



Royal College of  
General Practitioners

# RCGP Guide to the Credit-Based System for CPD

Version 2.0 | January 2010





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The Royal College of General Practitioners was founded in 1952 with this object:  
*'To encourage, foster and maintain the highest possible standards in general practice  
and for that purpose to take or join with others in taking steps consistent  
with the charitable nature of that object which may assist towards the same.'*

Among its responsibilities under its Royal Charter the College is entitled to:  
*'Diffuse information on all matters affecting general practice and  
issue such publications as may assist the object of the College.'*

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# Introduction

The RCGP Credit-Based System for Continuing Professional Development (CPD) is a mechanism for GPs to record their CPD based on the time spent on the activity and the impact it has on the doctor, his or her patients and the service.

*In essence 1 hour of education is 1 learning credit. However, if that education leads to changes for patients, the doctor or the practice, the GP can claim 2 learning credits for each hour of such education.*

*Credits are self-assessed and verified at appraisal, and account should be taken of the need for GPs to use their CPD to ensure that they are up to date in all areas of their work.*

*The system will help GPs meet their revalidation needs by providing a mechanism for collecting and demonstrating their CPD credits.*

# Background information

The Academy of Medical Royal Colleges (AoMRC) has a consensus view that CPD activity for the purposes of revalidation should be recorded in a credit-based system. Furthermore, the AoMRC expects 250 credits to be accumulated in a 5-year revalidation cycle, with 50 credits normally accumulated in a year.

The RCGP has recognised that a wholly time-based credit system will not recognise the true value of CPD. A system based on the impact of a developmental activity and, to a lesser extent, the challenge involved in completing the activity was piloted between September 2008 and May 2009. Lessons learnt as a result of that pilot informed the development of this system. The latter is based partially on time spent on the learning but with an opportunity to gain further credits by demonstrating the outcome (*impact*) of development.

*Impact* in this context refers to the impact on:

- patients (e.g. a change in practice, implementing a new clinical guideline, initiating a new drug for the first time)
- the individual (personal development, e.g. development of a new skill or further development of existing skills)
- service (e.g. developing and implementing a new service, becoming a training practice, teaching others)
- others (teaching, training, NHS locally or nationally).

This approach to CPD is also endorsed in the report of the Chief Medical Officer for England's Working Group, *Medical Revalidation: principles and next steps*:

*6.3 It will be desirable to increase the linkage between CPD and appraisal. Appraisal focuses on meeting agreed educational objectives. Monitored systems which define College or Faculty approved educational activities may assist the meeting of those objectives. Presently most College or Faculty schemes are based on acquiring credits. The advantage of this system is that the time devoted to CPD can be measured and recorded. The disadvantage is that it is insensitive to the quality and relevance of the various CPD activities. The more that credits can encompass the value of the learning and not simply the time spent engaged in CPD, the more it will be valued by doctors and the better a measure it will be of their CPD activities.*

*6.4 Effective CPD schemes are flexible and largely based on self-evaluation. This lets doctors develop what they do in the context of their individual professional practice while providing evidence for*

*external scrutiny. There is no single correct way of doing CPD. The methods chosen will depend on spheres of practice, learning styles and personal preference.*

*6.5 The principles underpinning CPD schemes therefore need to be as simple as possible while providing a good foundation on which to build an appropriate portfolio unique to the individual doctor.*

The important points within these three sections are:

- increasing the linkage between CPD and appraisal
- credits being based on the value of the learning
- flexibility of CPD schemes
- developing doctors in the context of their professional practice
- evidence for external scrutiny
- that multiple methods are appropriate
- building a portfolio.

GPs undertaking the normal route to revalidation will be expected to accumulate 50 credits each year. Appraisers should validate credits, aiming for a broad range of CPD appropriate for the work that the GP undertakes. GPs outside the normal route to revalidation should refer to the *RCGP Guide to the Revalidation of General Practitioners* at [www.rcgp.org.uk/revalidation.aspx](http://www.rcgp.org.uk/revalidation.aspx).

#### Guidance for claiming credits

GPs have different learning styles and learning needs. However, it is important that a variety of learning opportunities is used and that the broad work that a GP covers is included in the CPD record during a 5-year revalidation cycle. GPs should demonstrate a variety of learning that would encompass a blend of personal study, courses and interactive learning.

Over the revalidation cycle, GPs should aim for a mixture of time-based credits and provide evidence of implementation in practice with impact-generated credits. The demonstration of an evolving change is an important development. Evaluation of change through audit will attract both time and impact credits.

# 1 Accumulating credits

*A CPD credit is defined as being based on an hour of learning activity (including planning and reflection) recorded in such a way that it demonstrates the learning achieved relevant to the working situation of the GP.*

In its simplest form 1 hour of activity equates to 1 credit. Credits are self-assessed and, although a certificate of completion or attendance may be used as evidence of activity, it is the *demonstration of learning achieved and relevance to the work that the GP undertakes* that defines the credit. In short the RCGP does not advocate the collection of certificates. Rather, a collection of self-assessed acquired knowledge relevant to the individual's working situation is required.

The acquisition of knowledge in itself does not necessarily lead directly to patient benefit. Under this system demonstrating *impact* is rewarded by a multiplication factor of 2 applied to time spent.

For instance:

- an individual attends a meeting (1 hour) on heart failure, acquires the knowledge that certain beta-blockers are beneficial to patients with this condition, and then records this within his or her appraisal documentation
  - credits claimed 1 – this demonstrates the acquisition of knowledge and as yet there is no demonstration of personal, practice or patient benefit
- a different individual attends the same meeting. He or she records the same acquisition of knowledge. However, included are two patient case studies demonstrating the introduction of beta-blockers in heart failure
  - credits claimed  $1 \times 2$  (*impact*) = 2
- a third individual attends the same meeting. The acquisition of knowledge is recorded. However, in his or her appraisal folder, an audit is planned after consideration of current practice (1 hour). This individual demonstrates audit of his or her patients with heart failure, changes are made appropriately following discussion with colleagues (1 hour) and a second audit cycle demonstrates an improvement in care
  - credits claimed  $1$  (initial meeting (1 hour)) +  $2$  (planning (1 hour) and discussion associated with audit (1 hour))  $\times 2$  (*impact*) = 6.

In all of the above examples the GP would be expected to include the following evidence in his or her appraisal folder:

- a record of the developmental activity
- learning points acquired
- relevance to his or her working situation.

In addition, to claim the *impact* factor (credit × 2) the GP would be expected to include a demonstration of application of new learning:

- case study
- simple data collection
- audit
- reflective piece demonstrating change in a practice.

# 2 Appropriate claims

## What can be claimed?

Time spent on developmental activities may include preparation, activity and reflection. Credits should only be awarded when a demonstration of the learning achieved is relevant to the practice of the GP.

## What should not be claimed?

The credit-based system is designed to move beyond a simple 'hours = credits' scenario. By requiring the individual to record learning relevant to the GP's practice, simple certification of time spent is not adequate to claim credit. Examples of inadequate credit claim would be:

- reading the BMJ every week for 1 hour – claim 52 credits
- audit data collection, 6 hours – claim 6 credits.

The above example of reading the BMJ may be eligible for credit claims. However, in the format presented it gives little indication of relevance to the GP's practices, and such untargeted reading should not normally exceed 10 credits. Performing data collection for the purposes of audit should not be claimed.

# 3 Audit

Audit now occurs in every general practice in the UK as part of the Quality and Outcomes Framework (QoF) target system. It is inappropriate to claim credits for the process of data collection or QoF achievements. The process of improving or maintaining QoF points is of course a quality exercise in itself that has impact and would be eligible. Audit outside QoF would also qualify for credits. It must be remembered, however, that it is the development that leads to the credit and not the process of audit.

As audit is designed to improve systems and outcomes of care, it is likely that all developmental activity associated with audit will be eligible for the *impact* multiplication factor.

## Examples of credit claims

### 1. Audit of antibiotic prescribing in sore throat

*I enclose an audit examining my personal use of antibiotics in uncomplicated sore throat presentation. This was prompted by my reading an article in EKU [Essential Knowledge Update] 3 entitled 'Prescribing antibiotics for self-limiting respiratory tract infections'. This highlighted the CENTOR criteria, which may be applied to the presenting symptoms of a sore throat, helping to exclude beta-haemolytic strep. I looked at a 3-month period between January and March last year, and then prospectively examined my prescribing between the same months this year, applying the criteria to aid diagnosis.*

*I have demonstrated a 25 per cent reduction in the prescribing of antibiotics without any major ill effects. This activity seems to improve my practice and I intend to continue to apply the criteria in future.*

*The initial EKU learning module took about an hour, preparation and planning a further hour, discussion of changes to be made with my partners a further hour and writing up and reflection on the audits another hour. Total = 4 hours.*

- Credit claim – 4 credits for activity × 2 (impact) = 8.

## 2. Audit of diabetic care

*I recently joined an inner-city practice with a high prevalence of diabetic patients and low QoF achievement in diabetes. The initial data collection was based on QoF achievements from last year. The practice nurse and I attended a 2-day update on diabetes. We used this as a springboard to rewrite the practice diabetic protocol and to start a call and recall system. In the first 9 months we have seen an average 1 per cent drop in the HbA1C across the whole practice population of people with diabetes.*

*The prescribing of ACE inhibitors in microalbuminurea has improved, as has the prescribing of statins. There is still some work to do, notably around diabetic foot care and retinopathy screening. I intend to re-audit next year. The audit is included along with my reflections and suggestions for further change.*

- Credit claim – 10 credits for activity  $\times$  2 (impact) = 20.

## •3. Data collection on prescribing of gliptins

*I recently attended a diabetic update, focusing on newer agents. Amongst the learning points was this relatively new class of drug, the gliptins. Although expensive they seem to be a third-line choice for appropriate patients and indeed may be a second-line option for some. During the talk I immediately thought of two patients who could potentially benefit from the introduction of this agent. I intend to start prescribing these agents to my patients. The data collection included in my folder demonstrates the current situation and has highlighted four patients suitable for prescribing. Attached to the data collection are two case histories of the introduction of this drug and subsequent follow-up. It seems that initially good results are obtained. I suspect the numbers are too small to complete a full audit cycle for at least a further 2 years.*

- Credit claim – 3 credits for activity  $\times$  2 (impact demonstrated by case histories) = 6.

# 4 Distance and online learning

Many online and distance learning packs have a number of 'hours' attached. However, in order to claim credits a demonstration of learning achieved and relevance to general practice must be stated. Some online learning packages offer certificates with a number of hours attached – the indicated time often having little or no bearing on actual time spent. GPs are encouraged to claim actual time spent rather than the estimate given on such certificates. Distance learning packages may also stimulate related reading or activity; these activities are probably best presented within the same credit claim.

## Essential Knowledge Updates and Essential Knowledge Challenge

*Essential Knowledge Updates (EKU) are structured learning activities produced by the RCGP that help GPs to meet their CPD and revalidation commitments by assimilating and applying new and changing knowledge in clinical practice.*

- Two updates are produced each year.
- Each update consists of a series of online learning modules on different topics. They are divided into major items and briefings. The major items examine the source document in detail, giving applications in practice, further reading and a self-test quiz. The briefings simply report the outcome of the source document.
- The content summarises guidance in clinical areas of national significance where there is consensus about best clinical practice, as well as the latest information about changes to legislation or new ways of working.

Each update has an associated Essential Knowledge Challenge (EKC), an applied online self-assessment knowledge test, which will be issued 6 months after the update. The topics chosen for the ECU have been screened for new and changing information that is relevant to general practice. It is likely therefore that the majority of material will be appropriate for many GPs. The practical tips associated with the major items may be used to create impact, thereby multiplying the credit claimed. It is likely that the completion of an entire ECU (and associated EKC) would generate between 10 to 15 credits. Impact on practice may be demonstrated, increasing the credit value of this claim.

## Examples of credit claims

### 1. Chronic kidney disease

*I read the EKU item on chronic kidney disease – very relevant to general practice – and it helped me get straight in my mind the various stages of chronic kidney disease. I also discovered that statins are advised at a relatively early stage.*

- Credit claim = 1.

### 2. Prostate cancer

*A 74-year-old patient presented to me with a PSA of 8. This blood test had been taken following a recent hospital admission for a hernia operation. The patient was asymptomatic. My normal practice in this situation would have been to perform a rectal examination and then refer to urology, whatever the findings. The patient was not keen for onward referral and my examination revealed an enlarged but benign-feeling prostate. I was unclear where to go from here.*

*I gave the patient some information from our computer's information system and asked him to return in 2 weeks. I read the EKU on prostate cancer and from there followed through to the NICE guidance.*

*When the patient returned we were able to have a better-informed discussion. He had accessed the patient information held within the NICE guidance and we were able to adopt a watchful waiting plan. He will return in 3 months' time for a further PSA test. I now feel more confident to be able to apply what I have learned to subsequent patients.*

- Credit claim – 2 hours' reading × 2 (impact) = 4.

### 3. Certificate in dermatology

*This is a distance learning programme provided by our local university hospital. It consists of six modules dealing with common dermatoses. Each module involves reading and then responding to a written exercise, which is marked. Passes need to be obtained in all six modules to gain a certificate. This has helped me develop a management strategy when dealing with rashes and I'm far more confident in dealing with simple eczema and psoriasis than I was. I enclose a certificate of completion. I further intend to utilise this knowledge within the practice and am working on an internal referral system. I intend to present this and an audit of care in next year's appraisal folder.*

In this example it is tricky to decide whether or not impact has occurred. There is little evidence of a change in practice. However, a university-accredited certificate and an indication that this is going to change practice for the benefit of patients is explicit. There is however no evidence of application. It is likely that the impact will be seen next year where the credit may be claimed. This claim therefore will simply be on hours spent.

- Credit claim – 4 hours per module for six modules = 24.

# 5 Meetings

As with distance or online learning the knowledge gained at meetings should be made explicit, as should its relevance to general practice. Practice-based colleagues are often the source of nuggets of information that change what the individual does. More formal meetings are excellent resources for up-to-date information and professional interaction, although sometimes the impact on practice may vary from doctor to doctor in the same meeting.

## Examples of credit claims

### 1. Practice-based educational meeting on COPD

*I am the practice lead for QoF on asthma and COPD. I have noticed that our use of tiotropium has been dropping over the last 12 months. I examined a number of patients' records and it seems that the drug is being stopped because the patients do not perceive a benefit.*

*I presented a practice-based educational meeting on spirometry results and the benefits that can be expected from the various inhalers utilised. During the meeting one of the partners said that they had been actively switching patients off tiotropium as they had not seen any benefit. We were able to discuss the use of spirometry in assessing benefit of treatment in COPD and we have now agreed an algorithm for treatment (or cessation thereof).*

- Credit claim – 1 hour's activity × 2 (impact) = 2.

### 2. Meeting at local postgraduate centre – neuropathic pain

*I attended this meeting as I find it difficult to treat patients with neuropathic pain. Talking to my colleagues before the meeting it appears that everybody else is in the same boat. The presentation defined neuropathic pain and explained the aetiology in as far as it is currently understood. Treatment modalities were discussed as well as local referral routes. I came away from the meeting with a slightly better understanding of neuropathic pain and a clear plan of treatments I can use in my own practice. However, it was also clear that I'm not alone in finding this condition frustrating and difficult to treat.*

- Credit claim – 1 hour's activity = 1.

### 3. GI meeting run by local consultants

*This was a day-long meeting held at our local hospital which included a tour of the endoscopy facilities. I gained great benefit from the tour as the process of endoscopy and the facilities have changed markedly since I was a junior hospital doctor. There were also a series of lectures, one of which consisted almost entirely of photographs obtained at endoscopy (very little value and very little relevance to general practice). There was an excellent session on IBS and a further small workshop on the genetics of bowel cancer and endoscopic surveillance. The main benefit however was in the management of dyspepsia in the under-45s. A local algorithm was handed out which I will share with my partners.*

- Credit claim – 6 hours' activity = 6 (this activity does not qualify for impact as there is no evidence of application of knowledge, but if the treatment algorithm for dyspepsia was illustrated with a change in practice (e.g. case histories) then impact may have been demonstrated).

# 6 Practical skills

Practical skills are as important as knowledge in some areas of an individual's practice. The demonstration of acquisition or mastery of a new skill can be used in the credit system. It is not just new skills that may be used in the system. For instance, teaching others practical skills has some impact and a GP examining his or her own results, either through audit or other markers, is certainly a legitimate exercise (e.g. percentage of diagnoses of skin lesions subsequently proved correct on histology, or percentage of complete excision of BCC).

## Examples of credit claims

### 1. Shave biopsy

*I attended a practical skills update at the local postgraduate centre. There was a practical demonstration of a shave biopsy and an explanation of why this was preferable to excision. I felt quite confident afterwards and I plan to use the technique when I can arrange some supervised practice.*

- Credit claim – 2 hours' activity = 2.

### 2. Liquid-based cytology training

*I attended the mandatory training for liquid-based cytology. The techniques of collecting a good sample were demonstrated and it differs quite considerably from the old-fashioned spatula and slide method. There was also some very useful information given about results and how to interpret them. I'm now using the technique.*

- Credit claim – 2 hours' activity = 2.

*I have not claimed the extra impact as I have only used this technique a few times. I will in a year's time audit the adequacy rates of my cytology.*

### 3. Joint injection

*About 2 years ago I attended a meeting discussing the use of hyalgan in knee injection. I started using it on some patients with moderate arthritic problems and felt that the patients benefited. I look back on the seven patients that I have used this injection on [10 knees].*

*Two of the ten have subsequently had knee replacement surgery; seven of the ten have not consulted regarding knee pain since the injection. One of the ten has ongoing problems that are managed with analgesia.*

- Credit claim = 2 hours' activity planning and preparing data collection × 2 (*impact*) = 4.

# 7 Practice developments

Building a new surgery or buying an expensive piece of equipment often involves doctors in a managerial role. There may be the opportunity to gain some credits but only for development – for example managing the transition from old practice premises to new would present a challenge, and patients presumably would benefit. However, the credit claim would be related to the learning involved in management. Statements such as ‘I discovered new ways to motivate the team’ or ‘This process, far from causing conflict, has engendered a team spirit’ would demonstrate change.

Developing a new service (e.g. insulin initiation) would certainly have impact, and if this were measured by data collection or audit the impact could be shown to be significant.

Taking on a new role with new responsibilities could involve development (e.g. leading on the staff appraisal system, becoming the finance partner). The doctor should reflect on the changes to estimate credits.

## Examples of credit claims

### 1. Practice finance partner

*Our senior partner retired last year and he used to have responsibility for practice finance. On his retirement this responsibility fell to me. I have no real previous experience in this role. I initially sat for some time with my retiring partner learning the ropes. He had a mainly manual system with most transactions recorded in long hand. Our practice manager had suggested computerised accounts and indeed fortunately had an automated payroll. The first change I made was to purchase an accounting system and then my practice manager and I learned how to use it.*

*The first year although difficult has been a rewarding experience. I now understand practice finance much better and the system is fully automated, and this has led to a reduction in our accountant’s fee of over £2000.*

- Credit claim – 5 hours’ activity × 2 (impact) = 10 (this is probably a large underestimation of the time spent).

## 2. Patient participation group

*I have established a patient participation group in the practice. We had tried this initiative a few years ago and it had failed. It seemed reasonable to try and reinstate this and so I first looked at why the previous group had failed and I suspect quite strongly it was because there was no medical input. I therefore decided that we would reinstate the group and that a doctor would attend each meeting. We have now had six monthly meetings and at least one of our partners has attended. We have used the opportunity to disseminate patient information about our services and at one of the meetings I gave a talk about preventive medicine and healthy lifestyle. There was an attendance of approximately 50 patients at this meeting.*

*Developments arising from this include changes to our appointment system, upgrading our waiting room – including the seating – and the patients have started a collection for a second defibrillator for our branch surgery.*

- Credits claimed – 2 hours × 2 (impact) = 4.

## 3. Warfarin services

*I have become a doser in our anticoagulation service. This involved me completing the online learning module approved by our PCT and completing an application form to be recognised. I am now dosing the patients on Tuesday and Thursday.*

- Credits claimed – 3 hours for online learning × 2 (impact) = 6.

# 8 PUNS and DENS: patient case reports and clinical experiences

Patients are a rich source of learning opportunities; most will be familiar with Richard Eve's model of Patient's Unmet Needs (PUNS) and Doctor's Educational Needs (DENS) (see BMJ learning module, <http://learning.bmj.com/learning/channels/gp/punsanddens.html>). PUNS and DENS rely on the doctor having a need. Patient reports and experiences can be used as a narrative to demonstrate good practice, highlight a good experience or use a bad experience to examine the need for change.

A quote from 1905 (Cabot RC, Locke EA. *Boston Med Surg J.* 1905; **153**: 461–5.) is as true today as it was then:

*Learning medicine is not fundamentally different from learning anything else. If one had 100 hours in which to learn to ride a horse or to speak in public, one might profitably spend perhaps an hour (in divided doses) in being told how to do it, four hours in watching a teacher do it, and the remaining 95 hours in practice, at first with close supervision, later under general oversight.*

Recording what happens in a consultation (or case study) would be in the 'general oversight' category, demonstrating that an individual was using best practice, dealing with problems appropriately, responding to emergencies, dealing with difficult patients, keeping up to date with palliative care, using the BTS/SIGN guidance, etc.

The unusual presentation, the rare condition, the referral on instinct that turns out to be significant, the wrong word that changed the consultation, the last extra of the day with rectal bleeding or similar scenarios provoke thought, reflection and action, all of which may have impact on future behaviour.

This learning by experience or from anecdotes from others often goes unrecognised; the impact associated with this day-to-day learning can be converted into credits.

## Examples of credit claims

### 1. PUNS and DENS

*I have included in my folder four examples of PUNS and DENS which highlight the learning needs that these consultations exposed and the steps I have taken to fill them. The learning undertaken in total took about 4 hours. I have not yet demonstrated any impact of the new knowledge. However, this may come at a later date.*

- Credits claimed – 4 hours = 4.

## 2. Case study

*I have included in my appraisal folder a case study of patients with heart failure. I have highlighted the therapeutic changes I have made and the investigations that confirm the diagnosis, and monitor the patient's progress. I have maximised the patient's therapy appropriately and have referenced this to a lead article in the BMJ. I have reflected that this is my standard therapeutic regimen for patients with heart failure. Writing this case study has stimulated my interest in the subject and I think I would like to do an audit on the topic next year (to be included in my PDP [personal development plan]?).*

- Credits claimed – 2 hours' reading and reflection = 2.

## 3. Emergency treatment

*The mother of a patient aged 5 rang the surgery at 9.00 a.m. and asked for the child to be seen later. The receptionist taking the call recognised potentially serious symptoms and asked the patient to attend immediately. I was the on-call doctor and by 9.20 was able to assess the patient. The patient was demonstrating symptoms suggestive of meningitis. Another partner and our nurse attended, and we were able to administer benzylpenicillin and phone an ambulance. The patient did indeed have meningococcal meningitis and recovered well.*

*This case history demonstrates that systems within the practice worked well, appropriate treatment was given and we highlighted this in a practice meeting. In my appraisal folder I have highlighted the changes we have instigated in training our receptionists in assessing patients.*

- Credits claimed – 1 hour (mainly reflecting on the incident and feeding back) × 2 (impact) = 2.

# 9 Reading

Reading can be arbitrarily divided into structured and unstructured. Both have merit. An example of structured reading would be researching a condition – for example the use of the latest hypoglycaemic medication. An example of unstructured would be reading every issue of a journal. An individual is likely to gain some useful information, but it is likely that a great deal of time would be expended in order to gain this information.

In both cases the reflection on the impact of this activity is the important thing when assessing the credits.

It is suggested that unstructured reading forms no more than 10 of the 50 credits in 1 year.

## Examples of credit claims

*I read the BMJ each week and find that much of the information has little if any direct connotation to my work as a GP. I continue to do this mainly out of interest and occasionally assimilate knowledge that is useful in my role as a GP. I have highlighted in a separate credit claim an excellent review article that led me to change practice. On average reading the BMJ takes me an hour a week.*

- Credits claimed = 10 (although 50+ hours were expended, it is recommended that unstructured reading forms no more than 10 credits in any 1 year).

*I have updated my knowledge in diabetes this year. I chose to do this by researching and reading articles on the web. I include a list of the articles read and learning points from each. I estimate in total this took me 6 hours.*

- Credits claimed – 6 (if the impact of the learning had been demonstrated then this could be multiplied by a factor of two, but despite demonstrating an improvement of knowledge there is no demonstration of utilisation of that knowledge).

*A number of my patients are now using anti-TNF therapy. I had no knowledge of its mode of action, side effects or range of benefits. I read three different articles relating to its use in rheumatoid arthritis and psoriasis, and I now have much better understanding and should be able to use this if patients need counselling prior to or during treatment.*

- Credits claimed - 2 hours' reading = 2.

# 10 Significant events

Significant events as a learning tool have gained widespread acceptance. Adverse events or near misses can be used to address system or personal issues. However, positive significant events can be used to demonstrate impact and learning. An early diagnosis, dealing with an emergency, a medication review leading to significant improvements in a patient's wellbeing – all are positive examples that can be shared with the team as learning points and can attract credits.

## Example of credit claim

*The practice has a significant event system that I will share with my appraiser. We discuss significant events at our practice meetings and review the forms to ensure completion of changes necessary as a result. I have reflected on one significant event that directly involved me and I have contributed to many others throughout the year. In the significant event involving me I have demonstrated a change in practice and indeed a change in practice policy as a direct result.*

- Credits claimed – 4 hours expended × 2 (impact) = 8.

# 11

## Structured learning

Structured learning (including certificates, diplomas, etc.) within the auspices of a higher education institution can also be used for credits. Impact should be demonstrable as presumably this will have been planned for a service or personal reason.

### Example of credit claims

*I have completed the diploma in dermatology this year. In the practice we have an arrangement that dermatology referrals are made internally to me for first assessment and possible treatment. Our referral rate to dermatology has fallen by 30 per cent.*

- Credits claimed – 30 hours of activity × 2 (*impact*) = 60.

In this example 60 credits are claimed. However, it is important that in subsequent years variety is demonstrated in subjects. It would be acceptable for 1 year to be devoted to one topic, but the PDP should reflect a change in direction for the subsequent year.

# 12 Surveys

The impact of surveys (patient, 360°) will vary from individual to individual. There may be few learning points that can be gleaned from the exercise, or the feedback may include factors beyond the control of the individual. There may be instances, however, where changes are required and these changes when made have an impact on the way a GP works. The reflection on the results and subsequent changes are the areas to examine when judging the impact.

## Examples of credit claims

*We completed a patient survey this year; the results were quite favourable, although there was some feedback around ease of access to our appointments. We discussed this in a practice meeting and have made a few changes, which I've highlighted in a separate document. These changes seem to have eased pressure at reception without increasing the doctors' workload.*

- Credits claimed – 1 hour meeting and discussion of the changes  $\times 2$  (impact) = 2.

*I completed a 360° feedback exercise. I was gratified that most of the feedback was very positive. I did however receive some negative feedback regarding my record-keeping. I therefore examined the records from 20 consecutive consultations 3 months previously and found that, although diagnosis and prescribing were recorded well, the description of the patient's condition and plan of action were missing in over half of the consultations. I have therefore changed my practice and although it is early days examination of a further 20 sets of records showed an improvement to 95 per cent in both aspects.*

- Credits claimed – 1 hour in examining feedback, 2 hours in design and reflection including changes made in the patient audit =  $3 \times 2$  (impact) = 6.

# Frequently asked questions

## Why do I need to collect credits?

In common with all the other medical royal colleges the RCGP will require 50 CPD credits per year as evidence for revalidation. The RCGP is unique in developing a system that is not wholly time based. CPD credits will be one of the required elements all GPs will need to collect.

## What is a credit?

A CPD credit is defined as being based on an hour of learning activity (including planning and reflection) recorded in such a way that it demonstrates the learning achieved relevant to the working situation of the GP.

In its simplest form 1 hour of activity equates to 1 credit. Credits are self-assessed and, although a certificate of completion or attendance may be used as evidence of activity, it is the demonstration of learning achieved and relevance to the work that the GP undertakes that defines the credit. In short the RCGP does not advocate the collection of certificates. Rather, a collection of self-assessed acquired knowledge relevant to the individual's working situation is required.

The acquisition of knowledge in itself does not necessarily lead directly to patient benefit. Under this system demonstrating impact is rewarded by a multiplication factor of 2 applied to time spent.

## Revalidation evidence will be collected on a 5-year cycle – can I collect all my credits in 1 year?

GPs should collect a minimum of 50 credits each year adding up to a total of 250 credits over the 5-year period. It is expected that most doctors will collect 50 each year. However, some flexibility may be allowed in extenuating circumstances. The experience of a large pilot across the UK demonstrated that most GPs have no difficulty in achieving 50 or more credits a year.

## The guide states that credits are self-assessed – what does this mean?

When including a piece of developmental work within his or her appraisal folder, the doctor should assign a number of credits. If the development is relevant to the doctor's working circumstances, 1 hour of activity can equal 1 credit. If the doctor can demonstrate impact, as described in the guide, then this credit claim can be doubled. This self-assessment should be evidenced through reflection on activity and does not necessarily need to be backed up by certificates.

The guide further states that these self-assessed credits will be verified at appraisal – what form will this take?

As yet the mechanism for verification has not been developed. During the piloting of the CPD credits system appraisers were mainly positive about this process. There were, however, a significant minority of negative comments that have led to a simplification of the process. Once the system is fully operational it is likely that the discussion about credits will be short. As credits are self-assessed the verification process should really be one of confirming facts.

What if my appraiser disagrees with the number of credits I have claimed?

There are a number of scenarios covered by this question. In the pilot, in general, appraisees undervalued their credits. In this case the appraiser may verify more credits than actually claimed. It may appear to the appraiser that the doctor has overclaimed credits in this situation, and the appraiser may only be able to verify a smaller number of credits. If the appraiser is still able to verify 50 or more credits then this should not lead to any difficulties. In a situation where the appraiser is unable to verify 50 credits in a year then steps should be made to rectify this shortfall in a subsequent year.

What if an unforeseen circumstance prevents me from collecting 50 credits in a year?

The revalidation guide covers exceptional circumstances; examples might include maternity leave, a sabbatical or a period of illness. In these situations the doctor should refer to the online revalidation guide ([www.rcgp.org.uk/\\_revalidation/revalidation\\_documents.aspx](http://www.rcgp.org.uk/_revalidation/revalidation_documents.aspx)).

What can I claim credits for?

Credits can be claimed for many different activities. Some examples are highlighted in this guide, for example in the section on audit. The main criteria are that it must be a learning activity and that it must be relevant to the individual's working practices. Contained within the guide are the RCGP's suggestions for doctors collecting credits and for appraisers regarding credits.

What is impact?

Impact in this context refers to the impact on:

- patients (e.g. a change in practice, implementing a new clinical guideline, initiating a new drug for the first time)
- the individual (personal development, e.g. development of a new skill or further development of existing skills)
- service (e.g. developing and implementing a new service, becoming a training practice, teaching others)
- others (teaching, training, NHS locally or nationally).

How can I demonstrate impact?

Impact may be demonstrated in a number of different ways. Patient case studies with reflection on how learning has changed your management may be the simplest way. Audit showing an improvement in care, referral figures or – in the case of learning a new minor surgery skill – a case log all could be used.