved in trialing the LEAP CPD Framework during the 12 month pilot.

In the end, eight colleges (for a list of participating colleges, see page 18) agreed to participate. Whilst other colleges expressed interest, the timing of this project for them, was less suitable, as several had just introduced and were about to trial their own CPD program, which had some parallels with the LEAP Framework.

Mapping College CPD programs to the Framework

Participating colleges were asked to map their existing CPD program against the matrix of the Framework. This exercise, completed over a three to four week period, was performed in consultation with staff from the Project Office to ensure that all colleges placed similar professional development activities in the same strands, components and levels.

Where differences arose, the activities were placed where it was deemed the most appropriate after referral to the definitions in the LEAP Framework document and the revised ones agreed upon at the information and consensus workshop held previously. Where colleges gave different levels, credits and/or caps for common activities such as examining, teaching and conferences, these were given the same value, to ensure consistency and fairness. In most cases, this figure was averaged from the individual college credits normally given and/or based upon one credit per hour. In addition, all known, generic, non-clinical activities, were entered into each of the college programs, by the Project Office, to enable a more uniform program to exist.

Once completed, this process of mapping the individual college programs to the Framework matrix, provided a gap analysis, which indicated sparse offerings in approximately five of the ten components

of the Framework, particularly in Strands Two and Three, and a lack of Level Two and Three activities in college offerings.

More specifically, the following information was revealed:

- Each college had some CPD activities listed for each of the three strands.
- Four of the ten components had no listed activities. These were: *Clinical Information Access*, *Information Technology*, *Personal Management & Insight and Advocacy & Equity*. A fifth component, *Relationships and Accountability*, had only one activity listed by one college: mentoring.
- For the remaining five components, colleges with larger memberships tended to have more activities.
- The greatest number of college CPD activities were Level One activities, listed under the component *Clinical Expertise*.
- A number of generic CPD activities, such as conferences, professional reading, hospital attachments, teaching, examining, peer reviews, quality assurance activities and skills workshops, were common to many college CPD programs, but not necessarily all.
- Terminology associated with similar educational activities varied considerably between colleges, as did the credits or points available for their completion.

In addition, it was acknowledged by college CPD staff that they were not necessarily aware of all of the activities undertaken by their Fellowship. It was subsequently decided that any CPD program based on the Framework and developed for this project, should allow participants to add their own professional development activities in the Strand, Component and Level thought to be the most appropriate.

This collaborative exercise was useful for:

- developing a consistent college-specific CPD program;
- setting minimum guidelines for the pilot that would be achievable and realistic to all participants, regardless of their speciality or college;
- designing worksheets and templates to guide and assist uptake of level three activities;
- developing and implementing, via a concurrent project, a range of alternative non-clinical CPD activities that were not currently available in CPD programs.

Development of website to host the project

As the number of colleges wishing to be involved was larger than originally anticipated or required under the project contract, it was decided to develop individual college on-line CPD programs based on the Framework and to administer the project by email for greater efficiency and expediency. The Framework was given the acronym LEAP (Learning, Education and Professionalism) for easy identification and a separate website www.leapFramework.edu.au was created to publicise and host the pilot.

All information relating to the Framework and the project was posted on the website, including:

- The background behind the development of the Framework;
- The background, aims and objectives of the project;

- An explanation of the conceptual platform of *medical professionalism*, including the matrix of the Strands, Components and Levels;
- Examples of professional development activities;
- A list of the colleges involved; and
- Worksheets and templates for generic resources relating to Level Two and Three activities.

Employment of an Information Technology (IT) specialist to design an on-line program

An IT specialist was employed to design an on-line program that could host the individual college programs, be accessed via the LEAP website and fulfil the following requirements:

- Have the capacity to contain eight individual college CPD programs and activities based on the 30 cells of the LEAP Framework matrix;
- Allow individuals to choose activities from the pre-entered lists from their specific college program to devise a learning plan based upon the Framework;
- Be able to be accessed using an ID and password to ensure privacy;
- Allow the Project Office to enter new activities in college programs as they became known throughout the pilot period;
- Allow participants to enter their own professional development activities, if not listed, in the appropriate strand, component and level of the Framework matrix;
- Allow participants to add, change or delete activities at any time throughout the pilot period; and
- Be user-friendly in design.

This process took approximately eight weeks. Once completed, eight individual college CPD programs based on the Framework, were placed on the LEAP website. As the development of the on-line aspect took longer than expected, the starting and finishing dates of the 12 month pilot were delayed by approximately four weeks. Thus, for participants, the pilot officially began in October 2004 and finished at the end of October 2005.

Information to participants

Participants were sent an information pack in the mail prior to the start of the pilot. This contained:

- a series of information fliers about the Framework, summarised from the final report of the previous project that was conducted to construct a 'Framework for CPD for Medical Practitioners in Australia' (LEAP);
- a list of generic, non-clinical professional development activities that were being offered via a concurrent, but associated project, called *LEAP in a Rural Context*; responsibilities and expectations associated with participation;
- an ID and password;
- instructions on how to log on, use the website, complete a survey and prepare a learning plan.

In addition to the written instructions on how to navigate the on-line program and plan their learning, a videoconference was also offered to participants. This was held approximately two weeks after the information pack had been sent. Twelve participants attended at eight sites around Australia.

Communication after the mail out and videoconference, was conducted mainly by regular emails, although participants were encouraged to personally contact the Project Office if and when a problem or query arose.

Using their ID and password, participants were asked to complete an on-line survey before devising a personal learning plan using their college-specific CPD program.

From the variety and volume of questions received by the Project Office, it became evident that time commitments and the information technology skills and interests of participants, along with access to email and the internet varied considerably. Although some participants had no problem navigating the on-line program, some found it difficult. To help overcome these challenges, 'Frequently Asked Questions' and their answers were posted on the website and direct contact with the Project Office was encouraged. In addition to anecdotal evidence received during the project, an on-line questionnaire was devised at the end of the project, to help evaluate the CPD program developed and to better understand the major reasons contributing to the difficulties that some participants encountered.

It was deemed important to try and separate any thoughts and feelings about the on-line aspect of the project from those specifically about the Framework, thus ensuring it was the validation of the Framework being tested, not the program being used to host it.

Pre-pilot on-line survey

Participants were asked to complete an on-line survey before devising their learning plan. The aim of this survey was to identify patterns and trends within and across participants from different specialities and practice settings. Data was collated and summarised by college, as well as for the total cohort. College-specific information from this was conveyed to colleges at the commencement of the pilot.

As well as providing a demographic profile, the survey provided information about:

- Previous and current CPD practice;
- Areas participants felt that they had done well, as well as areas that hadn't met their full satisfaction and why;
- Preferred educational formats, times and course length;
- Sourcing and sources of professional development activities;
- Types of activities undertaken; and
- The areas or, more specifically, the strands and components in which CPD had been undertaken in the previous 12-18 months.

The survey was designed to encourage participants to reflect upon their practice and identify areas of knowledge or skills that they would like to learn more about - specifically in relation to the strands and components of the Framework, before devising their personal learning plans.

Learning plans

Once participants had submitted their surveys, they were asked to devise a learning plan to address their CPD needs for the following 12 months. Using their ID and password to access their own college CPD program based on the Framework matrix, participants could choose activities from the pre-entered lists to build their learning plan, or they could enter their own as a 'choose your own' activity under the strand and component thought to be the most appropriate. Participants identified both clinical and non-clinical areas of knowledge or skills that they wished to learn more about in order to enhance their practice. All were encouraged to undertake educational events that addressed what they considered to be deficits or insufficiencies, moving away from what they necessarily felt comfortable with, towards identified areas that they wished to develop further.

Whilst participants were encouraged to pre-plan and 'tailor' their CPD program in advance, they were also encouraged to take advantage of opportunistic learning throughout the project period.

Results of learning plans were again collated by college and total cohort and were conveyed to participating colleges at the commencement of the pilot.

Once the pilot began, the on-line learning plan became known as a 'learning log' for the 12 month period. Participants were encouraged to refer to their learning logs on a regular basis; to record details of any CPD activities undertaken in the templates provided; to read the attached fliers about new CPD

workshops that were being offered in Strands Two and Three of the Framework and to give feedback, ask questions and/or offer suggestions.

Both the initial learning plans and mapping of individual college CPD programs to the Framework matrix were designed to assist with the identification of CPD activities for use in validating the LEAP Framework. A key number of CPD activities, such as clinical audits, professional reading, conferences, teaching, peer reviews, hospital attachments, quality assurance activities and skills workshops were common to many colleges, although, as previously alluded to, terminology associated with these activities was not.

Identification of these more traditional, clinical-based activities provided useful information for the development and implementation of a range of alternative, non-clinical CPD activities that were not currently available in college CPD programs, to be initiated by a concurrent project, called *LEAP in a Rural Context*.

Identification and development of non-clinical CPD activities to help validate the LEAP Framework

Through the *LEAP in a Rural Context* project, funding was provided to source and/or deliver activities to test the validity in practice of the LEAP Framework, notably in the context of applicability to rural specialists. The scope of the project involved the development of activities that reflect aspects of practice from different strands and levels contained in the LEAP Framework matrix, concentrating on Strands Two and Three: *Risk Management* and *Professional Values and Responsibilities*, rather than Strand One, *Clinical Expertise*, which, traditionally, has been the focus of most specialist CPD programs.

A total of twenty-seven CPD events were delivered under this project, using eight core workshop activities contracted from third party providers, from October 2004 to August 2005. These eight core activities were repeated a number of times and addressed not only Level One activities, but also Level Two activities of the LEAP Framework that can be converted to Level Three. All eight activities were from Strands Two and Three of the Framework and involved those components where little, if any, professional development activities were being offered by colleges or providers.

In total, 384 specialists (163 rural, 193 metropolitan specialists and 28 non-specialist participants), from eight medical colleges participated in these CPD events.

In addition to information collected on the day of an activity, about the workshop content and conduct, feedback was also gained from participants several weeks after each workshop. This was to determine the extent to which participants felt the workshop was relevant to their practice, had been useful for their professional development and if attendance at the event had influenced them to make some changes to their professional practice.

As the basis/content of the workshops attended were all from the less commonly undertaken, non-clinical activities, it was felt that the results obtained would provide evidence for validation of the broader roles and responsibilities suggested by the Framework.

Workshops held for college CPD staff

Two workshops were developed and delivered to staff involved in college CPD programs and/or those currently working on Support Scheme for Rural Specialists (SSRS) projects, shortly after the commencement of the pilot. These events, which were attended by 26 staff from participating medical colleges, the SSRS National Office and the LEAP Project Office, addressed the gaps of continuing professional development activities in Strands Two and Three of the LEAP Framework, and the subsequent development of activities in these two strands, as well as how to build Level One activities to become Level Two and Level Three activities.

In addition to developing CPD activities at Levels Two and Three, the main intention of the event was to enable college staff to think about tools that can support Fellows in documenting their learning. At the beginning of each session, participants were given the opportunity to clarify a number of matters with the facilitators, including:

- Understanding of the educational and philosophical underpinnings defining the LEAP Framework;
- Benefits and challenges of introducing change into the already established CPD programs of medical colleges;
- Demands placed upon Fellows, such as the time and knowledge required to identify a Strand and/or Level within the LEAP Framework for an individual activity; and
- Implementation of the LEAP Framework into medical college CPD programs.

These workshops provided an opportunity for college staff representing a range of specialties, to identify and address the gaps identified in Strands Two and Three and Levels Two and Three of the LEAP matrix; to have input into the Framework; and to learn how to enhance current, and develop new, CPD activities for Fellows, particularly in areas not traditionally covered by existing College CPD programs. In addition, the sharing of information, knowledge and expertise between colleges of potential and existing activities and providers made this a useful and beneficial collaborative exercise.

Development of templates to help evaluate the effect of professional development activities undertaken

In addition to outlining the diverse roles and wide range of attributes considered necessary to being a medical professional today, the LEAP Framework advocates the recognition of a wide range of activities as valid for CPD, and proposes three 'levels' of CPD activities.

The three levels of activities are intended to reflect a 'hierarchy' of CPD activities that are based on the ability of the activity to effect and demonstrate change in practitioner behaviour and patient outcomes.

Measuring the ability of professional development programs such as that suggested by the LEAP Framework to effect change in practice is complicated and, realistically, beyond the scope of this project, particularly given the short time frame involved. However, to evaluate where possible, the effect of CPD activities undertaken, participants were asked to respond to a series of questions upon completion of each activity. Higher level activities required more detailed information to be entered.

All activities entered into learning logs required the name, type and level of activity, the date completed and the points allocated. Level Two and Three activities required additional information, including reflection and evaluation of the activity undertaken.

Upon completion of Level Two activities, participants were asked to answer the following three questions:

- Identify: the areas from the activity or event where you could improve or maintain your practice
- Set goals: give examples of what you would like to achieve in the above areas for improvement or developing your practice
- Follow Up: how do you intend to monitor your progress or assess changes you might make?

Upon completion of Level Three activities, participants were asked to address the following additional questions:

- Professional groups involved?
- Issue or topic: what issues were addressed?
- How did you assess the changes made - comparison with Best Practice/Guidelines, Peer Review, Audit, other?
- Data: types of data collected for baseline and comparison?
- Implementation: what ideas and methods were used to change practice? E.g. information sharing, training, incentives, opinion leaders
- Changes sustained: what changes were sustained?
- Challenges: what changes did not work, why ?
- Follow up: how do you intend to monitor your progress or assess whether the change is further sustained in the future?

The above questions were designed to encourage participants to identify, address, reflect and evaluate the action taken to maintain and/or improve their practice. Any changes in specialist practice recorded by participants are self reported. Providing hard evidence of the impact and effectiveness of any changes made on practice or health outcomes was not within the scope of this project.

Pilot guidelines

Guidelines were deliberately kept to a minimum for the pilot. Participants were asked to meet three criteria:

- Undertake CPD activities in each of the three strands (any components);
- Complete 10 points or credits in a level 3 activity (any strand, any component); and
- Obtain 50 points or credits in the 12 month pilot period.

The nature, (type, number, percentage, amount) of CPD to be undertaken in each of the different components was not stipulated or quantified. For most activities, one credit was the equivalent of one hour of CPD. It was not intended that participants should recognise facets of their practice or undertake CPD activities in all ten components of the Framework.

By participating in CPD activities from various components and levels of the LEAP Framework, participants were encouraged to address the broader roles and responsibilities expected of medical professionals today.

EVALUATION

Evaluation of the project involved a mixture of both quantitative and qualitative methodologies, and was conducted in collaboration with the Hunter Institute for Mental Health in Newcastle.

A number of evaluation tools and approaches were used to ensure triangulation and reliability of data obtained and a range of data sources enabled both formative and summative assessments to be made.

Evaluation Instruments

The main instruments and data used to evaluate the project were:

- An on-line survey conducted at the beginning of the pilot to provide a demographic profile and a learning needs assessment of all participants, as described earlier;
- Collection and collation of learning plan data at the start of the pilot to determine the strands, components, types and levels of professional development activities planned by participants;

and whether the guidelines set appeared to be reasonable and achievable within the timeframe given;

- Collection and collation of learning plan data at the end of the pilot to determine the strands, components, types and levels of activities completed by participants, as well as whether the guidelines were able to be met;
- Two participant questionnaires given at the conclusion of the pilot: one to evaluate the conduct of the project, particularly the IT aspect, and one to evaluate the implementation of the Framework into practice, including the theoretical platform on which it is based;
- Focus groups in two States, yielding qualitative responses to set questions on the relevancy of the Framework to participants scope of practice. The same facilitators were used for both groups to ensure consistency of delivery;
- Telephone interviews to help clarify quantitative data, validate other forms of data collection and identify any differences between specialities: these were conducted by one person to reduce response bias;
- Questionnaires to participating colleges to determine the relevancy and applicability of the Framework to their speciality; and
- An evaluation of the workshops conducted for the LEAP in a rural context project that was run concurrently from November 2004 to July 2005 to validate the LEAP Framework on a wider scale.

Participant sample

The twelve month pilot began with 194 participants from eight medical colleges. A variety of practice settings, sub-specialties, locations, gender, age, full/part-time and years of practice were represented.

Each of the 194 participants completed a demographic and CPD survey at the beginning of the pilot and a learning plan outlining their CPD plans for the coming 12 months (see Methodology section above).

During the course of the pilot, 40 participants formally withdrew. The main reasons given were:

- Time constraints (N=18);
- Over commitment to too many projects (N=7);
- Insufficient time to get to know the program better (N=4); and
- Not sufficiently computer literate (N=3).

Other reasons that were singularly cited, included:

- Change in work environment;
- Personal issues;
- Maternity leave and/or pregnancy;
- Close to retirement;
- Didn't wish to do CPD activities in areas other than clinical;
- Didn't believe that they could fulfill all three Strands adequately; and
- Too busy to participate in LEAP as well as the New Zealand CPD program.

By the end of the twelve month pilot period, 154 participants (retention rate = 79%) were officially still participating in the project. Each of these was sent initial reminders to update their learning logs and complete the first on-line survey about the conduct of the project. Those that had not managed to

do either or both of these by the dates set, were further contacted several times by email and phone. Due dates were extended to maximise numbers and to encourage participants who wished to fulfill their obligations to the pilot, but who needed extra time to do so. Participants were generally sent the second on-line questionnaire after the learning logs and the survey had been completed and personal contact made.

At the final cut-off date for the end of the pilot, 28 of the 154 participants had not updated their learning logs during the 12 months or completed the on-line questionnaires. As this group did not have any participation beyond their initial involvement, no contact with the Project Office during the project and no input into any evaluation of the Framework, they were considered to be informal withdrawals.

Thus, the remaining number left in the pilot for evaluation purposes is 126 participants (retention rate = 65%).

Withdrawals occurred across all colleges, age groups and from all states and regions. Of the remaining participants;

- 64% were located in metropolitan areas, 36% in regional and rural areas;
- 66% were male;
- 70% had practiced as a specialist for greater than 11 years, 13% between six & ten years and 17% less than five years.

The demographic profile of the remaining participants was representative of the original sample.

Figure 2 (over page) shows the original (n=194) and final (n= 126) participant numbers by college. The following abbreviations for the colleges have been used:

- RANZCP - The Royal Australian and New Zealand College of Psychiatrists
- RANZCOG - The Royal Australian and New Zealand College of Obstetricians & Gynaecologists
- RANZCO - The Royal Australian and New Zealand College of Ophthalmologists
- RANZCR - The Royal Australian and New Zealand College of Radiologists, Faculty of Radiation Oncologists
- RACP - The Royal Australasian College of Physicians
- RACMA - The Royal Australasian College of Medical Administrators
- ANZCA – Australian and New Zealand College of Anaesthetists
- ACD – The Australasian college of Dermatologists

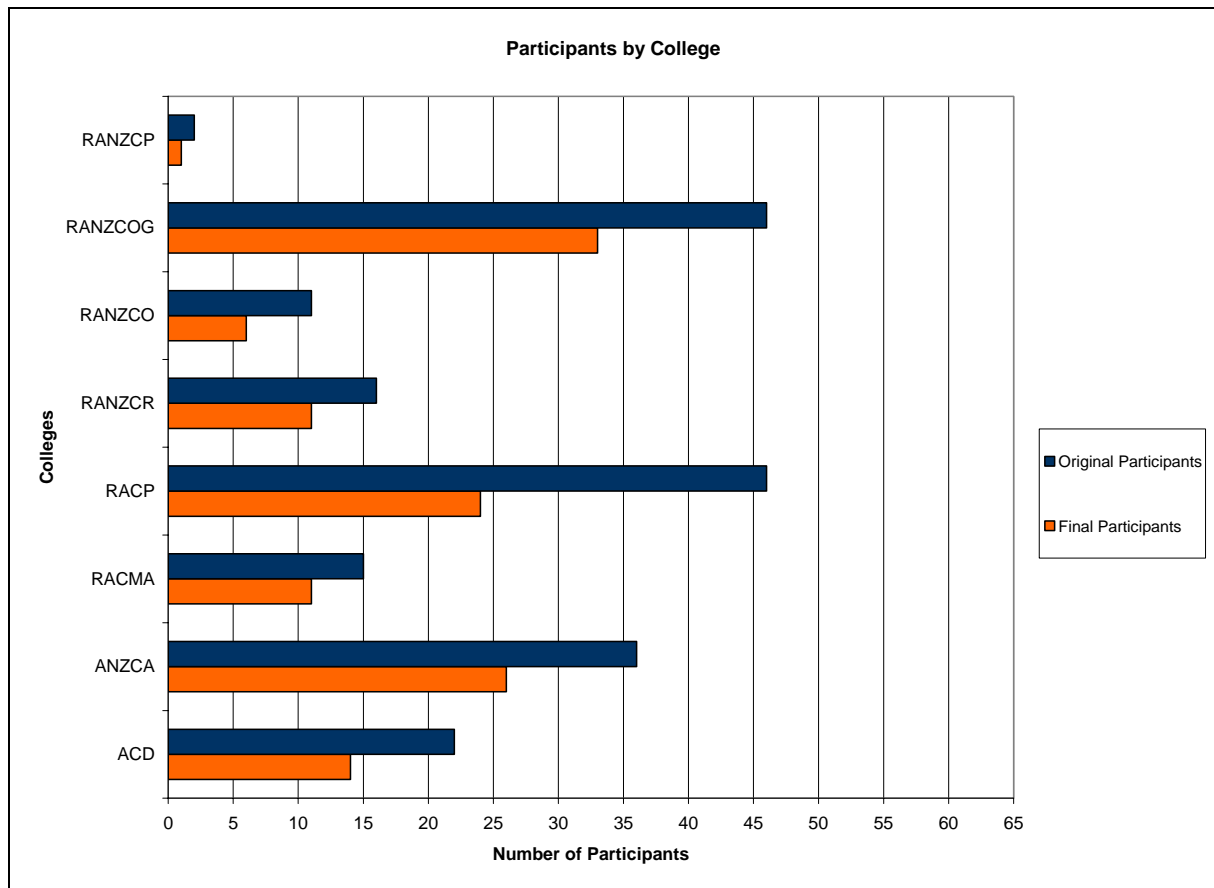


Figure 2 Number of original and final number of LEAP participants by college

Of the final number (126) involved in the evaluation at the end of the pilot:

- 101 (80%) completed their learning logs;
- 125 (99%) completed Questionnaire One on the conduct of the project;
- 102 (81%) completed Questionnaire Two on the Framework; and
- 92 (73%) completed all three final evaluation tasks.

In addition,

- 19 agreed to a telephone interview; and
- 12 attended focus groups held in Melbourne and Adelaide.

Where the above tools have been used in the next section to inform results in meeting objectives, it is acknowledged that participation bias exists as all information obtained is from the participants who remained in the project.

RESULTS: ACHIEVEMENTS AGAINST SET OBJECTIVES

OBJECTIVE 1: TEST THE VALIDITY OF THE CONCEPTUALISATION OF 'MEDICAL PROFESSIONALISM' USED AS THE THEORETICAL PLATFORM FOR THE FRAMEWORK

To test the validity of the Framework, a range of methods was used:

- Data collected in Questionnaire Two;
- Data collated in final learning logs ;
- Information obtained from focus groups; and
- Information obtained from telephone interviews.

The Three Strands

The Framework uses the concept of *medical professionalism* as its theoretical platform; three main *strands* of medical professionalism are identified: *Clinical Expertise*; *Risk Management* and *Professional Values and Responsibilities*.

In the second questionnaire, participants were asked to what extent the three strands accurately represent the major areas of practice associated with being a medical professional today. A Likert scale was used, with '1' being used to represent 'Strongly disagree' to '4' being used to represent 'Strongly agree'. Table 1 summarises the responses given.

	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)	Mean
Clinical Expertise	71	27	2	2	3.64
	69.6%	26.5%	1.9%	1.9%	
Risk Management	36	56	7	3	3.23
	35.3%	54.9%	6.9%	2.9%	
Professional Values and Responsibilities	52	41	7	2	3.40
	51.0%	40.2%	6.9%	1.9%	

Table 1: Feedback from participants in relation to the extent that the three Strands represent the major areas of practice associated with being a medical professional today (N=102)

Over 90% of participants agreed or strongly agreed that the three Strands accurately represent the major areas of their practice.

Information on the spread and percentage of CPD undertaken by participants in each of the three strands during the pilot, and reported in Objective 3 (see later), gives additional support to the three strands being a valid representation of the major areas of practice and that medical practitioners support the notion that being a medical professional today involves more than just the possession of technical knowledge and clinical expertise.

The ten components

As outlined earlier in the report, the above three strands or areas of practice are further divided into a series of ten *components* or domains of *medical professionalism*. Together they offer an outline of the diverse roles and wide range of attributes considered necessary to being a medical professional today.

Participants were asked to rate how relevant they consider each of the ten components to be to their practice.

Again a Likert scale was used, with '1' representing 'No relevance' to '4' representing 'Very relevant'. Table 2 (over page) provides a summary of the responses.

	Very relevant (4)	Relevant (3)	Little relevance (2)	No relevance (1)	Mean
Medical expertise	70	29	2	1	3.65
	68.6%	28.4%	1.9%	0.9%	
Clinical judgment	68	25	7	2	3.56
	66.7%	24.5%	6.9%	1.9%	
Clinical information access	40	49	11	2	3.25
	39.2%	48.0%	10.8%	1.9%	
Communication	59	38	4	1	3.52
	57.8%	37.3%	3.9%	0.9%	
Practice management	18	52	27	5	2.81
	17.7%	50.9%	26.5%	4.9%	
Information technology	24	60	17	1	3.05
	23.5%	58.8%	16.7%	0.9%	
Personal Management and Insight	41	49	10	2	3.26
	40.2%	48.0%	9.8%	1.9%	
Relationships and Accountability	41	46	14	1	3.25
	40.2%	45.1%	13.7%	0.9%	
Advocacy and equity	19	55	24	4	2.87
	18.6%	53.9%	23.5%	3.9%	
Education	44	51	6	1	3.35
	43.1%	50.0%	5.9%	0.9%	

Table 2: Feedback from participants in relation to the relevancy of each of the ten components to their practice (N=102)

The information in Table 2 indicates that a high percentage of participants rated each of the ten components as being relevant or very relevant to their practice. Not surprisingly, *Medical Expertise* was rated to be the most relevant, followed by *Communication*, *Education* and *Clinical Judgement*.

Adequacy of the Definitions of the Components

In addition to being asked about the relevance of the ten components to their practice, participants were also asked if the definitions given in the Framework, effectively described each of the components and what they were envisaged to encompass. Figure 3 (over page) summarises these results.

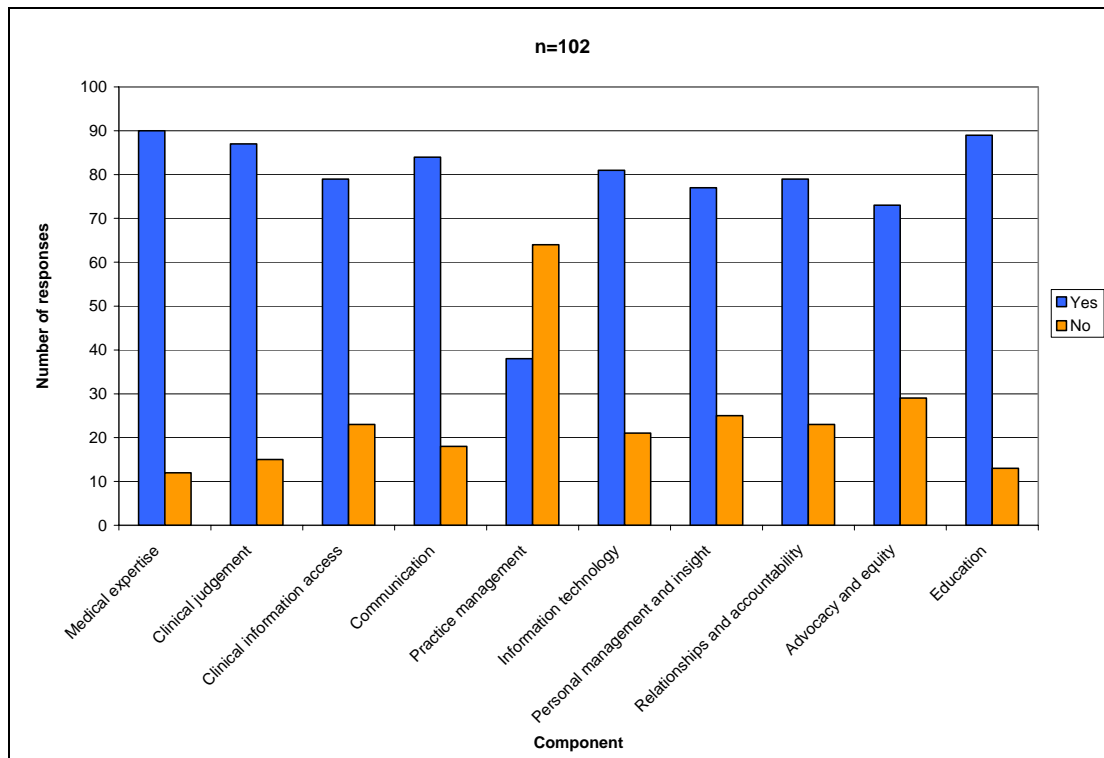


Figure 3: Feedback from participants about whether components are effectively described by their definitions (N=102)

The majority of participants considered nine out of the ten components to be adequately described. The definition of *Practice Management*, however, was felt not to be an accurate description by 63% of participants.

Other relevant data gathered from free text comments and interviews, specifically about *Practice Management*, suggests that:

- The term ‘Practice Management’ means different things to different practitioners, particularly in different practice settings. The brief and perhaps ambiguous definition given for *Practice Management*: “The medical practitioner is aware of the factors that contribute to effective practice management and strives for best practice in this area”, may have contributed to the result obtained.

Clearly, however, practitioners identified this area as one of high importance, as indicated by the number of professional development activities undertaken during the pilot period (see later). This suggests that participants had a problem with the definition of the component, rather than the validity of the component.

This component attracted the highest number and diversity of comments. Comments ranged from:

“Practice management is not concerned with risk management”.

“Practice management is only relevant to those who run a private practice, not to those working in public health”.

“It is the role of the practice manager rather than the practitioner to look after the practice, employ staff, technology, maintain resources etc.”

to those that suggested:

“Practice Management should be renamed, for example, to “Management in Medicine’ so that it is clear that it includes good management practices in the public and the private systems”.

General feedback collected about the other individual strands and/or components, included:

- It was felt that the title and description of the first strand, *Clinical Expertise*, would need to be modified or described differently to make it more relevant and to cover the broader roles of participants working in Medical Administration and Public Health. Suggestions included replacing *Clinical Expertise* with *Management Expertise*, *Professional Expertise* or *Job Expertise*;
- Research was felt to be under-represented in the Framework. Although the component of *Education* acknowledges “the promotion and involvement in credible scientific research” in its definition, several felt that the importance of research was not recognised and, in fact, was highly undervalued. A separate component for research and/or a more detailed explanation of research in the existing definition of *Education*, was suggested; and
- *Medical Informatics* was felt to be over-represented by being listed as two stand alone components in two different strands. This is further demonstrated by the low number of professional development activities undertaken by participants in these areas, although it may also be consistent with the lack of available activities currently offered by colleges.

Comprehensiveness of the Components

Feedback was gained about how comprehensively the ten components described professional practice (Table 3).

Very well (4)	Well (3)	Not well (2)	Not at all well (1)	Mean/4
33	61	7	1	3.24
32.4%	59.8%	6.9%	0.9%	

Table 3: Feedback on how comprehensively the ten components cover the roles and responsibilities of medical professionals today (N=102)

Ninety-two (92%) of participants indicated that the ten components covered the roles and responsibilities of medical professionals today, ‘well’ or ‘very well’. (Table 3)

Additional free text comments were also received. In general, these were very positive. A representative selection of comments, in relation to how comprehensively the ten components cover the roles and responsibilities of medical professionals, have been included below:

“I had thought that it would be extremely difficult to encompass such a wide range of practitioners i.e. those just beginning practice to those who have been working a long time. The Framework has been wide enough to cope with the range of ‘players’ involved and the selection of what one could do is really good”.

“As one who works in both public and private practice, parts of the Framework are relevant to one and other parts are relevant to the other”.

“The roles and responsibilities outlined generally touch on all aspects that I am involved in, except for perhaps Advocacy and Equity”.

“ I thought it was a very good mechanism for looking at CPD and found it very helpful”.

“It is indicating the areas that we now need to be covering. We were not doing this a few years ago e.g. looking at the way our practice is set up, looking at our communication skills etc”.

Less positive comments included:

“The need to do activities and earn points in other areas is de-emphasizing the clinical and technical skills and clinical judgement areas”.

“Some areas I will not be doing as I am too busy and the suggestions go a little beyond what I need”.

“I am familiar with the Canadian system and I think it is better”;

Participants were also asked to specify any additional areas that they felt were part of their role of being a medical professional, but which were not covered in the ten components. Most indicated that the ten components covered their practice reasonably well. Where additional areas were given, most were already covered in the existing component definitions. Those that weren't specifically covered were:

- Increasing community awareness of health issues.
- The value of multidisciplinary teams and relationships.
- Leadership and team building.

All three areas, however, are implicitly covered in the three components of the third strand of *Professional Values & Responsibilities*. The definitions may therefore need to be more explicit.

Additional feedback gained from telephone interviewees and focus group members indicated, that in general, the strands and components encompass their scope of practice and represent a holistic approach to the roles involved in being a medical professional today.

Many felt that, over time, and at different stages of their career, they would choose to complete CPD activities across most components.

For many, having to undertake CPD across the three strands but not in all ten components, was seen as a strength, encouraging participants to choose more widely than they may have done in the past, but in areas of the Framework individually targeted as an immediate need or priority. Most participants stressed that it would not be practical, desirable or necessary to complete activities in all ten components in each CPD cycle, but it was reasonable to be asked to undertake CPD across a range of areas, including non-clinical. In addition, the flexibility of being able to add one's own professional development activities to the components, allowed the Framework to be more relevant to individuals.

Summary and Conclusion

There was general agreement that the three strands and ten components of the Framework comprehensively cover the roles and responsibilities expected of medical professionals today, represent a holistic approach to professional practice and provide a helpful structure to the medical profession of the variety of CPD that is expected today.

In addition, the Framework and participation in the pilot, encouraged participants to think more broadly about the competencies and responsibilities involved and the type and areas of CPD undertaken.

The theoretical platform of the Framework is thus considered sufficiently relevant, applicable and flexible enough, albeit with modifications, to encompass a wide range of specialist's practice. In particular, modifications to the title and/or descriptions of the *Risk Management* Strand and the components of *Clinical Expertise* and *Practice Management*; higher profile for 'research' and a lower profile for the two components of *Medical Informatics*.

OBJECTIVE 2: DEVELOP METHODS FOR CONDUCTING LEARNING NEEDS ASSESSMENTS FOR MEDICAL SPECIALISTS.

To determine the learning needs of participating medical specialists, a range of methods was used:

- Pre-pilot online survey;
- Learning plans analysis; and
- Data collected from Questionnaire Two.

Pre-pilot survey

As outlined earlier in the methodology section, an initial pre-pilot survey provided information about:

- Previous and current CPD practice;
- Areas participants felt that they had done well, areas that hadn't met their full satisfaction and why;
- Preferred educational formats, times and course length;
- Sourcing and sources of professional development activities;
- Types of activities undertaken and the areas, or more specifically, the strands and components from which CPD had been undertaken in the previous 12-18 months.

The following points were collectively identified by the total cohort:

- Areas of practice that specialists felt that they had improved over the last 12-18 months were: improved communication with patients, families and referring doctors; improved clinical skills and practice and more efficient practice management and/or clinic organisation.
- Areas of practice that specialists identified as not meeting their full satisfaction or where they felt improvement could be made were: keeping up to date with current practice and research; time management and organisation; supervision of medical students, RMOs and registrars and undertaking clinical audits and research.
- Case presentations and skill workshops were identified as being the most effective and preferred types of educational formats: self-directed educational packages, including CD-Roms were seen as the least effective or helpful format.
- Specialists indicated that, as well as gaining new knowledge from attending professional development activities, confirmation of their own practice was also an important benefit. The lack of opportunity, however, to adequately practice the new skills learnt adequately, usually due to a lack of time, equipment and/or mentors, meant that their learning was often not maximised and/or reinforced to their satisfaction.
- Monday to Friday evenings was the most popular choice for participation in CPD activities, with 3-4 hours as the most preferred course length; however, most indicated that, if an activity or event was of interest, the day, time and/or length is less important.

- Specialists find out about professional development activities from a range of sources; the most commonly cited were college correspondence, conferences, professional journals and specialist societies.

When asked to identify the areas of CPD undertaken in the last 12 to 18 months, particularly in relation to the three strands of *medical professionalism* outlined in the Framework, a high percentage of participants indicated that they had completed some CPD in all three strands. Not surprisingly, less CPD was undertaken in the two non-clinical strands. It should, however, be noted, that the amount spent on CPD in each strand, was not quantified.

Each of the three strands was further broken down into the various components, with the following results.

- Most specialists reported completing CPD in all three components of the first strand, *Clinical Expertise*, with *Medical Expertise* being the component with highest percentage (more than 80%) reported.
- Fewer specialists reported completing CPD in the second strand of *Risk Management*, with 15% indicating no professional development had been undertaken in this area. Of the four components, however, 62% of participants reported that they had completed professional development activities in *Communication*. Approximately 38% indicated some professional development had been undertaken in each of the three remaining components.
- Just over 20% of participants reported that they had not undertaken any professional development in the third strand, *Professional Values and Responsibilities*. Whilst nearly 70% of participants reported undertaking CPD activities in *Education*, the remaining two components of *Relationships & Accountability* and *Advocacy & Equity* were the areas where CPD was least undertaken when all ten components were compared.

Participants were also asked to classify the CPD activities undertaken in the previous 12 to 18 months, by levels. Not surprisingly, Level Three activities represented the lowest proportion of CPD undertaken by participants.

- More than 50% of participants indicated that over half of their professional development activities would be classified as Level One; e.g. conferences, professional reading, committee membership, etc.
- More than 50% of participants estimated that only 20-50% of their CPD would be Level Two activities; e.g. practice review, patient satisfaction surveys, participative workshops etc.
- Approximately 86% of participants indicated that less than 20% of their CPD would be Level Three activities, such as implementation and evaluation of an activity/intervention or the completion of a quality cycle project.

By identifying types, areas and levels of CPD undertaken in the past 18 months, the survey encouraged the participants to reflect on what they had previously completed and, subsequently, on what they might like or need to learn. Identifying issues, skills, and/or topics was designed to help participants, when completing the next step of devising their learning plans, to move away from choosing those educational events that fit in what they already know, towards those areas in which they may be deficient or would like to learn more about.

Learning plan analysis

After completing the initial survey, participants were asked to devise a learning plan encompassing all three strands and levels of the Framework. The collation of these provided another source of information about learning needs:

- Of the activities entered, approximately 53% of the chosen activities were in the area of *Clinical Expertise*, 21% in *Risk Management* and 26% in *Professional Values and Responsibilities*.

These figures suggest that, whilst *Clinical Expertise* is still regarded as the most important or preferred area for professional development, other, non-clinical, areas that address the broader roles and responsibilities expected of medical practitioners today, are also recognised by participants as being an important part of their practice.

Each of the three strands was further broken down into the ten components to determine the nature and type of activities that had been entered, differentiating between those that were chosen from the pre-entered lists, as well as those that had been entered as 'choose your own' activities.

- Most participants tended to choose activities from the lists provided; however, each component had some 'choose your own' activities entered. The capacity to enter one's own activities was included in the program as colleges may not know of and realistically cannot be expected to be aware of the breadth of professional development activities undertaken by their members. The colleges where CPD has been compulsory for a number of years were able to provide more extensive and comprehensive lists of activities. For the smaller colleges and those that have a number of Chapters, Divisions and/or Faculties, the lists of activities provided were generally more sparse and, in general, the number of 'choose your own' activities, greater.

In summary, the activities listed in the initial learning plans provided additional and complementary information for use by the Project Office to source providers who could offer non-clinical workshops in the areas listed as a priority by participants. As identified previously, these were in Strands Two and Three, and in the components where little, if any, professional development activities were being offered by colleges or providers.

In particular, the following areas were commonly identified and entered into learning plans by participants across all colleges: information technology skills; internet research; accessing up-to-date on-line information; mentoring, work-life balance; communication skills; presentations; public speaking; and trainee supervision.

The LEAP Framework specifically acknowledges general adult learning principles relating to the ways in which medical practitioners learn and that relating to the effectiveness of CPD. As such, individuals are encouraged to identify their own needs in relation to practice, formulate their own objectives, identify resources to meet those objectives and reflect upon the learning undertaken.

As outlined above and earlier in the report, participants were asked to reflect on CPD practice from previous years, identify their learning needs, devise a learning plan using the Framework, and then seek out activities to meet the needs identified. Information collected from learning logs at the end of the pilot, indicates that many participants sourced and undertook professional development in the areas identified in their original learning plans. Table 4 (over page) provides feedback in reference to this process.

	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)	Mean
Preparing a learning plan at the beginning of the pilot helped to identify my needs	0	81	21	0	2.79
	0.0%	79.51%	20.69%	0.0%	
Preparing a learning plan was a way of encouraging me to identify activities throughout the pilot to meet my needs	0	78	24	0	2.76
	0.0%	76.5%	23.5%	0.0%	
Preparing a learning plan to help identify CPD activities that enhance my learning	0	88	14	0	2.86
	0.0%	86.3%	13.7%	0.0%	

Table 4 : Feedback from participants about preparing learning plans (n=102)

There was agreement by a high percentage of participants that using the Framework to prepare a learning plan at the beginning of the pilot helped identify needs and encouraged identification of CPD activities to meet those needs to enhance learning.

In addition, the Framework is considered to be a useful tool for helping practitioners to identify their learning needs, particularly in areas other than traditional medical and clinical knowledge and expertise.

OBJECTIVE 3: DEVELOP, ADMINISTER AND EVALUATE CPD PROGRAMS BASED ON THE FRAMEWORK AT BOTH THE COLLEGE AND FELLOWSHIP LEVEL.

To develop and administer college-specific CPD programs based on the Framework, a range of sources were used:

- Information gained from a consensus workshop held prior to the commencement of the pilot;
- Consultation with CPD staff from participating colleges;
- Mapping of individual college CPD programs to the Framework matrix; and
- Design of an on-line program and employment of an Information Technology specialist;

Information gained from these four sources, and which were reported on under 'Project Methodology', were used to develop and administer the CPD program that was used by participants during the pilot.

To evaluate the CPD program based on the Framework, a range of sources were used:

- Data collected from an on-line questionnaire conducted at the completion of the pilot;
- Data collated from learning logs; and
- Information collected from telephone interviews and focus groups.

Data was collated from participant learning logs to help evaluate: whether the actual CPD program developed was helpful and relevant to their needs, and, in particular, whether participants were able to undertake professional development activities across the range of strands, components and levels suggested by the Framework; and were able to meet the guidelines set for the pilot.

Further data was also obtained to evaluate and provide insight into the on-line aspect of the CPD program developed, the practicalities of using a web-based program to record learning activities and email as the major method of communication, as well as valuable information for any future on-line projects for medical specialists.

Evaluation of the CPD program based on the Framework

During the pilot, participants were asked to meet three guidelines:

- To undertake CPD activities in each of the three strands, in any components;
- Complete 50 credits overall in the 12 month pilot period; and
- Obtain a minimum of 10 points or credits in a Level Three activity.

Data taken from the learning logs showed that the first two guidelines were able to be met by the majority of participants, with 88.1% completing CPD in each of the three strands and 97% obtaining a minimum of 50 credits during the 12 months. Fewer participants were able to meet the third guideline, with 54% of participants completing a minimum of one Level Three activity. However, almost all Level Three activities that were entered earned a minimum of ten credits and 21% of participants actually reported completing more than one Level Three activity.

These results are reported in more detail below.

Professional development activities undertaken, by strands.

Individual leaning logs were examined to determine how many strands were selected by the participants. Table 5 summarises the number of participants who completed CPD activities in each of the three strands.

	Three Strands	Two Strands	One Strand
Participants	89	10	2
	88.1%	9.9 %	1.9%

Table 5: Number and percentage of participants who completed CPD in each of the three Strands (N=101)

Eighty-nine (89) out of 101 participants completed CPD across all three strands. A further 10 completed activities in at least two of the three strands. Thus, the majority of participants identified and undertook CPD activities in areas additional to those directly related to their clinical area.

Further data was then obtained from learning logs to determine the percentage of CPD that was undertaken from each of the three strands. The information collected is summarised in Figure 4 (over page).

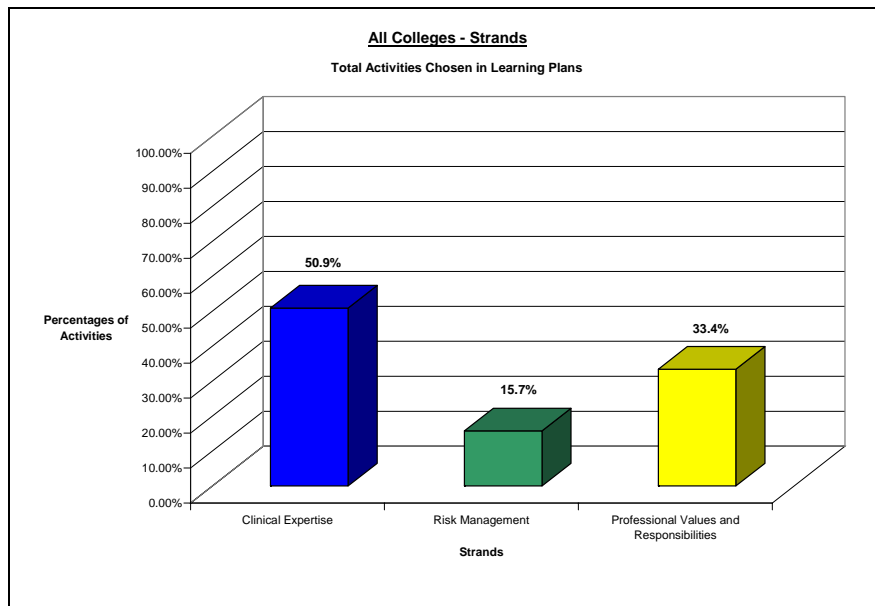


Figure 4: Percentage of CPD activities undertaken by participants in each of three Strands (N=101)

Reference to Figure 4 indicates that, of the activities undertaken, just over 50% were in *Clinical Expertise*, 33% in *Professional Values & Responsibilities* and the remainder in *Risk Management*.

From the information above, it would appear medical practitioners support the notion that being a medical professional today involves more than just the possession of technical knowledge and clinical expertise, and that CPD may involve participation in activities other than those with a clinical basis.

Professional development activities undertaken by components

Data was also collated from learning logs to determine the percentage of professional development activities actually completed by participants in each of the ten components. The results are consistent with how they rated their relevance, which was reported on in Objective One. Figures 5, 6 and 7 show the percentage of activities completed by the total cohort in each of the components, by strands.

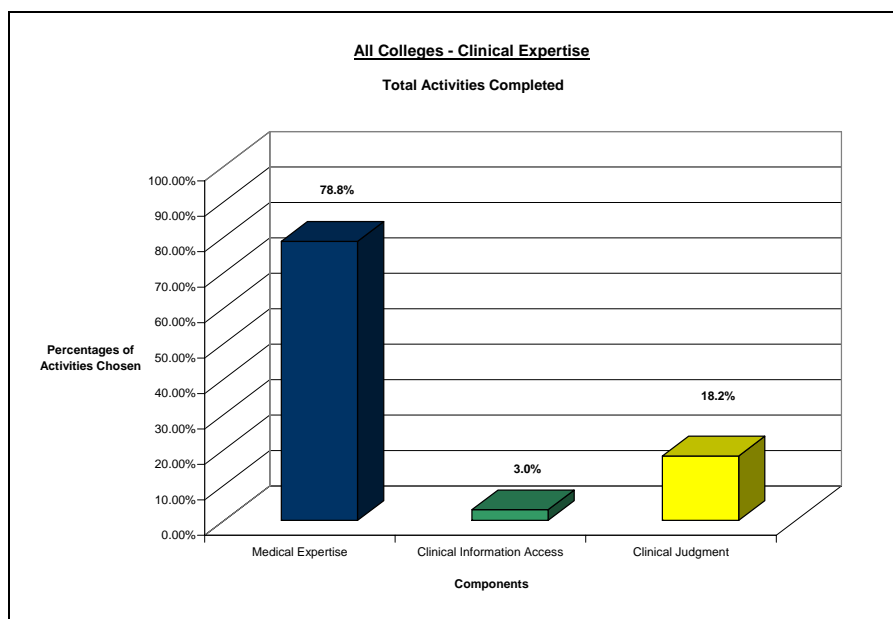


Figure 5: Percentage of activities completed by participants in the components of Strand One - Clinical Expertise (N=101)

Nearly 79% of activities completed in Strand One were in the component of *Medical Expertise*, with *Clinical Judgement* being the next highest component with approximately 18.2%. It should be noted that when mapping the college CPD programs to the Framework at the beginning of the project, none of the colleges had identified any activities under *Clinical Information Access*. This may help to explain the lack of activities in this component.

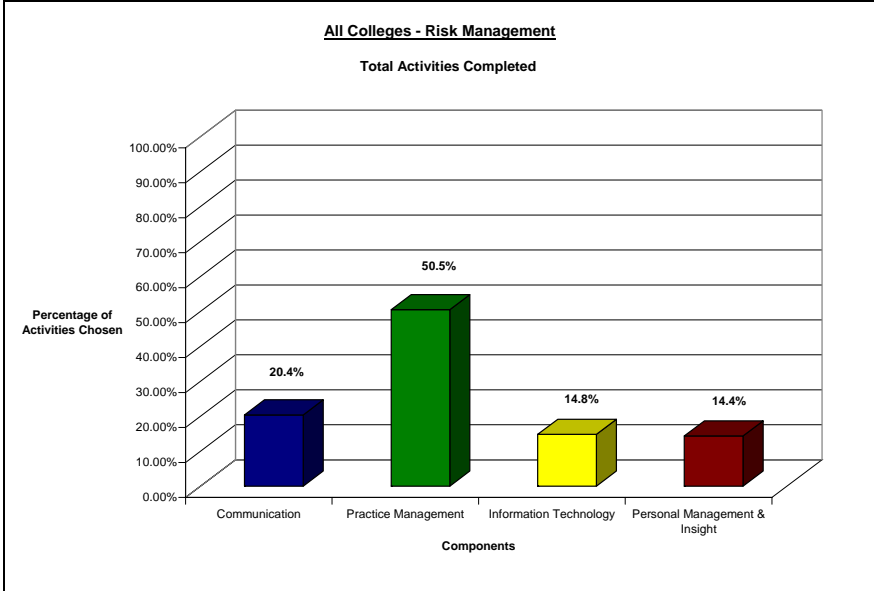


Figure 6: Percentage of activities completed by participants in the components of Strand Two – Risk Management (N=101)

Approximately half of the activities completed in Strand Two were in the component of *Practice Management*, with *Communication* having the next highest number at 20%. No college had activities entered under *Information Technology* originally, although workshops developed during the project in this component, as well as in *Personal Management & Insight*, were offered to participants during the pilot period.

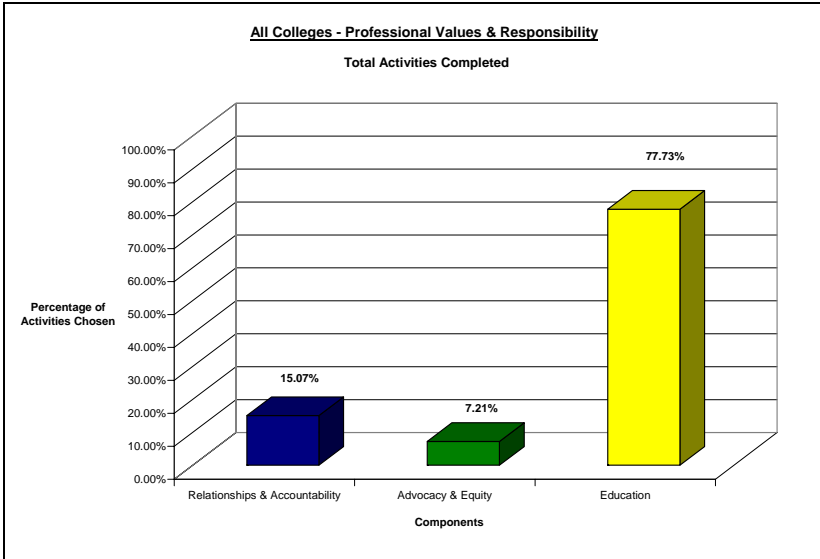


Figure 7: Percentage of activities completed by participants in the components of Strand Three – Professional Values and Responsibilities (N=101)

Over three-quarters of the activities undertaken in Strand Three were in *Education*. Whilst *Advocacy & Equity* had the lowest number of activities, more participants ended up completing activities in this component than they indicated in their original learning plans.

Again, no college CPD program had any activities entered under this component. Four ‘Introduction to Expert Witness Training’ workshops were developed, however, and offered to participants during the pilot. This may help to explain the increase, albeit small, in activities completed in *Advocacy and Equity* and suggests that some participants identified this less traditional area as one area of importance.

General feedback collected about the individual strands and/or components within the CPD program, developed for use in the pilot, includes:

- Undertaking continuing professional development in some of the components appears to be more difficult than others because of a lack of available current activities. In particular, the components of *Advocacy & Equity* and *Personal Management and Insight* were highlighted. During the project, workshops in expert witness training and mentoring were developed and offered under the concurrent *LEAP in a Rural Context* project. Both were repeated four times, as a result of demand. Identification by participants of these two non-clinical roles as areas of importance give some validity to the relevancy of these two components;
- Another component where few, if any, CPD activities were provided by colleges is in *Information Technology*. Again, workshops to address this area were sourced and offered to participants through the concurrent project. These were repeated according to demand. Seven ‘Computer Based Literacy’ workshops and two ‘Introduction to Evidence Based Medicine’ workshops were conducted over an eight month period, Again suggesting the validity of these less traditional, non-clinical areas of practice;
- For those working in a small rural practice or those not involved in a teaching hospital, fulfilling requirements from Strand Three, *Professional Values and Responsibilities*, was cited as obtainable but challenging to achieve; e.g. teaching, mentoring and presenting are not usually associated with private practice;
- Classifying ‘choose your own’ professional development activities into the relevant strand and component was not always straight forward, despite the definitions given; In Questionnaire Two, 59% of participants expressed difficulty and some confusion in doing so. It was felt that the content of some activities meant that the activity could theoretically fit under more than one strand and/or component, therefore it became necessary to make an arbitrary decision, acknowledging that another practitioner from a different or even the same college may classify it differently; and
- The unfamiliar and less traditional terminology used for the component headings made it initially difficult for some participants to identify different aspects of their practice to the Framework and also how to include them in their CPD program.

Levels of professional development activities undertaken by participants

In addition to undertaking professional development across the three strands and various components, participants were asked to undertake different levels of CPD activities, and where possible, to undertake a Level Three activity. As reported earlier, 54% of participants completed a minimum of one Level Three activity; 21% of participants reported completing more than one level three activity.

Level One and Two activities were undertaken in all three strands and all ten components.

Level Three activities were undertaken across all three strands and in a range of components.

The highest number of Level Three activities were in the components of *Clinical Judgement* and *Practice Management*. The components of *Education* and *Medical Expertise* had the next highest number. Figure 8 shows the number of Level Three activities by strand and component, taken from learning logs at the completion of the project.

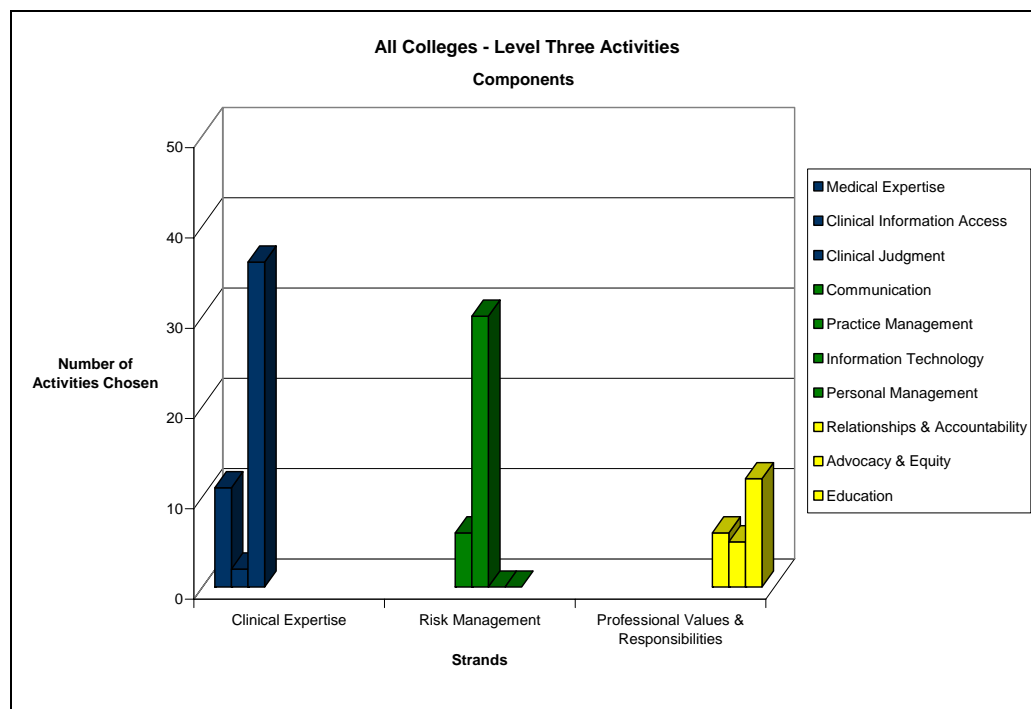


Figure 8: Number of Level Three activities undertaken by strands and components(N=101)

As several colleges represented in the project did not have any Level Three activities entered under any strand or component, the Project Office developed generic worksheets and templates to assist participants. These were entered into each college-specific CPD program for participants to view and/or download. Many used these examples, which were based on completing the quality cycle, to design their own Level Three activity. Where participants were unfamiliar with the processes involved, they were encouraged to choose a small area of their practice to review, such as an audit of a technique, treatment or policy. A range of Level Three activities were undertaken by participants, including practice visits and risk assessment activities encouraged by individual Medical Defence Organisations.

Despite some colleges not having Level Three activities in their current college CPD programs, participants from all colleges managed to undertake Level Three activities. For some participants, it was the first CPD activity that they had completed of this nature.

The following is a list of the generic types of level three activities undertaken. Most involve Quality Assurance/Practice Improvement activities. Specific topics have been omitted.

- Practice Review activity on operating and/or performing procedures with a peer
- Clinical Audit of a new procedure instigated
- Review and revision of a hospital policy
- Practice Review activity on a practical skills workshop attended
- Revalidation audit
- Design, facilitation and evaluation of a workshop
- Audit of an education module designed for registrars
- Audit of the introduction and review of a new service
- Mastering Adverse Outcomes - Practice Review audit activity

- Major Review of current Practice Policies
- Medical Indemnity Organisation - Risk Management activities
- Extensive Research activities
- Clinical Audit for accreditation by the ACHS
- On-site Professional Practice Review

From the list above and the information contained in learning logs, it is evident that activities varied in the degree of planning and evaluation involved, ranging from small-scale follow-up issues arising from involvement in other CPD activities, to larger-scale, longer-term involvement in formal quality assurance projects or targeted interventions.

Whilst it appears that with encouragement and guidance, some participants were able to complete such activities, other participants found it more challenging.

When asked if completing a Level Three activity was difficult, responses ranged from those who expressed no difficulty, to those who experienced considerable difficulty.

For those participants who did complete a Level Three activity, many responded very positively about their experience:

“Once I thought about what to do and involved the staff in my practice, everyone was really keen and enthusiastic to do it”.

“Planning a Level Three activity made me think very deeply about what to do and what to evaluate. I felt really good thinking about the practice”.

“The Level Three activity I chose was one we had planned on doing anyway. This gave me the impetus to actually do it. There are twenty of us in the practice and if each of us set up our own survey we would have to employ more people to collate the results”.

“I completed an audit for mine and got the information I required, enabling me to see that my change in Clinical Practice was producing the effects that I thought it was”.

“The pilot and the Framework encouraged me to actually conduct an audit, something I had been thinking about, but had not previously got around to doing”.

For those participants who expressed difficulty in completing a Level Three activity, the most common concerns included:

- the time, thought and effort required;
- the difficulty of choosing an appropriate activity; and
- the need for more guidance, advice and support, particularly for those in private practice.

It was universally agreed that more than a twelve month time period is needed to complete Level Three activities.

Some of the reasons given for not completing a Level Three activity include:

“Whilst I implemented and evaluated a change, there was insufficient time to take it further. In a rolling three year program, this would not be a problem”.

“It was very difficult to think about the examples given and apply them to my area of expertise. Auditing my own activities is difficult as everything I achieve is by influencing other

people. I cannot envisage implementing a new technique and evaluating the outcomes. This is an area where I would like more guidance from my college”.

“It was not clear enough and that made it difficult. I did not do it because I did not have the time to spend trying to understand it in the first place”.

” To prove that one has actually completed a Level Three activity is quite difficult: e.g. one can complete all of the preliminary tasks associated with an audit, and work out how to implement the changes; however, the difficulty is in proving that the problem and the effect of change is measured. I do not know how one would do that properly”.

“One needs more advice on what a Level Three activity is and how it might be carried out in one’s practice”.

“A lot more thought, time and effort goes into planning and operating a Level Three activity. The idea that I collect information, analyse it, formulate a plan and collect more information, I find really difficult. Quality assurance type projects are sometimes carried out where I work. While to a certain extent they do provide relevant information, they require an enormous amount of work on somebody’s part to manipulate the information. I do not have the ability, inclination or time to do it”.

“I am not looking at conquering mountains at this stage of my career, so I have a philosophical problem with completing Level Three activities”.

Additional feedback about the levels of activities identified a number of general issues:

- Difficulty and/or confusion in allocating professional development activities to levels, as it was felt that some activities could cross two levels;
- Many level two activities are currently undertaken by practitioners without a formal follow-up or review of subsequent outcomes because of the time involved. Therefore, despite their ability to do so, some practitioners would not progress them into level three activities;
- Some felt that the distinction between level one and two was minimal and in fact could be combined as one; others found it difficult to distinguish between level two and three activities; and

Issues raised specifically about Level Three activities were:

- Level Three activities should be weighted more highly than a level one or two activity as activities should be weighted to reflect what a specialist learns from the activity; the benefit or outcome for the practitioner and patients; and/or to the amount of work involved.
- Level Three activities should not be expressed as those that place a higher demand on the practitioner as this implies they are more onerous to complete.
- Level Three activities are generally seen as difficult because of the time commitment involved, the guidance needed and previous lack of experience in undertaking one.
- Completing a Level Three activity within 12 months is difficult for some activities because of the amount of data collection required.
- Level Three activities were generally seen as more difficult and less practical to complete by those in private practice;

- Those in the hospital system or involved in multi disciplinary teams appeared more comfortable and familiar with level three activities such as reviewing practice, undertaking audits and completing the quality cycle; and
- Whilst the generic Level Three worksheets and templates were useful, more college-specific examples and guidance would have been even more helpful and likely to increase participant confidence and motivation to undertake a level three activity.

In summary, for those who completed a Level Three activity, it was seen as a challenging yet satisfying and positive learning experience. For those who didn't manage to undertake one during the project, more time, guidance, support and crediting the activity with a higher weighting system more commensurate with the energy and effort involved, may act as an incentive. Identifying and choosing an area within the context of the work environment or practice is also important.

In addition to being asked to record information about CPD activities undertaken in their learning logs, participants were asked to respond to statements about the types and levels of activities undertaken. Table 6 summarises these responses.

	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)	Mean
In the pilot I have undertaken more Level 2 activities than I would have done previously	0	14	76	12	2.02
	0.00%	13.73%	74.51%	11.76%	
In the pilot, I have undertaken more Level 3 activities that I would have done previously	0	20	68	14	2.06
	0.00%	19.61%	66.67%	13.73%	

Table 6: Feedback on statements about the amount of Level Two and Three activities undertaken (N=102)

Feedback suggests that, whilst the majority of participants may not necessarily have undertaken more Level Two and Three activities than in previous CPD periods, some did.

Fourteen (14 percent) of participants indicated that they had undertaken more Level Two activities and 20% of participants more Level Three activities, than they would have done previously. Although this represents a relatively small number of participants, it does suggest that the hierarchy of levels of professional development activities presented by the Framework encouraged some participants to identify and choose more professional development activities that are seen as able to effect change in practice, than they may have otherwise done.

General feedback about the three levels of activities

There was strong agreement amongst the focus groups and telephone interviewees that the three levels of activities represented the depth and breadth of activities undertaken for CPD, were within the bounds of expected professional development and were adequately differentiated according to their capacity to increase knowledge, facilitate and/or evaluate change in professional practice.

Participants were also asked to what extent having to think about and undertaking a Level Two and Three activity, promotes reflection and evaluation of practice.

There was strong agreement that, by their very nature, undertaking a Level Two and Three activity does cause one to reflect and evaluate practice and/or health outcomes. These are reflected in comments such as the following:

“Having changed from public to private practice I feel that reflection and evaluation have not been addressed in the latter as people have other agendas. I think that it is critical”.

“While reflection is an absolutely key part of learning we are all so busy it is difficult to assess how much one actually does reflect. One needs to set aside a specific time to actually reflect. When writing up a Level Three activity, the structure of the questions in the learning log enables and encourages one to reflect from that point of view”.

“In the past clinicians attended conferences and lectures and just sat and listened. Quality improvement and evaluation is relatively new to many, particularly to those in clinical practice, although not to those who work in a hospital”.

“It certainly makes one think, what have I changed? What do I think I could do differently? If you have effected a change, was it was most likely valuable?”.

“I tended to enter my information too infrequently and while I did reflect when I recorded information, it was not often enough. This problem would have been worse had one recorded the information manually. On-line prompted one to reflect on areas that might not have been thought about had it just been straight record keeping”.

“The ones you are involved in will be reflected upon without specifically noting that one is reflecting. This would not happen when reading a journal so the process is quite valid”.

“Having the three levels, certainly made me think about higher level activities and reflect on them”.

In conclusion, participants agreed that undertaking Level Two and Three activities encourages and promotes reflection and evaluation of practice.

Evaluation of the on-line aspect of the CPD program

Feedback on the on-line program used to host the Framework

Navigation of the on-line program was found difficult or very difficult by 58% of participants, with many stating that the program needed to be more intuitive, user friendly and less time consuming, particularly for infrequent users. The participants who found the program relatively easy to navigate tended to be those who already did their existing college CPD program on-line, those who regularly used email and the internet either at work or after hours, those that visited and/or updated their learning logs more regularly and those who were younger.

As the majority of participants only updated their learning logs every two or three months, or at the start and end of the project, it is perhaps not surprising that many found the program challenging. Additional comments received from the telephone interviews and focus groups identified three major reasons for the difficulties encountered by some participants:

- Infrequent use;
- Lack of computer skills and/or access; and
- Non-intuitive nature of the on-line program.

“ In retrospect, I wished I had more regularly updated my log throughout the project as I realised it was a good system to adopt in the end”.

“ I realise the complexity of the program could have been reduced by more continual use”.

“ As long as one has the time to go through it and read it all, it is able to be understood”.

“It did take some time to familiarise oneself with the process, but once in place, it was quite straight forward”.

“I used the hospital to access everything and found it was not entirely reliable to do so”.

“Too often assumptions are made that everyone has the same access to technology and that is simply not the case. Some people will be left behind”.

“ My main problem has been my lack of IT skills. I really needed an online, at-home, after-work tutorial. I would then have been more motivated to use the website”.

“People who are not regular computer users will be put off if it is not easy to use. They will just continue to put it off and never actually get around to recording the information. Despite the fact that I am fairly computer literate, it should be more user friendly”.

“Make it more user friendly. One does not access it frequently and to find time to do so is difficult enough, one does not then want to learn how to use a programme that is so unfamiliar”.

“Manoeuvring around the programme in the various Level s was quite difficult because it was not possible at any stage to see the big picture. There was never any stage where I could get an overview of the whole Framework. It was not until the very end that I appreciated the various components of it”.

“It is too cumbersome. I was happy with what I was able to achieve with my CPD this year, however when it came to recording it I found that the most difficult and time consuming. It was a busy time of the year and I did not have time to sit down, read and re-remember the Framework on the computer. While the focus is to make sure people are keeping up to date with CPD it is essential that the process is not too burdensome”.

“Make the steps a little more intuitive and have a link to immediate help. If one was attempting to put an activity in the wrong area, it would be very helpful for the program to let you know. Access to help needs to be immediate”.

Feedback on communication issues

When asked about using email as the major method of communication for the progress of the project, 86% of participants reported that it was an effective or very effective method of communication, although only 50% admitted that they read their LEAP related emails immediately or within 2 days of receiving them. A further 26% said they read them within one week. Only two participants suggested that emails should be followed up by hard copies of correspondence.

Participants were very satisfied that they were able to ask questions or make suggestions throughout the pilot, with many using email and the phone to seek assistance. This was particularly important as the on-line aspect proved a challenge for many. As the Project Office could access individual learning logs at the same time as the participants, many chose to add and delete from their learning logs whilst on the phone with a staff member. Whilst initially time consuming, this one-on-one support enabled the major difficulties and common problems to be identified and addressed and allowed participants the freedom of exploring the program without fear of doing something wrong.

Feedback on on-line delivery of a CPD program

Despite the difficulties encountered with the actual software program, many participants liked having their learning log and their college CPD program and activities listed on-line. Comments such as the following were representative of this group of participants.

“I liked having so many choices for the activities listed, along with the dates and contact phone numbers, which made it so much easier to get on and actually do the activities”.

“An on-line program is great. It was very helpful to record my learning activities in that manner and to be able to revisit it when one wanted to amend it or think about what points needed to be allocated. This definitely brought the rigour into it for me. Often we do activities and never record them. However, this meant that I had to think about it to begin with, then when completed, I had to think about what I had done and write it up. I found this best of all and really enjoyed it”.

“The electronic system allows one to review the activity at any time and see the accumulation of points to ensure that individuals satisfy the requirements”.

“Having an idea of workshops and resources that are going to be available in advance or later in the year is very useful for planning”.

“Recording the information this way is much better than registering the information in document form with the college”.

“I think the overall idea and presentation of the LEAP Framework and a learning plan is a good one. The electronic documentation of activities certainly helps one to keep track of activities you have done, if you can be disciplined about keeping it up”.

There were only a few participants who did not like the on-line aspect of planning and recording their CPD. Given that the project was advertised as an on-line project, this is perhaps not surprising. The main reasons given were the time and complications involved:

“There is no way that I would do it on-line. It is extremely frustrating. For sixteen years I have recorded it longhand and my staff type it up for me. I am most comfortable with this”.

“This is more wieldy. I keep a tally on the top of the page in my diary. At the end of the year I go through it and add up how many hours I have completed in each category. It probably only takes an hour at the end of each year”.

Most participants appreciated that the program allowed them to choose from their college lists, as well as entering their own activities under each of the components. A number of issues, however, were identified:

- Some college activities were not listed at all;
- Some activities did not contain enough details, such as dates, venues etc;
- Familiar activities, such as giving lectures, journal reading and attending conferences were listed under different sub-headings than their current college CPD program;
- The credits or points given in LEAP were different to what participants had previously collected and where credits were not given for activities in college programs, some participants would have preferred them to be stipulated.

Summary and conclusion

The Project Office, in consultation with staff from participating colleges, mapped existing college CPD programs and activities to the matrix of the Framework. An IT specialist was then employed to design and develop a program that would encompass eight college-specific on-line CPD programs and could be accessed by individuals via the LEAP website.

Participants used these to devise a personal learning plan for the 12 month pilot period, choosing activities from those activities already listed under each of the strands and components, or entering their own activities. New CPD activities and events were added to each of the college programs as they became known. Individuals were encouraged to visit and update their learning log as regularly as time would permit.

Participants were asked to meet three guidelines. A high percentage were able to meet two of these, with 88% of participants completing CPD in each of the three strands and 97% obtaining a minimum of 50 credits during the twelve month pilot. Fifty-four (54%) of participants completed a minimum of one Level Three activity.

Despite some colleges not having Level Three activities in their current colleges CPD programs, participants from all colleges managed to undertake Level Three activities.

For those who completed a Level Three activity, it was seen as a challenging, yet satisfying and positive, learning experience. For those who did not manage to undertake one during the project, more time, guidance, support and crediting the activity with a higher weighting system more commensurate with the energy and effort involved, may act as an incentive. Identifying and choosing an area within the context of the work environment or practice is also important.

Participants agreed that undertaking Level Two and Three activities encourages and promotes reflection and evaluation of practice and that the structure of the Framework encouraged them to incorporate a broader range of activities into their CPD, many of which address the needs and expectations of the broader community.

Many participants found the design of the on-line program complicated and not sufficiently intuitive for routine use. A lack of time, ready access to email, the internet and a lack of IT skills, made the program even more challenging for some. However, participants appreciated having college-specific

and generic CPD activities listed, despite the fact that the terminology and credits allowed were sometimes different from their normal college program.

The flexibility of on-line delivery of CPD programs was seen as a strength by participants, as was the ability to choose, plan, source, record and change learning activities on-line.

In principle, a CPD program based on the LEAP matrix would, with simplification and modification be a reasonable model for colleges to adapt and adopt for their Fellowship.

OBJECTIVE 4: EVALUATE SPECIFIC CPD ACTIVITIES [IN STRANDS TWO AND THREE IN PARTICULAR], THAT WILL ENABLE THE FRAMEWORK TO OPERATE SUCCESSFULLY IN PRACTICE

To evaluate CPD activities that will enable the Framework to operate in practice, a number of methods were used:

- Results collected from the *LEAP in a Rural Context* project report
- Data collected from participant Learning Logs

Through a concurrent project called *LEAP in a Rural Context*, funding was provided to source and/or deliver activities to test the validity in practice of the LEAP Framework, notably in the context of applicability to rural specialists. The scope of the project involved the development of activities that reflect aspects of practice from different Strands and Levels contained in the LEAP Framework matrix, concentrating on Strands Two and Three: *Risk Management* and *Professional Values and Responsibilities*, rather than Strand One, *Clinical Expertise*, which, traditionally, has been the focus of most specialist CPD programs.

A total of twenty-seven CPD events were delivered under this project, using eight core workshop activities contracted from third party providers, from October 2004 to August 2005. These eight core activities were repeated a number of times and addressed not only Level One activities, but also Level Two activities of the LEAP Framework that can be converted to Level Three. All eight activities were from Strands Two and Three of the Framework and involved those components where little if any professional development activities were being offered by colleges or providers.

In total, 384 specialists (163 rural, 193 metropolitan specialists and 28 non-specialist participants), from eight medical colleges participated in these CPD events.

The activities offered, along with their applicable Strand and Component from the LEAP Framework are as follows.

- **Introduction to Evidence Base Medicine (EBM)**
Strand: Risk Management
Component: Information Technology
- **Introduction to Expert Witness Training (EWT)**
Strand: Professional Values and Responsibilities
Component: Advocacy and Equity
- **Computer Based Literacy (CBL)**
Strand: Risk Management
Component: Information Technology

- **Difficult Doctor Patient Relationships (DDPR)**
Strand: Risk Management
Component: Communication
- **Mentoring in the Workplace Environment (MWE)**
Strand: Professional Values and Responsibilities
Component: Education
- **Work Life Balance (WLB)**
Strand: Risk Management
Component: Insight and Personal Management
- **Teaching on the Run (TOTR)**
Strand: Professional Values and Responsibilities
Component: Education
- **Medical Responses to Adults who have Experienced Sexual Assault (RSA)**
Strand: Professional Values and Responsibilities
Component: Advocacy and Equity

Feedback from the workshops was generally very positive and addressed not only the content and conduct of the workshops, but also whether the activity had influenced a change in clinical practice. Three evaluation surveys, distributed at different times relative to the CPD event were used to determine this. Most notably, a survey sent towards the end of the project period indicated that 97% of respondents considered the activity(-ies) they had attended had been relevant to their practice; 95% of respondents considered the event(s) had been useful for their professional development and 86% of respondents indicated that attendance at the event had actually influenced them to make some change in their professional practice.

Given that the activities provided were all from Strands Two and Three of the Framework, the concept of offering these types of activities as CPD for specialists would also appear to be valid. This adds to the evidence for the validation of the Framework overall.

Unexpected benefits included the mix of specialists attending the same workshop and understanding the perspective of others, some participants using videoconferencing for the first time as a means of professional development and specialists seeking out non-clinical workshops, thus acknowledging the wider range of knowledge, attitudes and skills required to keep abreast of the changing nature of specialist medical practice.

For all activities, information was collected on the day of the activity to ascertain participants' attitudes toward the workshop in relation to aspects of each of the following:

- workshop content;
- workshop materials; and
- workshop facilitator.

Approximately six weeks after an activity, additional information was collected from participants that sought to ascertain the extent to which an activity was felt to have produced a change in knowledge or practice, based on the objectives of each activity.

Information was generally collected using statements attached to Likert scales with ratings from '1' (Strongly disagree) to '4' (Strongly agree).

At the core of its philosophical underpinnings, the LEAP Framework aims to involve medical specialists in CPD that is relevant to their practice, useful in terms of their professional development

needs, and able to influence change in their professional practice, consequently either maintaining or improving the standard of healthcare provided by the practitioner. Towards the end of the project, all attendees (both rural- and metropolitan-based) who had attended any of the events provided under the project were sent a survey asking them to rate the extent to which they agreed with each of the following statements, in the context of the activity(-ies) that they had attended.

- The Workshop was relevant to my practice.
- The Workshop influenced me to make changes to my practice.
- The Workshop was useful for my professional development.

It is thought that the extent of agreement to these simple statements can give an indication of the extent to which participation in the activity in question matches the broad aims of the Framework and, as far as is possible, indicates face and content validity of the Framework.

Consequently, it is the face and content validity of the activities and the Framework that were evaluated in the project that delivered these activities.

Evaluation of the effectiveness of CPD activities

Discussion in the previous section in regard to each of the activities indicated that, immediately after the workshops, participants were, generally, extremely positive about the nature of the material covered, the learning materials supplied and the presenters.

The survey administered six weeks post-workshop aimed to gauge what participants had learnt from the CPD event, their views as to whether the activity had produced any change in attitude, and whether any change in practice had been influenced. Although the surveys were specific to individual workshops, a number of general questions were asked. Table 7 indicates a summary of responses across all workshops where the information was available to some key statements that were common across the activities that addressed the aforementioned issues.

	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)	Mean/ 4
An information gathering exercise that increased my knowledge	28	105	6	2	3.1
An activity that is unlikely to lead to a change in practice	4	27	85	27	2.1
An activity that is likely to lead to change in my attitudes	19	99	23		3.0
A theoretical event that I will need to translate into my practice	9	88	41	3	2.7
An event where I added to my knowledge	24	114	4		3.1
An event that will most likely influence change on this topic	13	97	29	1	2.9
An event that was work based rather than theoretical	10	97	34	1	2.8

Table 7 Combined responses to survey questions investigating perceptions of effect(s) of attendance at activities (taken approximately six weeks after an event) (N=143)

Clearly from Table 7, approximately six weeks after attendance at a particular workshop, attendees were:

- Very much of the view that the activity had increased their knowledge (96% and 97% responded ‘Strongly agree’ or ‘Agree’ to statements 1 and 5);
- Confident that the activity would lead to a change in practice (78% responded ‘Strongly disagree’ or ‘disagree’ to Statement 2; 79% responded ‘Strongly agree’ or ‘Agree’ to Statement 6);
- Confident that the activity would lead to a change in attitude (84% responded ‘Strongly agree’ or ‘Agree’ to Statement 3).

The need to adapt or translate this knowledge into clinical practice was also agreed upon by 69% of Fellows (Statement 4), while 75% felt the activity to be work-based, rather than theoretical (Statement 7)

Support of this Level clearly suggested not only the value of the CPD activity to both professional and personal practice, but its ability to be relevant and useful to clinical practice.

A number of free text comments suggested sustained relevance with the CPD activities. Comments such as; *“it was stimulating, thought provoking and challenged some thinking and was enormous fun”* (TOTR workshop) to, *“you can teach old dogs new tricks”* (DDPR workshop) was helpful in gauging the value of the workshop. Many Fellows also suggested that follow up workshops in *Expert Witness Training, Evidence Based Medicine, Difficult Doctor Patient Relationships, and Mentoring* would not only be beneficial, but help to reinforce the skills learnt in previously run workshops.

In regards to the impact of CPD activity on practice, Fellows were asked to provide optional free text comments to the question, “If the activity influenced a change in practice, what role did it play?” Comments varied amongst participants and workshops, but a number of similar themes were encountered. The CPD activities:

- Informed and improved practice based knowledge. Comments about the extent of new knowledge varied, but feedback such as: *“it educated me on breaking down the teaching tasks into bite-size pieces”* (TOTR workshop); *“it lead to a better global understanding”* (EWT workshop); to *“it increased the importance of knowledge and evidence in clinical practice”* (EBM workshop); and *“made me aware of deficiencies in my work/lifestyle balance”* (WLB workshop) touched upon the relationship between the uptake of knowledge and possible changes to practice.
- Described changes to professional confidence. Many Fellows noted an improvement in their clinical or professional confidence. This confidence appeared to be directed at both patients and colleagues, and included such comments as: *“After this workshop, I was more inclined and able to discuss difficulties with my patients; to acknowledge them as such”* (MWE workshop); *“It managed to make clear and force me to act on many issues on which I had been equivocal”* (DDPR workshop); and *“the workshop confirmed that changes I made are in the right direction”* (WLB workshop).
- Encouraged the dissemination of workshop findings. A number of key comments suggested that information gained from the workshop helped develop a number of new clinical and professional initiatives. Examples of this included: *“I am now co-ordinating a Mentor program. It has allowed me to give information to others”* (MWE workshop); and *“I now use the language on the course as an integral part of my teaching practice”* (TOTR workshop).

The responses to surveys distributed toward the end of the project period supported the above data, and confirmed the apparent relevance and effectiveness of the activities.

Of some note also, is the number of specialists and practitioners, other than LEAP participants who attended the above workshops. Of the 384 participants who attended, 102 were LEAP participants. The remaining 282 came from a variety of medical colleges and practice settings, thus giving further

support to the interest in and relevance of the wider range of non-clinical CPD activities suggested by the LEAP Framework.

As outlined earlier in this report, when current college CPD activities were placed against the matrix of the LEAP Framework at the start of the project, the results showed sparse offerings in a number of components contained within Strands Two and Three. Specifically, no college had activities listed in *Information Technology*, *Personal Management & Insight and Advocacy & Equity*, and only one college had one activity listed in *Relationships & Accountability*. Thus, when devising their learning plans, participants originally had few or no activities to choose from in these components. However, as CPD activities were developed and advertised during the project, many participants obviously identified them as a need and subsequently enrolled in the areas and workshops of interest.

For example, in the second Strand, *Risk Management*, nearly 50% of the activities completed by participants during the twelve month period were in the components of *Communication*, *Information Technology and Personal Management & Insight*.

In the third Strand, *Professional Values & Responsibilities*, 22% of activities undertaken were in the components of *Relationships & Accountability and Advocacy & Equity*.

Thus, the number and variety of CPD activities undertaken by participants in Strands Two and Three, also gives some validation to the broader roles and responsibilities suggested by the Framework.

In addition, the Project Office received many inquiries from CPD staff from a variety of specialist medical colleges, seeking information about the various workshops that had been held through the concurrent *LEAP in a Rural Context* project. Some participants had contacted their college after attending a workshop to recommend it to their college and Fellowship. This again suggests the workshops touched on non-traditional, non-clinical areas that practitioners had identified as an important part of their professional practice.

Summary and conclusion

Twenty seven events were sourced/developed and delivered to test the validity in practice of the LEAP CPD Framework for medical practitioners over an eight month period. The emphasis of these was on the less commonly undertaken non-clinical activities from Strands 2 and 3 of the Framework; *Risk Management* and *Professional Values and Responsibilities*, rather than clinical-based activities.

A total number of 27 CPD events based around eight core workshops sourced from third party providers were delivered from October 2004 to August 2005. The workshops were: *Introduction to Evidence Base Medicine*; *Expert Witness Training*; *Basic Computer Literacy*; *Difficult Doctor Patient Relationship*; *Mentoring in the Workplace Environment*; *Work Life Balance*; *Teaching on the Run*; and *Medical Responses to Adults who have Experienced Sexual Assault*.

A total of 384 participants (163 rural, 193 metropolitan specialists and 28 non-specialist participants) from eight medical colleges participated in the CPD activities.

Feedback from the events was generally very positive, with many participants citing that the workshop not only increased knowledge and awareness of the areas covered, but that the activities chosen had actually led to a change in aspects of professional practice. This was consistently the case for both rural- and metropolitan-based specialists who attended the workshops.

Given that the activities provided were non-clinical and all from Strands Two and Three of the Framework, the concept of offering these types of activities as CPD for medical practitioners would appear valid. Thus, the nature of the Framework gains some additional validation from these.

In addition, LEAP participants identified areas of need within Strands Two and Three in their learning logs and participated in a variety of relevant CPD activities and learning opportunities within these areas during the project, giving further validation to the broader roles and responsibilities suggested by the Framework.

OBJECTIVE 5: EVALUATE THE EFFECTIVENESS OF THE FRAMEWORK IN TERMS OF SATISFACTION OF PARTICIPANTS AND WHERE POSSIBLE THE ABILITY OF PROGRAMS BASED ON THE FRAMEWORK TO EFFECT CHANGE IN SPECIALIST PRACTICE

To evaluate the effectiveness of the Framework in terms of satisfaction of participants and the ability of programs based on the Framework to effect change in specialist practice a range of tools were used:

- Data collected in Questionnaire Two;
- Information obtained from focus groups;
- Information obtained from telephone interviews;
- Data collected from Level Two and Three templates in learning logs; and
- Feedback from *LEAP in a Rural Context* workshops;

Participant satisfaction with the LEAP Framework

Across all of the sources of data collected, views were mixed in terms of satisfaction with the Framework, ranging from those who were highly satisfied, to those who thought that with some modifications it would be very useful, to those who believed it to be too demanding and not tailored enough to an individual specialist's practice. Some liked the ten components, but not the levels, whilst others thought the levels were important, but not the components. In addition, some thought that the Framework was a good basis for a universal CPD system, whilst others believed it to be too generic to meet individual college needs.

For those who liked the Framework, either as it is currently, or with some modifications, the following comments were representative:

"I think the LEAP Framework was excellent. Obviously a lot of work had gone into making it so relevant for each college. I found being 'forced' to plan the year's CPD activities in advance very helpful and although I did not necessarily do all that I had set out to, it gave me something to work towards. I liked the flexibility of the program such that I could change my goals as the year progressed. I also liked having so many choices for the activities listed along with dates and contact phone numbers which made it so much easier to get on and actually do the activities. I sincerely hope that LEAP becomes a regular part of our college CME program".

"LEAP is a good initiative and with some improvements I look forward to seeing it adopted. As I am in quite an isolated area, the more we can do easily and conveniently the better".

"The Level it is at re paperwork and bureaucracy is just about right. It does not need to be more involved than it is and it does not require any more stringent stimulation".

"I would have thought that most people would have enjoyed it".

"If our college agreed to go ahead with it, I think it would be a reasonably good idea, as,

it solves the documentation issue; is very easy for those in the middle to monitor it; and the internet-based activity is pretty easy. It maybe difficult forcing people to pre-plan at the beginning of the year for the next twelve months. However, some areas could be planned, and others would need to be spontaneous learning; e.g. bird flu. Some headings may need to be changed to be appropriate for each particular college and one would need discipline to log in, record information and keep up to date. However, it has definite advantages”.

“At present I have a problem with the number of multi compliances we have to do. It would be much better for them all to be integrated and not competing against each other. If this Framework were tailored to individual colleges to make it more relevant, then it would be suitable”.

“It needs further refinement, development and a more comprehensive matching of the Framework to real practice by colleges”.

“I really would like this to be successful. However, it is essential that it is simple to record”.

“The on-line environment is essential to the ease of use and completion rates of these activities. Congratulations on implementing a very useful and well thought out Framework”.

For those participants who did not like the Framework, comments such as the following were given:

“It tries to tie a common thread across the whole range of specializations in medicine. It is intellectually uncomfortable. If this was mandatory, I would oppose it”.

“In this Framework, knowledge and skills are consigned to Level One and given the lowest weighting. This is where the clinically relevant activities are. This is where knowledge and skills are improved. This is where clinical practice is improved. These are the only clinically relevant activities aside from the simulator. Whilst personally, I have an active interest in many of the Level Two activities, they are special interest activities, not activities required for professional competence. As for the Level Three activities, they are not at all clinically relevant. It is nonsensical to make these activities compulsory. They are also the most time consuming. There is no correlation between time spent on these activities and improved clinical practice”.

“It is too cumbersome. I was happy with what I could achieve with my CPD this year, however, when it came to recording it, I found it difficult and time consuming. It was a busy time of the year and I really didn’t have the time to sit down, read, and re-remember the different aspects of the Framework on the computer. While the focus is to make sure people are keeping up-to-date with CPD, it is essential that the process is not too burdensome”.

Overall, whilst opinions varied, as shown by the comments above, more participants believed that a common Framework across medical colleges, was a good idea, than did not.

Some participants offered suggestions on how the LEAP Framework could be improved to increase satisfaction. In addition to those that focused on improving the user-friendliness of the IT aspect of the program, if adopted on-line, other comments included:

- Offering workshops on how to develop Level Three activities, such as, auditing one’s practice. It was felt that many practitioners would not be able to conduct Level Three activities without more guidance and assistance;
- Improving communication about the range of CPD activities offered by third party providers and medical colleges, particularly in the non-clinical areas;

- Providing individual assistance to help specialists understand/define/categorise and document their CPD activities in relation to the Framework;
- Providing more college-specific examples of suitable activities for each strand and component;
- Greater shared discussion between colleges to ensure similar CPD activities are given similar weighting and terminology where possible; and
- Allowing the Framework, if adopted, to remain in place for several years. It was felt that constant changes in programs and requirements make it difficult to keep abreast of what is expected.

Of significance is that, not only were views about the Framework varied across participants, they were also varied across colleges. Similar responses did not necessarily occur between Fellows belonging to the same medical college or gender, between those in private or public practice, between metropolitan or rural practitioners, or even years of practice. The on-line aspect used to test the Framework, however, was more of an issue for the older practitioner.

To further evaluate the satisfaction with and the effectiveness of the LEAP Framework, all participants were asked to respond to a number of general statements about the Framework. Again, a Likert scale was used, with '1' representing 'Strongly Disagree' to '4' representing 'Strongly Agree'. Table 8 provides a summary of the responses.

	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)	Mean
Framework is sufficiently flexible to be used	11	52	23	16	2.57
	10.8%	51.0%	22.6%	15.7%	
Framework is sufficiently relevant to be used	7	61	21	13	2.61
	6.9%	59.8%	20.6%	12.8%	
Framework would help professionals improve their practice	7	49	39	7	2.55
	6.96%	48.0%	38.2%	6.9%	
Framework is useful for identifying CPD needs	10	68	14	10	2.76
	9.8%	66.7%	13.7%	9.8%	
Framework assisted in practitioner adopting more of a planning approach	8	30	45	19	2.26
	7.8%	29.4%	44.1%	18.6%	
Participation in pilot has led me to think more widely about the type of CPD that I undertake	10	52	24	16	2.55
	9.8%	51.0%	23.5%	15.7%	
I undertook professional development activities in areas that I would not normally do	6	21	59	16	2.17
	5.9%	20.6%	57.8%	15.7%	
The pilot highlighted areas in which I do not undertake CPD	12	54	28	8	2.69
	11.8%	52.9%	27.5%	7.8%	
Participation in the pilot did make me think more broadly about professional competencies and responsibilities	10	56	26	10	2.65
	9.8%	54.9%	25.5%	9.8%	

Completing CPD across the three Strands represents a holistic approach to professional practice	7	58	25	12	2.59
	6.86%	56.86%	24.51%	11.76%	
I think the Framework forms a useful basis for a program to aid medical professionals to keep up-to-date	9	57	24	12	2.62
	8.82%	55.88%	23.53%	11.76%	

TABLE 8 Feedback responses to statements about CPD and the LEAP Framework (n=102)

Participants responded positively to a number of statements about the Framework and, in particular, agreed or strongly agreed about its usefulness in identifying CPD needs, its relevancy, its flexibility and the breadth of professional competencies and responsibilities that are part of professional practice today. Fewer participants, however, agreed that the Framework assisted them in adopting more of a planning approach or that they undertook professional development in areas they wouldn't normally do.

The ability of programs based on the Framework to effect change in specialist practice

Measuring the ability of CPD programs such as that suggested by the LEAP Framework to effect change in practice, is complicated and, realistically, beyond the scope of this project, particularly given the relatively short time frame involved. A number of mechanisms, however, were used to appraise, where possible, the effectiveness of CPD undertaken by participants.

Much has been written on the role of CPD and the effect on practice. The literature suggests, that at least in relation to CPD, that learning is more likely to lead to a change in practice when a needs assessment has been conducted, the education is linked to practice, personal incentives drive the educational effort, and there is some reinforcement of the learning. It is also recognized, however, that wider professional learning not related to a specific need is also of fundamental value where practice is not predictable. Practitioners will always continue to require a wide knowledge and depth of experience, so more general learning, such as that gained from professional reading and attending conferences, still needs to take place along side learning to address specific needs or problems.

The LEAP Framework is based on adult learning principles. As such, participants in the project were encouraged to: identify and plan their learning needs in advance; take advantage of unplanned or opportunistic learning opportunities that arose; undertake different types and levels of activities; include both formal methods of learning such as attending specific courses, skills workshops, and conferences and informal methods of learning such as reading journals and consulting with colleagues; and then to reflect upon the learning undertaken.

To help evaluate where possible, the effect of the professional development activities undertaken, participants were asked to respond to a series of questions upon completion of the activity. Level Two and Three activities, in particular, required the participant to reflect and evaluate the effect of the activity undertaken.

The questions, (outlined earlier in the methodology section), were designed to encourage participants to identify, address, reflect and evaluate the action taken to maintain and/or improve their practice. Based on self report, many positive changes in specialist practice were reported.

Additionally, evaluation of activities offered under the *LEAP in a Rural Context* project, and referred to in the previous section, indicated that attendance at the activities had influenced them to make some change in their professional practice. Hence, although based on self-reporting, and not actually based

on hard outcomes data, participation in activities that form part of the Framework in practice, appears to offer an opportunity to effect change in professional practice.

Summary

In summary, although some participants were clearly more satisfied with the LEAP Framework than others, a number of overall strengths of the Framework were identified. It:

- encourages practitioners to think more broadly about the competencies and responsibilities involved in professional practice today;
- serves to refocus the profession on the practice of medicine in a wider context;
- is a useful tool for helping practitioners to identify their learning needs, particularly in areas other than traditional medical and clinical knowledge and expertise ;
- allows practitioners to incorporate a broader range of activities into their CPD, many of which address the needs and expectations of the broader community; and
- is considered sufficiently relevant, applicable and flexible enough, albeit with modifications, to be used by colleges.

Participation in activities that form part of the Framework appear to offer the capacity to effect change in professional practice.

PARTICIPATING COLLEGE VIEWS ON THE LEAP FRAMEWORK

Towards the end of the project, participating colleges were asked to comment on a series of questions about the LEAP Framework and in particular about its relevance and applicability to their Fellowship.

Specific strengths and weakness were identified by colleges about various aspects of the Framework. In addition, many positive comments were made about the advantages and usefulness of having a potential universal CPD Framework or system across colleges. Comments such as the following were made:

“For the first time the LEAP Framework offers the possibility of having a consistent approach to CPD across all medical specialities”.

“Our College thought that LEAP was a useful activity to try and formulate a generic program. For some Colleges it has shown the importance of ‘soft skills’ activities within the Framework and legitimized their inclusion. It has also shown the benefits of working together and providing an opportunity for specialists to meet with others and share their similarities and differences. There is a place for that within CPD”.

“Collaboration with other medical colleges has the potential to establish core elements of CPD programs that may be common across colleges, although the unique CPD needs of individual colleges must be continually respected”.

“A ‘clearing house’ of CPD activities would be useful for both medical colleges and CPD providers alike and would eliminate a lot of duplication of documentation”.

Several colleges also suggested that the LEAP Framework was being used as a reference for reviewing their existing program:

“Our College was influenced by the LEAP Framework when designing the CPD program for the next triennium. The different levels and the three strands categorization was the approach the college wanted to take and the LEAP Framework provided a useful catalyst. We have adopted some of the common paperwork produced by LEAP but have altered it to meet our specific needs”.

“Our College’s CPD Program is currently being re-evaluated and modified to bring it up to current best practice. The program will be more clinically relevant for our Fellows and does have some similarities to the LEAP Framework”

“The LEAP Framework was a useful resource document and our College is referring to it as it updates our current CPD Program”.

“As a college, using the methodology developed for LEAP in relation to documentation and assessment would be most useful. However, the three Strands and the ten Components would be replaced by our modified CanMeds”.

“Our College’s CPD Committee will be considering if and how the current College CPD program would need to be modified to fit the LEAP Framework. The final LEAP report will inform this discussion”.

Strengths identified by colleges include:

“On-line program is great. Very helpful to record learning program in that manner. Participants are able to go back, amend it and think about what points need to be allocated”.

“The best part of LEAP was the structure that it gave to CPD in relation to having to plan ahead, the on-line structure and filling in the on-line information as one went along”.

“The hierarchy of activities from Level one to Level three prompted one to assess activities and concentrate on more active educational pursuits”.

Specific criticisms or problems were also identified:

“It is difficult to have a common program to accommodate the wide variation of emphasis of all Colleges, considering they have different requirements”.

“Some of our Fellows would experience difficulty in completing Level three activities ~ closing the quality loop. This does not mean that these activities should be disregarded but more energy would be needed to support Fellows so that they are able to complete these activities”.

“There is an overlap in practice between several components e.g. Communication could arguably be a Strand rather than a Component as Communication is relevant to all three Strands”.

“Informatics is not a term widely understood or used in our College, and certainly not by the community”

“The introduction of “Professionalism” into a practical model of CPD that might encompass the needs of different medical colleges is inappropriate and should not be supported until there is a much more wide ranging discussion of the idea between colleges and within the memberships of colleges”.

“Although the ten components relate to the diverse roles of our Fellows, having ten is too complicated a concept and would lead to increased fragmentation of CPD activities instead of encouraging a more holistic approach”.

“The LEAP Framework ranks the merit of CPD activities based on a value system (‘professionalism’) that has not been accepted by Fellows and without consistent evidence that one type of CPD activity is better than another. This attempt at prematurely shaping what

is a preferred CPD was rejected by our College during a recent review of the MOPS program. Endorsing LEAP would be a backward step”.

“While Levels Two & Three are reasonable, there is a problem with Level Three. Busy practitioners, particularly in rural areas, and in private practice, do not have the luxury of time and the infrastructure necessary to engage in most of the activities described. If Level Three continues to be defined as “change – evaluating activities”, then there needs to be added a choice of projects. These would probably be within the category of “completion of a quality cycle where an action plan has been developed, implemented and evaluated”. They need to be achievable by clinicians rather than by academics or bureaucrats”.

In summary, there was general agreement that in principle, a common Framework such as that denoted by the LEAP Framework or something similar, would allow a more consistent approach to CPD across colleges than currently exists. Sharing of relevant CPD activities between colleges was seen as worthwhile, as was the identification of needs and the preparation of a learning plan at the beginning of a CPD learning cycle and the use of an on-line system to record and reflect on activities undertaken. However, not all components were seen as relevant, completing level three activities were identified as being potentially difficult for some Fellows and it was felt that further discussions about the concept of *medical professionalism* needs to take place between colleges.

SUMMARY

The LEAP Framework aims to involve medical specialists in CPD that is relevant to their practice, useful in terms of their professional development needs and able to influence change in their professional practice, consequently either maintaining or improving the standard of healthcare provided by the practitioner.

This project has highlighted a number of issues and benefits not only for those Fellows participating in the LEAP Framework pilot but also to medical colleges and professional organisations involved in the development, implementation and delivery of CPD programs and activities that are attempting to address the wider range of skills, knowledge and attributes now considered to be part of professional practice.

RECOMMENDATIONS

A number of recommendations are made

1. A CPD program, such as LEAP, which defines/outlines a profile of the ‘medical practitioner’ involved, is to be strongly encouraged among specialist medical colleges, rather than simply relying on a system based on types or categories of activities. Such a profile should include the non-clinical components of practice and incorporate mechanisms for both planned and opportunistic learning.
2. In addition to the development and implementation of a more consistent but college-specific CPD program based on the above suggested profile, the adoption of common terminology for similar professional development activities across specialist medical colleges would be particularly useful and helpful for those specialists who belong to more than one college.
3. CPD activities that include a focus on non-clinical skills programs are relevant and worthwhile for all specialists and, according to participants in this project, can facilitate change in professional practice. Thus, specialist medical colleges should be encouraged to develop, promote and endorse such activities to their Fellowship.

4. Encouraging practitioners to identify needs and devise a learning plan to meet those needs, whilst also taking advantage of unplanned or opportunistic learning, throughout a CPD cycle, should be endorsed.
5. Given the satisfaction experienced by and the wide range of specialists represented at workshops conducted during the Project, cooperation between specialist medical colleges to develop shared non-clinical CPD activities would seem logical.
6. Sourcing third-party providers willing to run CPD activities across the range suggested by the Framework can contribute to the provision of high quality, well received activities. However, the offerings can be quite expensive on a cost per head basis, particularly for rural practitioners and thus the benefits in working together and sharing resources between colleges should be supported.
7. Given the enthusiasm and benefits to practice acknowledged by participants, colleges should look at specific ways to guide, assist and support their members in planning and undertaking appropriate and relevant activities of the type labelled Level Two and Three in the LEAP Framework. Activities that encourage evaluation and completion of the quality cycle should be endorsed.
8. Specialist medical colleges should be encouraged to explore specific evaluation tools that can be used to assess the benefits of participation in CPD activities, including their relationship and impact on practice (i.e. Level 3 activities).
9. Specialist medical colleges should be encouraged to explore collaborative projects that can be used to assess or evaluate the long term effectiveness on practice of a CPD program based on a profile of a medical practitioner that includes clinical and non-clinical components of practice.
10. Introducing a weighting system in all CPD programs whereby professional development activities recognised as being able to influence change in professional practice are rewarded more highly than passive activities, should be encouraged.
11. The adoption of an on-line CPD program, can encourage reflection about the activities/events undertaken, more so than the paper-based system of record keeping required by many colleges. Workshops or training sessions may be needed, however, for practitioners who are inexperienced or less confident IT users. Additionally, any program developed/adopted needs to be sufficiently user-friendly to be embraced by practitioners.
12. The following changes should be incorporated into the LEAP Framework: the removal of the two *Medical Informatic* components as separate stand-alone components and their inclusion in other existing components; the expansion of the definition of the component of *Practice Management*; 'undertaking research' to be given a higher profile, either as a separate component or within *Education*; and minor changes to the title and/or description of the *Clinical Expertise* strand to more satisfactorily cover the roles of practitioners working in Medical Administration and Public Health.

Notwithstanding the above suggested changes, the Framework has been shown to be sufficiently robust and to possess the necessary broad applicability required to render it suitable for use as a framework for medical specialist CPD.

APPENDIX A – PROJECT REFERENCE GROUP MEMBERSHIP

Chairperson

Dr Andrew Child
Former Chair Committee of Presidents of Medical Colleges
and Former President, The Royal Australian and New
Zealand College of Obstetricians and Gynaecologists

Members

Dr Rick McLean
Principal Medical Adviser, Department of Health and
Ageing
University of WA. Acting Head of Department ICU,
Royal Perth Hospital , AMA representative

Clinical Associate Professor Geoff Dobb
NSW Medical Board
Neurological Surgeon at Westmead Hospital

Associate Professor Michael Fearnside
Chair, CPMC CEOs' Forum
Chief Executive Officer,
The Royal College of Pathologists of Australasia

Dr Debra Graves
Head, Department of Medical Education
School of Medicine, University of Flinders

Professor David Prideaux
Director of Education,
Australian and New Zealand College of Anaesthetists

Ms Valerie Jenkins
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Ms Sheryn Payne
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Australian Department of Health and Ageing

Dr Heather Wellington
Australian Commission for Safety and Quality in Health
Care

Dr Deeta Kimber
Trainee Specialist, The Royal Australian and New Zealand
College of Psychiatrists

Dr Peter Maguire
The Royal Australian College of General Practitioners

Mr Les Apolony
Chief Executive Officer,
Committee of Presidents of Medical Colleges

In Attendance

Dr Peter White
Chief Executive Officer,
RANZCOG

Dr Eleanor Long
Chief Executive Officer (until Feb 2006)
RANZCOG

Ms Lyn Johnson
Project Manager, LEAP Framework RANZCOG