APPRAISAL, REVALIDATION & PORTFOLIO | MODULE 06

Quality improvement and significant events: evidence of learning

Show meaningful participation in improvement and explain learning from safety events without confusing appraisal with incident investigation.

✓ 12 min reading

✓ Full teaching, practical next steps and reflection

✓ Six practice questions with answers and explanations

✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

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Using this module

Independent education	This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Describe your contribution, evaluate the work and explain the action that followed. Report and escalate safety concerns through the proper system; appraisal reviews learning and does not replace that process.

Three next actions

- Identify a relevant improvement activity and your contribution.
- Check the governance record for events involving your practice.
- Plan how to review the effect of any resulting change.

Learning objectives

- Choose proportionate quality-improvement evidence.
- Distinguish event reporting from appraisal reflection.
- Explain outcomes and limitations honestly.

Choose work that examines quality

Quality improvement can include an audit, structured review, evaluation of teaching or management activity, or another relevant examination of practice. The GMC requires active participation at least once in the revalidation cycle, with the appropriate type and frequency agreed for the scope of work. It also expects regular review of practice. This is not a universal rule that every doctor must personally lead one large audit every year.

Begin with a question that matters locally and that can be answered with authorised information. For example, a team might examine whether a newly introduced handover field is being completed usefully. The project needs a purpose, a sensible method and a way to review what happened. Do not choose an impressive title first and then look for data that makes it appear successful.

Explain your contribution within team work

Describe the part you played: identifying the question, agreeing the method, collecting or reviewing information, discussing findings, implementing change or evaluating follow-up. Be explicit about shared work and where other colleagues led. An appraisal account should make your learning understandable without appropriating the team’s achievement.

A doctor who joined a project after data collection can still make a substantive contribution through interpretation and implementation. The account should say so. Attach or reference an approved summary, explain what you learned and identify any limitation. A project certificate may confirm involvement, but the discussion should go beyond the name on the certificate.

Evaluate the result and the next step

Separate the intervention from its outcome. A new form is an output; whether it improved useful communication is a different question. Decide what observation or measure would test the intended change. Where follow-up is incomplete, say what remains to be evaluated and include a feasible review in the development plan.

In an original example, completion rates rise after a teaching session, but staff report that the field is being filled with unhelpful stock phrases. The reasonable response is to examine usefulness, not merely celebrate the numerical rise. An honest appraisal can explore why the measure was incomplete and how the team will improve it. Learning may be more valuable than a simple positive headline.

Declare events and keep the purposes separate

The GMC definition includes unintended or unexpected events that caused or could have caused patient harm. Declare and reflect on every significant event in which you were involved since the previous appraisal, including relevant team involvement. If none occurred, declare that and reflect on risk reduction or the local process. Local terminology may differ.

The official event record, investigation and appraisal reflection have different purposes. Use the organisation’s reporting and candour arrangements at the proper time. For appraisal, explain your learning and action without copying identifiable investigation material into an unapproved portfolio. A pending investigation may limit what conclusions can safely be drawn; distinguish confirmed facts from matters still being examined.

Consider personal action and the working system

Ask what you knew at the time, what information was available, what you did, what constraints mattered and what could change. Avoid hindsight certainty. Recognising a system factor does not remove individual responsibility, and acknowledging your own learning does not require accepting an inaccurate account of events. Obtain individual advice where formal proceedings or contested statements are involved.

A useful reflection may identify a personal change, such as making an escalation request clearer, and an organisational action, such as clarifying the response route. Record who owns each. Do not label the organisational problem as resolved because you have written a reflection. If risk persists, keep using the appropriate governance or speaking-up process; it should not wait for next year’s appraisal.

Look for repeated themes

Review the set of experiences rather than treating each item as an isolated form. Recurring uncertainty about handover, prescribing systems, supervision or access to advice may deserve a coordinated response. Share themes through authorised governance channels in a way that protects individuals. Appraisal can help identify your learning needs and how to contribute to improvement.

Use a short action record: issue, personal learning, team or organisational action, responsible role, and review point. If the action depends on another service, record the request and response rather than promising an outcome you cannot control. The quality of the account lies in its accuracy and follow-through, not in declaring every issue closed.

Common mistake

Avoid this	Using an appraisal reflection instead of reporting a safety event, or claiming a project improved care without evaluating the result.

Pause and reflect

What did your last improvement activity actually establish, and what remains unknown?

Takeaways

- Show your contribution and evaluate the result.
- Report safety events through the proper system.
- Keep unresolved risks visible.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. Which QI statement is most accurate?

A. The activity and frequency should fit the scope and be appropriately agreed.

B. Only projects with statistically significant results can inform appraisal.

C. Teaching or management evaluation can never be QI evidence.

D. Every doctor must lead one full clinical audit annually as a universal GMC rule.

2. A doctor joined a project during implementation. How should the work be described?

A. Omit the project because only the original lead can learn from it.

B. Explain the implementation contribution and learning, acknowledging the team’s earlier work.

C. Claim to have designed the entire project because it was later presented at appraisal.

D. Use the team’s outcome as proof of sole personal impact.

3. A new form is completed more often, but the entries are unhelpful. What is the best interpretation?

A. Completion improved, but usefulness needs evaluation and further change.

B. The project has definitively improved communication quality.

C. The data must be excluded because it complicates the success story.

D. The form should be described as ineffective without examining why.

4. A doctor was part of a team involved in a near-harm event. What is required?

A. Exclude it because no harm ultimately occurred.

B. Use the reporting process and declare and reflect on the relevant event.

C. Record it only if the doctor was the sole person responsible.

D. Wait for appraisal before deciding whether to report it.

5. A safety event involved both personal communication and a system gap. What is most useful?

A. Identify personal learning and separate organisational actions with appropriate owners.

B. Attribute everything to the system and omit personal learning.

C. Accept all responsibility to demonstrate reflection.

D. Mark the system issue closed once the reflection is written.

6. Several events involve the same escalation difficulty. What should the doctor consider?

A. Keeping each account isolated so no pattern is visible.

B. A coordinated review of the theme through authorised governance routes.

C. Publishing identifiable examples to demonstrate the concern.

D. Waiting for a revalidation decision before raising the theme.

Answers and explanations

1. A — The activity and frequency should fit the scope and be appropriately agreed.

The GMC recognises varied improvement activity and a proportionate approach. A single rigid annual project formula does not represent the guidance.

Review the named teaching section, then explain the next step in your own words.

2. B — Explain the implementation contribution and learning, acknowledging the team's earlier work.

Appraisal can recognise meaningful participation at different stages. The account should be specific about contribution and avoid appropriating colleagues' work.

Review the named teaching section, then explain the next step in your own words.

3. A — Completion improved, but usefulness needs evaluation and further change.

An output measure can miss the intended benefit. Reflect on what the measure establishes and what further inquiry would improve the intervention.

Review the named teaching section, then explain the next step in your own words.

4. B — Use the reporting process and declare and reflect on the relevant event.

Significant events include potential harm and relevant team involvement. Appraisal reflection does not replace timely reporting through the organisation.

Review the named teaching section, then explain the next step in your own words.

5. A — Identify personal learning and separate organisational actions with appropriate owners.

A balanced account can examine both individual and organisational factors. Reflection neither allocates all blame nor resolves an ongoing system risk.

Review the named teaching section, then explain the next step in your own words.

6. B — A coordinated review of the theme through authorised governance routes.

Patterns can identify a need for wider improvement. Share them through appropriate channels while protecting individuals and continuing any necessary risk escalation.

Review the named teaching section, then explain the next step in your own words.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

GMC: quality improvement activity
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/quality-improvement-activity

GMC: significant events
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/significant-events

GMC and partners: reflective practice principles
UK · https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/the-reflective-practitioner---guidance-for-doctors-and-medical-students/ten-key-points-on-being-a-reflective-practitioner

GMC and partners: disclosure of reflective notes
UK · https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/the-reflective-practitioner---guidance-for-doctors-and-medical-students/disclosure-of-reflective-notes

Edition and verification

Editorial edition: 9 September 2026. The page source-review date is 2026-09-09. A publication date, editorial edit and substantive source check have different meanings. See sasdoctors.com/corrections for material corrections and the scope of review.

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