CPD and Revalidation
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RCGP Guide to the Credit-Based System for CPD

Royal College of General Practitioners
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‘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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anical, photocopying, recording or otherwise without the prior permission of the
Royal College of General Practitioners.
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 with reflection and the impact it has on the doctor, his or her patients and the service.

In essence 1 hour of learning activity accompanied by a reflective record is 1 learning credit. However, if the doctor can demonstrate that the learning has been implemented in practice, resulting in improvement in patient care or positive changes in an area of the doctor’s work, the GP can claim 2 learning credits for each hour of such learning activity.

Credits are self-assessed and verified at appraisal with relevant supporting information, 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 using a variety of learning methods.

The system is designed to help GPs meet their revalidation needs by providing a mechanism for collecting and demonstrating how their learning is used to improve patient care in all aspects of their work.

The credit system is not mandatory but provides a simple way of recording CPD. All the royal colleges are using a credit system for measuring CPD (1 hour of learning plus a reflective record equals 1 credit) with 50 credits required each year.
Your CPD should keep you up to date and competent in all the work that you do. It should affirm what you do well, address areas requiring improvement and explore new knowledge, skills and behaviours.

This statement from the General Medical Council (GMC) guidance on CPD for revalidation summarises the aims of CPD and it is in this context that the CPD credits system should be understood.

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 a doctor to accumulate 250 credits 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. Piloting of a system based on the impact of a developmental activity was completed in 2009 and informed the development of the current system, based not only on time spent on the learning but also allowing an opportunity to gain further credits by demonstrating the outcome (impact) of the professional development.

Impact in this context refers to the demonstration of implementation of learning on:

- patients (e.g. a change in practice, implementing a new clinical guideline, initiating and monitoring 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, developing a local patient pathway, teaching others)
- others (teaching and training, leadership within the NHS locally or nationally).

This approach to CPD was 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 and including a record of reflection and learning points
- flexibility of CPD schemes
- developing doctors across the context of their professional practice
- evidence for external scrutiny
- that multiple methods are appropriate
- building a portfolio over the 5-year revalidation cycle.

Unless there are exceptional circumstances, all GPs will be expected to accumulate 50 credits each year. Doctors should aim for a broad range of CPD appropriate for the work that the GP undertakes.

GPs have different learning styles and learning needs. However, it is important that a variety of learning opportunities are 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 ways 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. It is important to note that not all learning activities will lead to change or have impact. However, a few examples of impact are expected every year.

So in essence a good CPD log would:

- satisfy the accumulation of 50 points
- include a variety of learning styles
• cover a range of clinical and non-clinical topics relevant to all the doctor’s roles, covering the full scope of his or her practice over the revalidation cycle
• include a few examples of impact with supportive documentation.

In planning and reviewing progress with CPD over the year GPs should:

• have a PDP that meets their own development needs and that of their workplace
• have a system for recording what has been learned and their reflections on it, in both planned learning and incidental learning
• consider how their learning can be used to improve patient care
• claim CPD credits at double the time spent if a demonstrable change in care has resulted.
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 accompanied by a reflective record 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 without additional written reflection on learning and how it might influence practice. Recording the thoughts and plans stimulated by the learning activity very soon afterwards is helpful in promoting later change in practice. These reflections should be kept in the CPD part of the GP’s portfolio.

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 × 2 (impact) = 2
- a third individual attends the same meeting. The acquisition of knowledge is recorded. However, in his or her appraisal folder, following a discussion with colleagues an audit is planned after consideration of current practice (1 hour). This individual demonstrates audit of the practice’s 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)) = 3

total credits × 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
- personal learning acquired from the activity
- 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, e.g.:

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

The RCGP Impact Toolkit contains a number of examples of how impact can be demonstrated.⁴

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Appropriate Claims

What can be claimed?

Time spent on developmental activities may include personal preparation, activity and reflection. Credits should only be awarded when a demonstration of the learning achieved is relevant to the scope of 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 British Medical Journal (BMJ) every week for 1 hour – claim 52 credits
- audit data collection, 6 hours – claim 6 credits.
- attendance at 10 × monthly practice business meetings, 10 hours – claim 10 credits
- teaching a trainee on video consultations for 1 hour – claim 1 credit.

The above example of reading the BMJ may be eligible for credit claims if learning points are recorded. However, in the format presented it gives little indication of relevance to the GP’s practice. Regular reading of peer-reviewed journals is an important part of CPD because it helps the GP to be aware of current thinking in several therapeutic areas and of medical changes generally. A simple learning log can be used to show which items have helped the GP to stay up to date. For example, articles about National Institute for Health and Care Excellence (NICE) guidance in the BMJ can trigger the GP to examine how his or her current practice measures up to latest guidance.

Reading alone cannot supply all of the GP’s CPD and agreement needs to be reached with the GP’s appraiser according to the GP’s context of practice.

Performing data collection for the purposes of audit should not be claimed. Attendance at practice meetings may have educational value but this must be made explicit and the appraisee’s personal learning documented. Preparation for teaching may also be used to demonstrate learning, particularly if it is in the development of a new tutorial for example; again this learning should be made explicit and the appraisee’s personal learning documented.
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 unless an action plan with implementation of change is developed with a re-audit to demonstrate improvement. The same may apply to other widespread audit activities, for example for prescribing incentive schemes. The process of improving or maintaining QOF points or of looking at cost-effective and safe prescribing is of course a quality exercise in itself that has impact and would be eligible as long as personal involvement could be demonstrated. Audit outside QOF could qualify for credits, although it must be remembered 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% 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/peer group a further hour and reflection on the audits another hour. Writing up an audit and conducting an audit cannot be claimed as credits. Total = 4 hours.

   - Credits claimed – 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% drop in the HbA1C across the whole practice population of people with diabetes. The prescribing of ACE inhibitors in microalbuminuria 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. Planning and reflection is counted for credits but conducting and writing up an audit cannot be counted as credits.

- Credits claimed – 10 credits for activity × 2 (impact) = 20.

What should not be claimed?

- Audit where there is little or no personal involvement, or that cannot be justified, e.g. auditing the DNAs to the nurse-led clinic, carried out by practice manager and nurse.
- Audit and ‘learning’ of the same activity on an annual basis where no cause for concern has been shown and the activity has not changed e.g. auditing the infection rate after joint injection by the same partner when this has been shown to be negligible.
- Conducting and writing up an audit.
- Writing protocols. However, the learning undertaken in order to prepare to write a protocol is CPD.
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 Challenges**

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), which is an applied online self-assessment knowledge test, that will be issued 6 months after the update. The topics chosen for the EKU 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 EKU (and associated EKC) would generate between 10 to 15 credits. Impact on practice may be demonstrated, increasing the credit value of this claim.

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**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.

   - Credits claimed = 1.

2. **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.

   - Credits claimed = time spent including reflection and recording learning points.
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).

• Credits claimed – 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.

• Credits claimed – 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.

- Credits claimed – 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).

4. GP trainer group meeting

I attended our local trainer group meeting, which lasted 3 hours. We covered the use of web-based teaching and educational resources. All of us had to bring an example of what we found useful and then share this with the group. We had internet access and I’m now aware of a much greater range of e-learning and web-based resources than before. I will certainly be using the New Zealand dermatological website in a forthcoming tutorial, and I was also shown a useful presentation on teaching and learning styles which I will use as a base for discussion for the next induction session of the new trainee. The last hour was devoted to deanery resources – I had been sceptical about using these but after being shown how to access the deanery virtual learning environment I was pleasantly surprised at the information there that could support my training role. I am using the guidance on writing a good Educational Supervisor’s Report right now and I hope to demonstrate improvement in this area when I get feedback on this from the deanery lead in this area.

- Credits claimed – 2 hours’ activity (without impact) + (2 × 1 hour’s activity on deanery resources for impact on ESR report writing) = 4.
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 basal cell carcinoma).

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.

- Credits claimed – 2 hours’ activity = 2.

2. 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 demonstrated patient benefit through a survey using pain scales. I looked back on the seven patients that I have used this injection on [ten 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.

- Credits claimed = 2 hours’ activity planning and preparing data collection × 2 (impact) = 4.
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 of over £2000 in our accountant’s fee.

   • Credits claimed – 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 to 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. I have recorded the changes and their impact on improving the patient experience.

- 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 Primary Care Organisation and completing an application form to be recognised. I am now dosing the patients on Tuesday and Thursday and have demonstrated this through case reviews.

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

4. Locum pack

I locum in five different practices and noticed that only two of them had a locum pack and neither of these was fully up to date. I discussed the matter in both of the practices that had locum packs and offered to work with a partner and the practice manager to draw up a list of useful resources and contact details for locums working in those practices. During the course of this activity I learnt a lot more about the resources I could be using during consultations with patients. I have presented this to our local locum educational group who approved it and made further suggestions for inclusion. I have now introduced this pack with its templates to the three other practices that I locum in and find it personally useful. Other locums have fed back to me that they also found it helpful when working there. I have provided supporting information in the form of feedback showing the effect of implementing learning.

- Credits claimed – 3½ hours for learning from colleagues × 2 (impact) = 7.
Patients are a rich source of learning opportunities; most GPs will be familiar with Richard Eve’s model of Patient’s Unmet Needs (PUNS) and Doctor’s Educational Needs (DENS). 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 Medical and Surgical Journal 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 British Thoracic Society/Scottish Intercollegiate Guidelines Network 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 five 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 a.m. 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.
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 and recording of learning points for this activity is the important thing when assessing the credits.

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 three excellent review articles that led me to change practice. I have also included an article on treating patients equally and the new equality legislation, as this came up in a practice meeting and I agreed to look into it on behalf of the practice. On average reading the BMJ takes me an hour a week. I have written a short reflective paragraph on each of the ten articles of sufficient significance to warrant an entry in my learning log.

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. 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 = 10. (Although many more hours were expended, the GP felt that 10 hours were related to the learning and reflection demonstrated. It is important to use a variety of learning methods in the CPD portfolio to include, for example, peer group learning, courses and conferences as well as personal learning such as reading and e-learning. The blend of learning is dependent on the preferred learning style of the GP and his or her working circumstances.)
Significant events as a learning tool have gained widespread acceptance. Adverse events or near misses can be used to address systemic or personal issues. However, positive significant events can be used to demonstrate impact and learning. An early diagnosis, dealing with an emergency, or a medication review leading to significant improvements in a patient’s wellbeing are all positive examples that can be shared with the team as learning points and can attract credits. The number of points claimed for a significant event analysis (SEA) will depend on the GP’s involvement in learning and impact.

Example of credit claim

I submitted a significant event involving the management of a terminally ill patient who died peacefully at home with his family. The team worked well together implementing anticipatory care. The family sent in a thank you letter showing their appreciation for the care received. The event was discussed as a team highlighting what went well.

- Credits claimed = 1 hour.

My partner submitted a significant event where a 90-year-old patient had developed vulval cancer. She had been diagnosed with lichen sclerosis 5 years ago. However, she had been lost to follow-up. Although it is unlikely that in this case an earlier diagnosis would have altered her management as she was very frail and had multiple morbidities, it was felt that appropriate follow-up would have been beneficial. As a result of this protocol, the partner produced a practice protocol for the management of patients with lichen sclerosis to ensure they had an annual check. I had been involved in the discussions and have reviewed two patients as a result. A formal audit has been submitted with my appraisal paperwork.

- Credits claimed 1 × 2 for impact.

(Although the GP had not written the SEA, she had been involved in the discussion and updated her knowledge with the new protocol and participated in the audit that showed impact on patient care.)
Structured Learning

Structured learning (including certificates, diplomas, etc.) within the auspices of a higher education institution or an external organisation 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 and have recorded the key learning points and reflections. 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%.

- Credits claimed – 30 hours’ 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.

I am now the partner responsible for research in the practice - this is a new role for me and as a practice we have only been involved in this area for 3 years. I have attended a day’s training (6 hours) with the university as I needed to learn about process. I was also given several folders of guidance documents on research governance and patient safety issues – these took me another 5 hours to read. We had a need to tidy up our processes in research work, and I now feel much more confident in taking on this role. I have summarised the findings and presented them in a 2-hour partners’ meeting to ensure the whole practice is aware of the issues and some recent changes to the process.

- Credits claimed – 13 hours’ activity × 2 (impact) = 26.
The impact of surveys (patient, colleague) 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 negative feedback around ease of access to our appointments and time patients spend waiting at the reception desk. Much of this centred around our telephone answering system. We discussed this in a practice meeting and one of the doctors had brought some information to the meeting on a range of available telephone systems that we could consider as alternatives. I learned quite a bit about the pros and cons of call options and having dedicated lines for nurse advice, repeat prescription orders, etc. My partner took up the responsibility for inviting a telephone company to give us a quote for a new system and we as a practice have made a few changes to improve access, which I’ve highlighted in a separate document. These changes include a self-check-in system and seem to have eased pressure at reception without increasing the doctors’ workload.*

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

*I completed a colleague 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% in both aspects.*

- Credits claimed – 1 hour in examining feedback, 2 hours in design and reflection including changes made in the patient audit = 3 × 2 (impact) = 6.
Other Quality Improvement Activities

There are a number of other quality improvement activities that you may claim credits for. These may be related to a review of prescribing, review of referrals, case reports, trigger review of patient records or many other examples. The important point is to record how much time it took you to perform the review, and, if this has changed practice, then you can multiply this by submitting supportive evidence to justify impact.

Example: 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 have included two case histories of the introduction of this drug and subsequent follow-up. It seems that initially good results are obtained.

- Credits claimed – 3 credits for activity × 2 (impact demonstrated by case histories) = 6.

Trigger review of clinical records

I performed a trigger review on patient records and identified a 55-year-old patient with chronic kidney disease who had been prescribed an NSAID drug. There had been no check of the patient’s kidney function since. I have subsequently sent for the patient and discontinued this medication and arranged a blood test, which was stable. I wrote this case up as an SEA and shared it with the team. I also performed a search on the computer records to ensure no similar cases had occurred and include this review in my appraisal documents.

- Credits claimed – 3 credits for trigger review and writing and discussing SEA × 2 (impact) = 6.
Frequently Asked Questions

**Are learning credits mandatory?**

The credit system is not mandatory but provides a simple way of recording CPD. All the royal colleges are using a credit system for measuring CPD (1 hour of learning plus a reflective record equals 1 credit) with 50 credits required each year. The RCGP also recognises the value of implementation of learning in practice and so the time-based credit can be doubled if the GP can demonstrate how the learning has had a positive impact on his or her patients or practice. If the credit system is not used a doctor has to decide how to show the appraisers that he or she is keeping up to date.

**Can mandatory training count towards learning credits?**

Yes, as long as learning is demonstrated through a reflective note. We would encourage a GP to try to demonstrate implementation of learning in practice, in which case credits can be doubled.

**I am undertaking a diploma that involves 10 hours of study a week and will equate to 1200 hours of learning. Should I record all these hours as credits?**

Your learning should reflect the scope of practice and you should select 50 representative credits for discussion with your appraiser each year. It might be the case that, in one particular year, your CPD will be oriented towards a particular activity, such as a diploma. However, you might agree with your appraiser that you should diversify the range of your learning activities the following year and concentrate on other areas.

**If I attend a two-day conference, should I claim time credits for the duration of that conference?**

We would advise that you record the parts of the conference that you consider valuable CPD as separate learning episodes, each with a reflective record. You may choose to claim impact credits for these learning episodes at a later date.

**What are the ways in which impact can be demonstrated?**

To claim points for impact, a GP needs to demonstrate evidence of change (for patients, the individual, the service or others, e.g. NHS locally or nationally). There are numerous ways to demonstrate this. These may include:
• performing an audit with evidence of change (e.g. if the learning point was the use of beta-blockers in heart failure an audit can provide evidence of implementation of learning with improved patient care)

• writing up a case report demonstrating how the newly acquired knowledge has been applied in practice (e.g. submitting a case report on management of a patient with newly diagnosed atrial fibrillation using the recently acquired knowledge from a learning activity)

• developing a protocol with evidence of applying this in practice (e.g. implementation of a new protocol for use of antibiotics in a practice with evidence of reduction in prescribing antibiotics following implementation)

• demonstrating improvement in patient survey or MSF results following learning activities or practice development (e.g. following completion of communication course or leadership course)

• developing and implementing a new service in the practice following a learning event (for example joint injections or insertion of contraception devices)

• taking on a new role following training and documentation of learning points (e.g. an undergraduate tutor role or staff appraisals)

• providing evidence of changes in the practice as a result of SEAs (e.g. implementation of anticipatory care planning for palliative care patients following an event where treatment was delayed or a case report describing the implementation of the new changes with positive feedback from a family).

For further information on impact, see the RCGP Impact Toolkit (www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx). See also the learning credits section of the RCGP Revalidation Question and Answer Bank (www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx).