NHS
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Clinical Case Review Policy

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4.1	June 2023	Risk Team	D	TMG approved extension until August 2024
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4.3	June 2025	Tim Millington	D	Amended following recommendations from EIA review
5.0	September 2025	Risk Team	A	Policy approved in September Clinical Governance Group
A = Approved D = Draft				
Document Author = Tim Millington, Associate Director Paramedic Practice				
Associated Documentation: • Investigations and Learning Policy • Grievance Policy and Management Procedures • Clinical Action Plan				

Staff Summary

To ensure staff are supported to where training, education or assessment is required
To define how cases will be reviewed and by whom
To ensure that in the course of reviewing any clinical case, near misses or incidents are recorded appropriately on the DATIX system so that themes and trends can be identified
To ensure themes and trends are reported quarterly by the Risk Department to the quality committee. Learning through clinical case reviews is included in that report.

1.0 Introduction

1.1 Yorkshire Ambulance Service is dedicated to patient and staff safety and to providing excellent clinical care to service users. The Trust is committed to a culture of openness and fairness, where any learning from incidents and excellent clinical practice is harnessed to inform future practice at individual, organisational and health economy levels.

1.2 Within YAS a range of healthcare professionals practice across a spectrum of clinical settings in the course of providing care to patients. This policy sets out the way in by which clinical cases are reviewed throughout the Trust and across all clinical grades and settings.

2.0 Purpose/Scope

2.1 The Trust is committed to a culture where staff see reporting of incidents positively and actively contribute to learning from mistakes, errors and incidents. No member of staff will ever be punished for making a clinical error except where their actions constitute cause to enact the Disciplinary Policy i.e. negligence or misconduct. Staff will be supported to continually improve, develop professionally, reflect and learn through the application of this policy.

2.2 The aims of this policy are:

- To enable a safe environment where staff can discuss incidents, mistakes or errors
- To ensure staff are supported where remedial training, education or assessment is required
- To define how cases will be reviewed and by whom
- To ensure that in the course of reviewing any clinical case, near misses or incidents are recorded appropriately on the DATIX system so that themes and trends can be identified.
- To ensure themes and trends are reported quarterly by the Risk Department to the Quality Committee. Learning through clinical case reviews is included in that report.
- To support a *Just Culture* throughout YAS in line with the NHSE ‘Being Fair Tool’ (that has replaced the Just Culture Guide).

3.0 Process

3.1 There are a number of reasons why it may be necessary to hold a clinical case review (CCR), including:

- A written complaint or concern made by a patient or staff member (anonymous concerns will not be reviewed).
- A service-to-service concern made to the Trust.
- Self-referral

- The Trust's own internal reporting mechanisms.
- A police or coronial investigation involving the Trust
- Areas of excellent practice where there may be an opportunity to learn
- Feedback from professional networks and patients groups (e.g. Major Trauma Network, MINAP (Myocardial Ischaemia National Audit Project etc.

3.2 If at the time of an incident being considered for review under this policy, there are also factors that would warrant formal investigation under the Disciplinary Policy, this policy should not be used, and Disciplinary Investigation should be commenced immediately.

3.3 If during the course of a clinical case review, factors become apparent that would warrant investigation under the disciplinary policy, the case review should be concluded and the matter referred to the staff member's line management for enactment of the Disciplinary Policy.

3.4 A flowchart outlining the process for clinical case reviews is in Appendix B. The flowchart should be used in conjunction with the guidance set out in the Investigations and Learning Policy, in reaching a decision as to the potential risk associated with an incident or near miss.

3.5 The principles captured within 'Being Fair Tool' which has replaced the 'Just Culture' guidance, involve transparency and adopting a position of no blame from the offset and should be upheld whether the investigative officer opts to review a case via CBD or CCR process. The delivery of either a CBD or CCR, and the questioning involved, should not feel different to the member of staff in attendance, should they be invited to CBD or CCR. The key difference between these two processes centres upon the level of rigor applied to the documentation process. CBDs will involve a brief summation of any discussion and learning plan, typically in paraphrased bullet points. CCRs will capture a more detailed description of events, using a structured format. This mechanism of comprehensive documentation involved with CCRs will support clinical managers and, importantly, the effected staff members should the case attract any future coronial interest (as an example). The coronial interest in a case is not always predictable, hence a level of professional judgement will be required by the CCR lead.

3.6 On certain occasion it might be required that, during the CBD process, the clinical manager identifies issues that suggest the need for more in-depth record keeping of the discussion. As described in 3.5, cases that might potentially trigger a coronial interest are one such example. It is important to reiterate that these are not always recognisable at the point of the initial review of the Datix record. In such circumstances the clinical manger is supported to continue the meeting as a CBD and inform the staff member of their rationale behind opting to document the interaction as a CCR. This decision comes with no added implications to the staff member and is purely a matter of documentation and record keeping.

3.7 Any relevant documentation or records relating to the case should, where possible, be made available in advance of the clinical case review being facilitated. In exceptional circumstances it may be possible to facilitate a clinical case review where it is prudent to do so without any such records.

3.8 No member of the facilitating team will have been directly involved in the case being reviewed.

3.9 Where deemed appropriate by the clinically responsible manager, a case may be reviewed with multiple members of staff involved.

3.10 The decision to facilitate a clinical case review in this way must consider, the welfare of staff involved, the potential for differing learning styles of staff involved, operational pressures, and the availability of appropriate facilitators.

3.11 Where it is possible that conflict may arise between parties involved a case review may be held separately. Support should always be provided to staff involved in cases and where necessary consideration to the Issue Resolution Policy be given.

3.12 The COVID-19 pandemic resulted in the requirement to implement social distancing measures, therefore CBDs and CCRs have been successfully conducted virtually via digital media, with the agreement of all parties. This process of CBD and CCR delivery can continue and will support operational teams with the practicalities involved in the delivery these sessions. It is important that when a case review has been conducted using digital media the meeting MUST NOT be recorded.

3.13 Whereas CBDs will be summarised, Clinical case reviews will be documented and notated in more detail, however a verbatim account of the discussion will not be produced. A copy of the notes will be made available to the participants for their review. These may be anonymised and form part of a clinician's evidence to demonstrate continuous professional development and changes to practice if submitting a professional portfolio of evidence to a registering body.

3.14 Commitments

3.14.1 A clinical case review is not adversarial and should feel supportive and psychologically safe. The purpose is to identify learning and improve the service we offer to patients, done so through the holding of a conversation to support reflection. In all case-based discussions and clinical case reviews facilitators must be trusting, fair, respectful and understanding. In turn, participants will be required to be open, honest, professional and demonstrate a willingness to reflect and learn.

3.14.2 Wherever possible, Clinical Case Reviews (CCRs) should be conducted within 4 weeks of the case being raised to support timely learning and accurate recollection of events. However, in recognition that some incidents may be distressing or traumatic for those involved, consideration must also be given to staff wellbeing and emotional readiness. Where appropriate, and in consultation with the staff member, the timing of the review may be adjusted to ensure a psychologically safe and supportive environment. In all cases, the CCR will be held as soon as is practicable, balancing both the importance of timely reflection and individual needs.

3.14.3 The CBD / CCR lead will also be assigned as the lead investigator or as support on the relevant Datix record. It is their responsibility to ensure this record is appropriately updated and the learning response is accurately captured therein, following completion of the CBD / CCR.

3.14.4 It is the CBD / CCR leads responsibility to update and maintain a log of CBDs/CCRs to enable learning or safety themes and trends to be identified and shared.

3.14.5 Documentation should be available in alternative formats for accessibility with appropriate workplace adjustments made to support staff when required.

3.14.6 Any details related to an individual's gender history must be treated with strict confidentiality and not disclosed unless explicitly relevant to the case and with the individual's consent.

3.14.7 Facilitators should consider the emotional impact of the case under review. Staff may request a delay, alternative format e.g. arrange an online meeting or bring a supporter to ensure the review is conducted in a psychologically safe and trauma-informed way.

3.15 Outcome

3.15.1 There are a number of possible outcomes from a clinical case review. The outcomes will be determined by the facilitators and will consider the learning style of the participants, the nature of the case being discussed and any risk identified.

3.15.2 A list of potential outcomes is outlined at appendix B.

3.15.3 There may be a range of outcomes to any case and outcomes may be used in conjunction with one another.

3.16 In addition to this, where an incident has been identified, the participants may be requested to complete a reflective account or piece of study around the case being discussed. This should demonstrate consolidation of the discussion and learning beyond the context of the review.

3.17 A formal assessment of competence may be requested from the YAS Academy or another suitably trained manager. This assessment may be requested where competence is ordinarily assessed by means of other simulated learning assessment. An assessment will be requested where a level of assurance is required around either a specific aspect of clinical practice or overall clinical competence.

3.18 A period of supervision or other clinical support may be requested from the Operations Directorate. Where a CCR highlights clinical decision making, or where an incident involves clinical decision making, use of guidelines and professional independence, that cannot practicably be assessed through a simulated learning assessment, a period of supervision will provide and support staff with an opportunity to reflect and develop. The duration of clinical supervision will be determined by the clinically responsible manager and the clinician involved.

3.19 At the end of a period of supervision, the clinically responsible manager must be provided with a summary report by the supervisor / mentor. This may take the form of a witness testimonial or live observation document as part of the Clinical Leadership Framework.

3.20 During the course of a clinical case review, excellent practice might be identified. The Trust is committed to recognising excellence, and in this instance formal recognition should be provided. The case should be referred via the relevant Recognition of Excellent Practice Process, an example being via GREATIX.

3.21 Where there are apparent patient safety risks (refer to Investigations and Learning Policy for guidance on determining Risk), it might be necessary to restrict their clinical scope of practice in conjunction with a period of support and remedial training. This decision will be taken by the facilitating managers in conjunction with the participant's line management. This decision will be formally communicated in writing.

3.22 In cases where an outcome requires a period of study, further learning, assessment, supervision or support, in order to provide clinical assurance or mitigate any identified clinical risks, a Clinical Action Plan will be formulated by the clinically responsible manager. This will be produced in accordance with appendix A and will clearly identify the areas requiring support and the necessary actions to provide that level of support and remediation. A copy of the Clinical Action Plan is available on Pulse.

3.23 Very occasionally a situation may arise where the content of a clinical action plan is not agreed between all parties. If this occurs, then the clinical action plan will be reviewed by an appropriate independent clinically responsible manager.

4.0 Training Expectations for Staff

4.1 Individuals facilitating Case Based Discussions and Clinical Case Reviews will be suitably trained to deliver case reviews and will be experienced in the clinical context being discussed. Where an incident involves specialist, advanced or medical practice a clinician with specific expertise to act as a subject matter expert should be involved in the case review.

4.2 Training and development of facilitators is recommended around protected groups and trauma from their lived experiences, so that they have an understanding of trauma informed approaches, inclusive language, trans awareness, and dignity in practice to support protected groups effectively.

4.3 Facilitators should also be able to guide staff for mental health first aid or wellbeing support where needed which might include offering those affected with follow-up check-ins and psychological support.

5.0 Implementation plan

5.1 The latest approved version of this document will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

6.0 Monitoring compliance with this policy

6.1 The outcomes of CCRs will be included in the quarterly risk report to the quality committee.

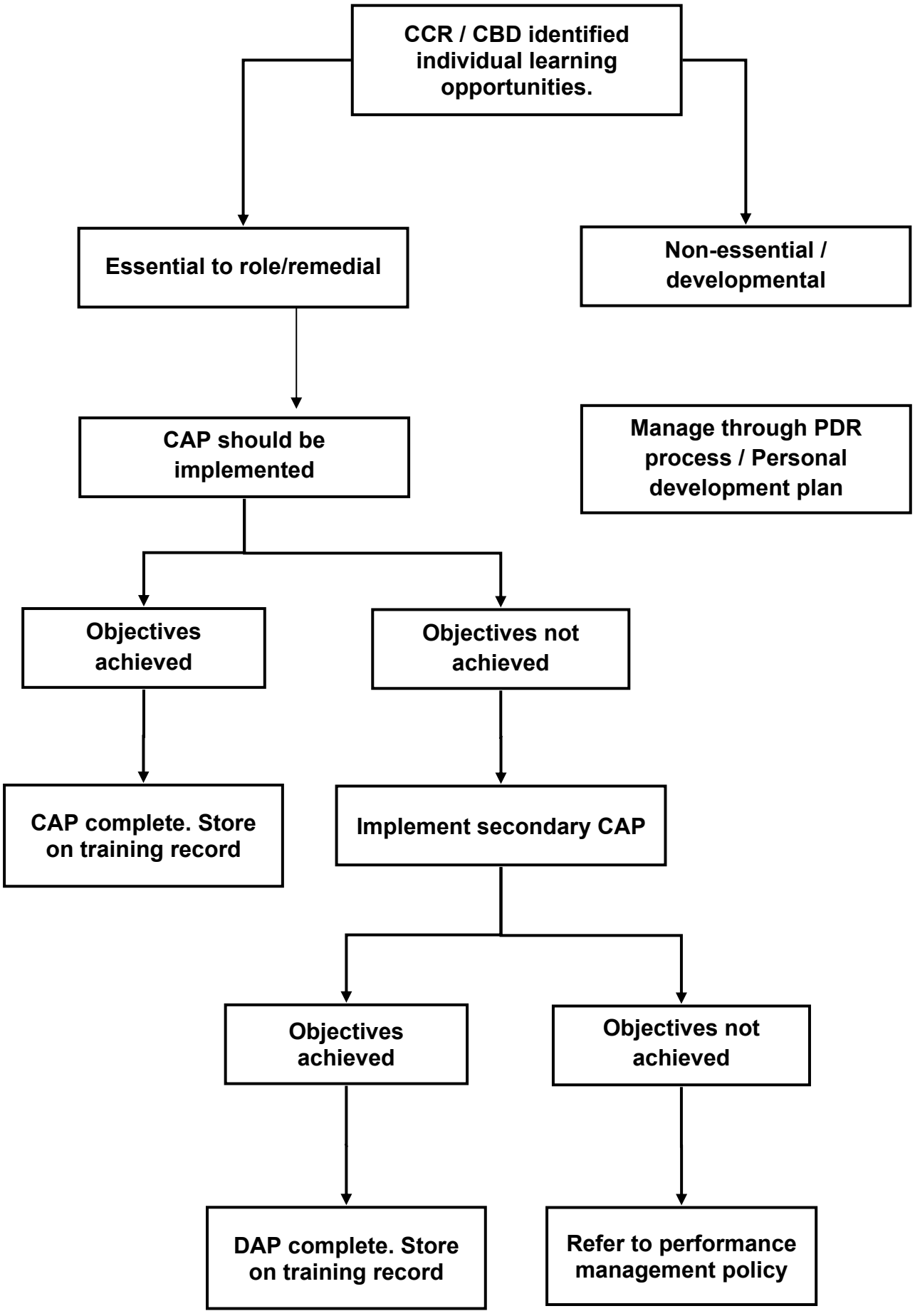
6.2 Demographic analysis of CCR outcomes by protected characteristics would benefit from annual review to identify and address any disproportionate impact.

7.0 Appendices

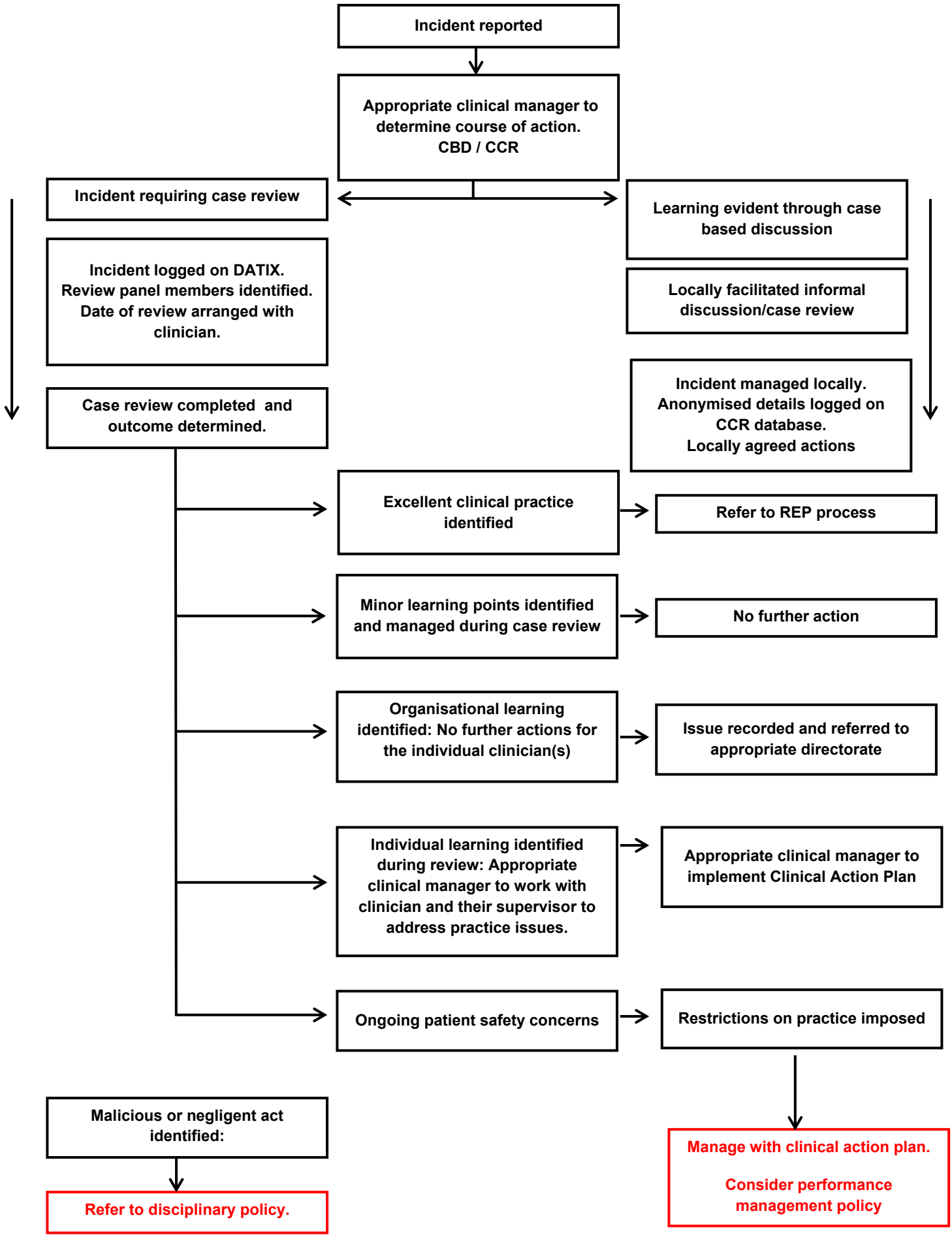
7.1 This Policy includes the following appendices:

Appendix A – Clinical Action Plan Process
Appendix B – Clinical Case Flow Chart
Appendix C – Roles and Responsibilities
Appendix D – Definitions

Appendix A – Clinical Action Plan Process



Appendix B – Case Review Flow Chart



Appendix C - Roles and Responsibilities

The Chief Executive has ultimate responsibility to ensure processes are in place to ensure patient safety, clinical standards and staff are supported to learn and develop.
The Trust board has overall responsibility for ensuring that investigation and analysis of incidents is monitored to optimise the recognition of trends and learning lessons.

The Quality Committee is responsible for ensuring lessons learned are shared internally and externally, and that necessary actions are taken to ensure patient safety and clinical standards.
The Incident Review Group is responsible for reviewing incidents and ensuring clinical risks are mitigated and patient safety is promoted.

The YAS Academy is responsible for providing high quality education programmes, and the timely provision of remedial training, education and assessment where necessary.
Clinically responsible managers are responsible to ensure that this policy is adhered to, incidents are reported appropriately on the Datix system, and that staff are benchmarked against current clinical standards. Within 999 operations the appropriate clinically responsible managers will be the clinical development managers. Within IUC the clinically responsible managers will be service delivery managers.

In highly specialist areas such as the YAA critical care team the clinically responsible managers will be determined by the medical director or the deputy medical director.
Clinical staff are responsible for ensuring that they comply with this policy in the course of their duties and that they report incidents and near misses and engage openly with case reviews with a view to continually improving and developing professionally.

Chief Executive
The Chief Executive has overall accountability for the clinical review policy.

Trust Executive Group
The Trust Executive Group has overall responsibility for all aspects of the clinical review policy.

Clinical Quality Development Forum
The CDQF will receive regular reports identifying any themes or trends emerging from the case review process and it will be responsible for identifying any actions plans required.

Clinical Governance Group
The Clinical Governance Group (CGG) is responsible for the implementation and monitoring of this policy. The Terms of Reference for CGC are available on the YAS intranet.

Executive Medical Director
The Executive Medical Director, through identified managers within the Clinical Directorate, will have overall responsibility for ensuring that this policy enables clinical incidents to be reported, reviewed and managed effectively.

Executive Director Operations
The Executive Director of Operations has responsibility to ensure all operational staff use this policy

Appropriate Clinical Managers
Appropriate Clinical Managers must ensure they are fully conversant with the policy so that they are able to support staff in understanding all aspects of the policy. They should be trained in root cause analysis, investigations, governance and learning, and dealing with difficult conversations or be in a process of training. They will ensure that the principles outlined in this

policy are implemented throughout their areas of work to ensure that clinical incidents are appropriately reviewed in a fair and supportive manner assisting clinicians to make safe decisions in practice.

A&E Operational Staff
All A&E operational staff have a responsibility to ensure that they are familiar with and adhere to this policy and clarify any areas of uncertainty with a Clinical Governance Manager, Clinical Development Manager or Clinical Supervisor.

All A&E operational staff have a responsibility to report any clinical incident, whether individual or institutional in nature, where it is felt that harm was or may have occurred.

Yorkshire Air Ambulance (YAA)
YAA staff have a responsibility to ensure that they are familiar with and adhere to this policy and clarify any areas of uncertainty with a Clinical Manager, Clinical Development Manager or Clinical Supervisor.

YAA staff have a responsibility to report any clinical incident through the standard YAS reporting procedures, whether individual or institutional in nature, where it is felt that harm was or may have occurred.

Appendix D – Definitions

A **patient safety incident** is defined by the National Patient Safety Agency as *'any unintended or unexpected incident which could have or did lead to harm of one or more patients receiving NHS funded care'*

A **case** is defined as any incident or encounter between a clinically trained member of staff, subcontractor and their staff, volunteer or associate, and a service user, patient or any other member of the public.

A **Clinical Case Review** is a meeting between staff and clinically responsible managers to discuss a case. This meeting will be notated and can constitute a formal record of reflection.
A **clinically responsible manager** is any individual who is professionally responsible for patient care in the context of the case being discussed.

A **Case Based Discussion (CBD)** is an informal discussion between an appropriate clinical manager and individuals. Unlike a Clinical Case Review, a minuted account of the discussion will not be created and the learning opportunities will be agreed locally with the appropriate clinical manager. Outcomes from case based discussion will be logged on the CCR log so themes and trends are captured.

Recognition of Excellent Practice (REP) is a process by which individuals are recognised and commended for demonstrating excellence in their work. It also provides a learning opportunity to understand and promote excellent practice widely.

A **Simulated Learning Assessment** is used to assess how a clinician would react to a situation they would encounter in practice. It would include the assessment of practice skills and or critical thinking in a safe learning environment. They also provide an opportunity for reflective practice.