

DRAFT FOR Department of Health (Prepared by BT Gillmer: 07/10/2015)

Department of Health

Guidance for seeking Approved Clinician status via the portfolio route

7 October, 2015

Acknowledgement

This Guidance document is based on the London Panel guidance for doctors seeking approved clinician status via the portfolio route (30/01/2015), which in turn drew on the approved clinician competency guidance for portfolios produced by the North England Approval Panel (NEAP, 2014) and the MHA 2007 New Roles document produced by the National Institute for Mental Health in England (NIMHE, 2008); and acknowledges the British Psychological Society's (BPS) guidance for registered psychologists in making applications to the BPS approved clinician peer review panel (2013).

This Guidance has been ratified by the National Reference Group for Approved Clinicians and Section 12 Doctors. The commentaries on a previous draft by that Group and the contributions made by the members of the Regional Panels are gratefully acknowledged.

Purpose

The Guidance is intended for persons from all eligible professions seeking approval as approved clinicians and who are not on the specialist register for psychiatry.

I am interested in applying for approved clinician (AC) status; what should I do?

1. Consider whether you are eligible to apply for AC status (see the statutory Instructions 2014 in essential reading below).
2. Ensure that you understand the role of the AC and the responsible clinician (RC).
3. Consider carefully why you are thinking of applying to become an AC.
4. Are you a senior clinician who is sufficiently experienced to capably, and with authority, exercise the autonomous decision-making required of an AC?
5. Discuss with your employer (professional/ line manager/ appropriate Clinical Director) and a current AC to ascertain whether they believe you have the competencies required to successfully apply to become an AC.
6. Consider with your professional manager whether you need to acquire additional skills, knowledge and experience through continuing professional development (CPD) and by undertaking further appropriate training before you will be eligible to apply for AC status.

7. Consult your employer's policies, procedures and selection criteria for approval as an AC, where these are available.
8. Ensure that you have organizational support from your line manager and a plan for your envisaged deployment as an AC/RC.
9. In addition you should ensure that such plans have the support of your Medical or other relevant Clinical Director. They will ultimately need to support your application.
10. Identify at least one mentor who is an AC and who is prepared to support you in your preparation.
11. Be mindful of the challenge to existing and traditional roles and conventions. In doing so consider potential cross-professional issues and conflicts especially the relevant responsibilities and authority of the responsible clinician and medical AC in treatments for which you may not have professional competence. Local policy guidance or practice notes should be consulted or developed as necessary.
12. Have access to the documents listed in essential reading below and familiarize yourself as necessary.

See APPENDIX D in the Guidance for a Checklist that confirms consideration of the above and which should be included in your portfolio submission to your Regional Panel.

Essential reading

Ensure you have a good knowledge of the following documents:

1. Mental Health Act (MHA) 2007 New Roles guidance produced by the National Institute for Mental Health England (NIMHE):
 - Annex E (1) of this document, produced by the National Advisory Group for Approved Clinician Training (NAGACT), provides a guide to becoming an AC.
 - Annex E (2), also produced by NAGACT, provides guidance on specific required competencies, their attainment and sources of evidence.

[Mental Health Act – New Roles Guidance \(PDF\)](#)

2. Mental Health Act 1983 Instructions with respect to the Exercise of Approval Functions 2014 (11 February 2014). These Instructions supersede elements of the New Roles Guidance.
3. **Revised MHA Code of Practice (2015)**

– applicants should consider buying or downloading a copy for reference.

3. [MHA 2007.](#)
4. [Practice Direction: First-tier Tribunal Health Education and Social Care Chamber: Statements and Reports in Mental Health Cases](#)
5. [Mental Capacity Act \(MCA\).](#)
6. MCA 2005 and the Deprivation of Liberty Safeguards (DOLS).
[Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments, England - 2012-13, Annual report](#)

and

[Visit the RadcliffesLeBrasseur website](#)

Especially their mental health law briefings under Publications.

7. If it is anticipated that you will be fulfilling AC/(RC) duties in relation to children and young people, familiarity with the Children Acts should be regarded as mandatory rather than recommended, and particular focus should also be given to chapter 19 of the Code of Practice (children and young people under the age of 18).

[Children Act.](#)

If your AC/RC responsibilities are in regard to other specific groups such as Older Adults and Learning Disabilities, then you should be particularly familiar with the Mental Capacity Act and relevant policies and guidance, as well as relevant NICE guidance.

[Mental Capacity Act \(MCA\)](#)

8. Psychologists considering preparation for approval are encouraged to consult the British Psychological Society Guidance for Registered Psychologists in Making Applications to the British Psychological Society Approved Clinician Peer Review Panel (April, 2013). This Panel will

indicate to the applicant and employer whether, from a professional perspective, the applicant's portfolio demonstrates competence for the role and, where there are shortfalls, how these may be addressed. This service is also available to psychologists who are not members of the BPS.

There is no hyperlink to this document at present but it can be obtained through the policy office of the BPS.

Additional recommended reading

- 10. Safeguarding vulnerable adults and children

References:

Read your own Trust's and local social services Policy document on safeguarding vulnerable adults and children.

and

[Children Act.](#)

- 11. Local, national, and international guidelines pertinent to your role. For example National Institute for Health and Clinical Excellence (NICE) treatment guidelines, CPA policy, safeguarding and risk assessment documentation etc.

- 12. Role of the CQC including role of SOAD.
[Visit the CQC website.](#)

- 13. [Care Act 2014.](#)

Competencies required for AC approval

Applicants seeking approval are required to demonstrate a comprehensive overall understanding of the role of the AC, including the specific role of the RC, as well as the legal responsibilities of and the key functions reserved to the RC.

The competencies¹ as outlined in New Roles (and the Approved Clinician (General) Directions, 2008 and as superceded by the Instructions with Respect to the Exercise of Approval 2014)) are (with *emphasis* added):

1. *A comprehensive understanding* of the roles, legal responsibilities and key functions of the AC and RC.
2. An *applied knowledge* of the legal and policy framework viz. the relevant mental health and all other relevant legislation, codes of practice; policy and guidance; and relevant NICE guidance.
3. Assessment:
 - a. *A demonstrated ability* to
 - i. clinically assess the presence and
 - ii. severity of mental disorder; and to
 - b. *knowledgeably apply* the statutory criteria for the key decisions reserved to the RC; and to
 - c. assess all levels of clinical *risk* to self and others within an *evidence-based* framework; and
 - d. undertake mental health assessments incorporating *biological, psychological, cultural and social* perspectives.
4. Treatment:
 - a. *An understanding* of
 - i. mental health related treatments (including physical, psychological and social);
 - ii. using different *evidence-based* approaches and their and their *applicability* to individual patients; and
 - iii. *Appreciating* the *range* of appropriate treatments and settings available that can be provided in *least restrictive environment*, that will deliver the necessary health and social outcomes.
 - b. *Demonstrating a high level of skill* in determining a patient's capacity to consent to treatment.
 - c. *Ability* to formulate, lead and review on treatment for which the clinician is appropriately qualified in the context of a multi- disciplinary team (MDT).
 - d. *Ability* to communicate the aims of treatment to patients, carers and the MDT.

¹ NOTE: The fully annotated competencies from the Instructions (2014) are incorporated into the Example Portfolio Framework that comprises Appendix A of the Guidance. What follows above is an outline that is consistent with the Instructions but which seeks to emphasise the nature of the competencies and the weighting of how the respective competencies should be prepared for and demonstrated.

5. Care planning:
A demonstrated ability to develop and manage care plans combining health, social services and other resources within the context of the Care Programme Approach (CPA).
6. Clinical Leadership and MDT working:
 - a. *Ability to lead a multi-disciplinary team effectively; including*
 - b. *Ability to assimilate the (potentially diverse) views of others, whilst maintaining an independent view; and to*
 - c. *Manage and take responsibility for making decisions in complex cases.*
 - d. *Understanding and recognizing personal limits of skills and to seek professional views to inform a decision.*
7. Equality and Diversity:
 - a. *Contemporary knowledge and understanding of equality issues.*
 - b. *Ability to identify, challenge, redress and actively promote discrimination and inequality in relation to the practice of an AC.*
 - c. *In applying mental health legislation and policy: to understand how cultural factors and personal values can affect personal judgments and decisions.*
8. Communication:
 - a. *Abilities to communicate effectively at all levels, especially in respect of decisions taken and the reasons for these.*
 - b. *Ability to keep appropriate records and to be aware of the legal requirements in regard to this.*
 - c. *To understand and manage the competing requirements of confidentiality and information sharing.*
 - d. *Compile and complete statutory documentation.*
 - e. *Write reports in role of AC/RC as required.*
 - f. *Demonstrated ability to present evidence to courts, tribunals and managers' hearings.*

Note: The list of skills and competencies, as summarized and *as emphasized*, is indicative of the qualities required of an AC and the manner in which these should be evidenced in your portfolio. Do however consider carefully the fully annotated competencies from the Instructions (2014) as incorporated into the Example Portfolio Framework that comprises Appendix A of the Guidance.

How may an applicant acquire or demonstrate that they have the competencies required for AC approval?

Annex E (2) of the MHA 2007 New Roles guidance produced by the National Group for Approved Clinician Training (published by NIMHE), provides a framework and examples of how potential ACs may develop existing competencies and demonstrate evidence of their attainment to achieve the full range of competencies required for the AC role.

The portfolio contents exemplar comprising Appendix A on pp 13-24 of the Guidance is derived from that framework and is illustrative of what needs to be submitted as part of your portfolio.

When you make enquiries for approval to your Regional Panel you will be provided with a proforma application form. This Guidance illustrates the kind of evidence that is likely to satisfy the panel of your competence. Where in doubt do check with your Regional panel for their specific requirements.

General considerations in making application to your Regional Panel:

1. Are you eligible to apply for AC status?
2. Is the evidence you have prepared comprehensive, coherent and of sufficient breadth and depth for the assessing panel to make an assessment of *each* competency?
3. Is the content of your portfolio consistent with your declared skills, knowledge and experience? The evidence must be able to support your declaration of competency for approval.
4. Have you made a declaration of agreement to comply with the Conditions of Approval? (See the *Instructions with Respect to the Exercise of Approval Functions 2014 Part 2 Section 7 (1)-(4) p.6*).

In demonstrating competence applicants may draw on a range of evidence, but as a minimum you should provide:

1. A contents page referencing each item submitted including an appendix referencing evidential documents and reports.
2. Documentary evidence of your professional qualification.
3. Evidence of current full registration with the regulatory body for your profession.
4. An up to date Curriculum Vitae pertinent to this application. That should include:
 - The time you have spent preparing for AC status.
 - What periods of shadowing you have undertaken; which services you have worked in; and the name/s of the AC/RCs who have been involved in shadowing and mentorship (see Testimonial Form Appendix B, p25).
 - Qualifications, including if MRCPsych has been achieved (medical applicants).

Commented [CG1]: MRCPsych = specialist register?

- Detail if you have Section 12 (2) approval (medical applicants).
- Include periods and nature of on-call work (medical applicants).
- 5. A summary of your experience and skills as relevant to the role of AC. A matrix as set out in Appendix A is required to detail skills and experience relevant to each competency, how these were acquired and cross-referencing the supporting evidence.
- 6. Evidence of completing an accredited statutory 'initial training' course for approval as an AC within the two year period immediately preceding the date of the application.
- 7. Reports and commentaries:
 - a) Two relevant, succinct, and ***anonymised***, statutory reports (e.g. a First Tier Tribunal, Managers hearing or Section renewal report) which you have prepared. The statutory reports may be hypothetical (i.e. they may have been prepared solely for the purposes of the AC application and as though for a statutory purpose), but must be based on your actual personal contact with a patient.
 - b) Two ***anonymised***, concise, case commentaries relating to your involvement in the care of a detained patient, which should demonstrate your awareness, understanding and reflection on key areas of applied AC competence, and the guiding principles of the Code of Practice. These commentaries could relate to the same cases as the statutory reports.
- 8. Two testimonies from suitably qualified professionals in a senior role who can validate your aptitude for the AC role, one of whom must be an AC. Your mentor/s could provide such testimony.
- 9. A 360 degree appraisal or equivalent that should, *as a minimum*, include your immediate line manager/supervisor, multi-disciplinary team colleagues, an AC and, if practicable, a service user, carer or advocate (IMHA).
- 10. Confirmation from your AC/RC mentor that you regularly take a lead role in managing a significant number of patients, including complex cases.
- 11. Evidence of shadowing and mentorship:
Please note that shadowing and mentorship should consistent include a sequence of observing, participating in, and being observed to have demonstrated capability for the competency and for executing any requisite decision.

Evidence is required for each of the eight competencies and especially for the decisions reserved to the RC. This should be in the form of written confirmation from the AC/RC you are shadowing, and/ or who is the RC who holds actual responsibility for patients that you are looking after, that you have - on more than one occasion - shadowed the AC/RC and have undertaken the

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competency sequence of observing, participating in, and being observed to have demonstrated capability.

You must provide a log of experience and the associated AC competency, affirmed by the mentoring RC(s). The Testimony of Demonstration of Competencies proforma (Appendix B) is suitable for that purpose.

12. Evidence of CPD such as registration for CPD with the Royal College of Psychiatrists, and a certificate of good standing from your professional or statutory body.

Medical applicants must be professionally up to date. Psychiatrists are usually registered with the Royal College of Psychiatrists CPD scheme for which a certificate of good standing should be provided with their application.

Psychiatrists who are not registered with the Royal College should be participating in a local CPD peer group which should meet the same standards as the Royal College.

Please note there is a requirement for 50 hours CPD evidence for all medical applicants.

Applicants from other eligible professions will be required to provide evidence of CPD appropriate to their professional role and in keeping with the CPD requirements of their regulatory body (ordinarily the Health and Care Professions Council).

It is recommended that ALL applicants complete the Proforma in Appendix C suitably adapted for their professional group. For example, re-validation for nurses has the following CPD requirement:

<http://www.nmc.org.uk/standards/revalidation/how-to-revalidate/>

13. In addition:

- a) It would be helpful to include **anonymised** examples of documentation, other than the case commentaries and statutory

MHA reports, in which you have taken a lead role without necessarily being under supervision/ mentorship. The documentation should demonstrate your further understanding of a particular AC competency and the guiding principles of the MHA Code of Practice and make meaningful reference to pertinent local, national and international policy or guidelines.

Examples of documentation may include descriptions of the MDT management of complex patients that evidence AC competencies, such as:

care plans, CPA documentation, CTT assessments, service specifications for patients being discharged, pre-admission assessments, case-based discussion, capacity assessments, SOAD request forms, clinic letters, risk assessment documentation and case note entries.

The documentation exemplified above could, for example, constitute evidence of:

- *Competency 2: an applied knowledge of relevant mental health legislation, policy and guidance; and/ or*
- *Competency 4: treatment; and/or*
- *Competency 6: clinical leadership.*

- b) It would also be useful to include completed MHA forms of an *anonymized* and, if necessary, fictitious nature, such as s17, T2, CTO1 CTO3 (recall), CTO7 (renewal), or S2/S3/37. The forms should be coupled with an explanatory commentary that demonstrates your understanding of the issues involved and highlights the competency you are offering evidence for example:
- *Competency 1: a comprehensive understanding of the ... key functions of the AC and RC; and further evidence of*
 - *Competency 2: applied knowledge; and/or*
 - *Competency 3: assessment.*
- c) The ***anonymized*** care plans and reports should provide evidence that you have considered and assessed the specific needs of the patients discussed with specific regard to any disabilities they may have or with regard to any of the protected characteristics such as gender, sexuality, age etc. Any cultural issues or needs should also be addressed and evidenced:
- *eg Competency 7: Equality and Diversity.*
- d) You are encouraged, with the permission of the hospital managers or First Tier (Mental Health) Tribunal (FTT), to attend hospital

managers' reviews and FTT hearings and to present the evidence on behalf of the RC (with the RC in attendance) for renewal of detention or discharge. Where this has been possible, the RC should provide written confirmation that you have presented the case soundly and competently. Where hospital managers or the FTT are in agreement with your evidence this should be highlighted as it provides good direct assurance of this competency:

- *eg. Competency 8: communication.*
- e) You should provide evidence of attendance on courses and of training undertaken that may be pertinent to any of the specific competencies – but not just certificates of CPD without reference to a competency.
- f) Evidence of reflective practice, such as reflective practice logs or reflection on case based discussion. Applicants should make reference to their respective professional guidance on reflective practice in order to demonstrate an understanding of this important aspect of practice in the AC/RC role. This can be downloaded from your professional body website.
- g) Evidence of receiving regular supervision from your AC mentor, and of undertaking an annual appraisal, including your preparation for the AC/RC role, with your line manager.

Caution

The contents of your portfolio must be your own genuine work. For example the **anonymised** reports must be your own original work and not a copy of reports produced by someone else.

APPENDIX A

Example portfolio framework:

1. The role of the approved clinician and responsible clinician

A comprehensive understanding of the role, legal responsibilities and key functions of the approved clinician and the responsible clinician.

How the competency was acquired	Evidence for competence	Page Number(s) in Portfolio
Existing professional skills, knowledge and experience. <i>And, in addition see specific AC preparation acquired below</i>	<ul style="list-style-type: none"> • Professional qualification • Evidence of current full registration with the regulatory body • Up to date Curriculum Vitae (CV) including: • Evidence of continued professional development (CPD) such as logs/certificate of good professional standing. • Anonymised reports; documentation created in current job eg care plans. 	
Shadowing AC/RC/Approved Mental Health Practitioner (AMHP), suitable coursework, seminars, teaching, learning set membership, specific training.	<ul style="list-style-type: none"> • Certificate of supervision. • Testimony of demonstration of competency proforma/ log. • Reflective log/journal. • Certificates of any specific training. • Certificate of statutory 'initial training' • 360 degree assessment. 	

This is an overarching competence. The AC and RC competencies will build on existing professional competencies. Additional skills, knowledge and experience should be acquired, where these are lacking, to demonstrate the full range of AC/RC competencies.

Shadowing of the AC/RC in order to demonstrate this overarching competency MUST include clear evidence of the applicant having demonstrated the ability to make ALL THE KEY DECISIONS reserved to the RC. Where exposure to certain decisions (eg application for CTO) is not readily available to applicants in the service where they are currently deployed, they should ensure that they can access such opportunities for observing and participating in such decisions with

an RC who can attest to their capability for making such decisions. They should have considered, on more than one occasion, each of the following decisions:

- Renewal of detention,
- Discharge from detention,
- Granting of s17 leave; and
- Application for CTO

Although the applicant cannot actually implement any of their decisions they must have written confirmation from the RC that they are shadowing that they have demonstrated sound decision-making ability, using appropriate and good clinical judgement and risk assessment skills. That should be undertaken in a sequence of observing, participating in, and being observed to have demonstrated capability for the relevant competency.

Where the applicant is a medical practitioner or nurse prescriber they should also demonstrate, on more than one occasion, consideration of the decision/s around consent to treatment specific to section 58 MHA.

2. Legal and Policy Framework

- (a) Applied knowledge of the Mental Health Act 1983, related codes of practice and national and local policy and guidelines.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Existing knowledge.	<ul style="list-style-type: none"> • CV. • CPD log. 	
Training by appropriate provider (law school, accredited body).	<ul style="list-style-type: none"> • Certificate. 	
Shadowing AC/RC/AMHP.	<ul style="list-style-type: none"> • Anonymised statutory reports/commentaries based on supervised practice/ shadowing. 	

- (b) Applied knowledge of other relevant legislation, codes of practice, national and local policy guidance, in particular, relevant part of the Human Rights Act (HRA) 1998, Mental Capacity Act 2005, and the Children Acts 1998 and 2004.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Existing knowledge.	<ul style="list-style-type: none"> • CV. • CPD log. 	

Training by appropriate provider (eg. law school, or accredited body).	<ul style="list-style-type: none"> • Certificate. 	
Shadowing.	<ul style="list-style-type: none"> • Anonymised reports. 	

(c) Applied knowledge of the relevant guidance issued by the National Institute for health and Clinical excellence (NICE).

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Applied knowledge of relevant* guidance issued by the NICE (see note below):		
Knowledge of evidence-based practice relevant to likely patient group (AMH, LD, CAMHS, Autism, PD, OP) about whom decisions will be made.	<ul style="list-style-type: none"> • CPD. • Learning set work. • Evidence/knowledge of; professional guidelines, NICE, National Service Frameworks, policies. 	

- In the above paragraph* 'relevant' means relevant to the decisions likely to be taken by an AC or RC. Where national or professional guidance is not available the applicant should use other evidence-based sources relevant to the patient group likely to be subject to their decisions.
- Because this competency relates to applied legal knowledge, the anonymised statutory reports are an essential primary source of this evidence.
- The applied component should be underpinned by shadowing AC/RC and, if practicable, AMHPs and by evidenced reflective practice in learning set.

3. Assessment

Ability to:

- (a) identify the presence of mental disorder;
- (b) identify the severity of the disorder; and
- (c) determine whether the disorder is of a kind or degree warranting

compulsory detention.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Existing professional training and experience. <i>And, in addition see specific AC preparation acquired below</i>	<ul style="list-style-type: none"> • Professional body accreditation of such competencies • Job description • CV • CPD. 	
Shadowing Coursework	<ul style="list-style-type: none"> • Testimony of competency • Statutory report and a linked commentary • CPD log 	

Whilst the relative seniority of many applicants should ensure a high degree of existing competency in assessment, evidence of shadowing of AC/RC and AMHP is useful and may be necessary to demonstrate RC competencies. It is especially important that the applicant can, in undertaking such assessments, show an applied understanding of the legal criteria for compulsory confinement and the statutory basis for making decisions reserved to them.

Shadowing of the AC/RC in order to show evidence of this competency must include clear testimony of the applicant having demonstrated the ability to have undertaken the relevant assessment in order to make all the key decisions reserved to the RC.

They should have considered, on more than one occasion, assessment of the patient prior to making each of the following decisions :

- Renewal of detention,
- Discharge from detention,
- Granting of s17 leave; and
- Application for CTO

Although the applicant cannot actually implement any of their decisions, which will be based on such assessments, they must have written confirmation from the RC that they are shadowing that they have demonstrated sound skills in

undertaking these pre-decision assessments, and have appropriately applied the relevant legal criteria, using appropriate and good clinical judgement and risk assessment skills.

The evidence should also be demonstrated in reflective learning sets / logs / journal.

3.2 Ability to assess all levels of clinical risk, including risks to the safety of the patient and others within an evidence-based framework for risk assessment and management.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> Professional body accreditation. CV. CPD. JD. 	
Training in relevant risk assessment and management tools and processes .	<ul style="list-style-type: none"> Certificate. Anonymised reports and commentaries; care plans. Learning set logs. Application of formal risk management tools (eg HCR-20). 	

3.3 Ability to undertake mental health assessments incorporating biological, psychological, cultural and social perspectives.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> Professional body accreditation. CV. CPD. JD. 	
Shadowing AC/RC/AMHP.	<ul style="list-style-type: none"> Testimonial; reflective log/journal. Evidence of MHA assessment involvement. Case reports and commentaries. 	

All the above evidence should be relevant to the patient/group/s the applicant is likely to be making about decisions about.

There should be confirmatory evidence from shadowing testimony that the applicant has demonstrated sound decision-making and assessment skills from a range of perspectives.

4. Treatment

Understanding of:

- (a) mental health related treatments, which include physical, psychological and social interventions.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience	<ul style="list-style-type: none"> • Professional body accreditation • CV • CPD • Job description 	
Commissioned didactic/seminar courses in areas of identified required knowledge/ need (e.g. psychopharmacology; ECT; psycho-surgery).	<ul style="list-style-type: none"> • Certificate of attendance. • CPD log. • Case reports and commentaries. 	

- (b) An understanding of different evidence-based treatment approaches and the applicability to different patients.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
As above.	<ul style="list-style-type: none"> • As above. • Reports and commentaries; care plans. • Testimonies of understanding across a range of applicable treatment approaches 	

The CPD and specific training will be pertinent to professions, for example nurse applicants may be registered on prescribing courses.

- (c) An understanding of the range of appropriate treatments and treatment settings which can be provided in the least restrictive environment and will deliver the necessary health and social outcomes.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
As above.	<ul style="list-style-type: none"> • As above. • Reports and commentaries; care plans. • Testimonies of understanding across a range of applicable treatment approaches and consideration of least restrictive environments within which to achieve the desired outcome. 	

4.2 High level of skill in determining whether a patient has capacity to consent to treatment.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> • Professional body accreditation. • CV. • CPD. • JD. 	
Workshops on MCA; consent to treatment. Shadowing.	<ul style="list-style-type: none"> • Certificate. • Awareness of professional guidelines. • Actual assessments of capacity together with • Testimonies of competence 	

In order to demonstrate this competency the applicant should include evidence from the AC/RC whom they are shadowing that they have carried out several actual assessments of capacity and determination of best interests and that their decision making has been sound and appropriate. Anonymised examples of assessments of capacity and best interest determinations should also be available within the portfolio.

4.3 Ability to formulate, review appropriately and lead on treatment in relation to which the clinician is appropriately qualified in the context of a multi-disciplinary team.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> • JD. • Reports/care/ treatment plans. • Testimonial, Multidisciplinary Team. • 360 degree appraisal. 	

4.4 Ability to communicate clearly the aims of the treatment to patients, carers and the team.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> • JD. • Professional body accreditation. • 360 degree appraisal. 	

Anonymised case note entries, setting out the explanations given to the patient and the discussions within the MDT, should be included in the portfolio as a particular means of demonstrating this competency.

5. Care Planning

Ability to manage and develop care plans which combine health (including measures related to physical and psychological health and medication), social services (including housing and employment), and other resources, preferably within the context of the Care Programme Approach.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional experience undertaking care co-ordination.	<ul style="list-style-type: none"> • JD. • CV. • CPD. • Anonymised care plan, case reports and commentaries. • Service specification reports. 	
Attendance at CPA case reviews, shadowing RC,	<ul style="list-style-type: none"> • Evidence of contribution to a care plan. • Certificate. 	

appropriate workshops/training.		
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6. Leadership and Multi-Disciplinary Team Working

6.1 Ability to effectively lead a multi-disciplinary team.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional and experience.	<ul style="list-style-type: none"> • CV. • JD. 	
Leadership training, team-work training, awareness of own leadership style.	<ul style="list-style-type: none"> • Certificate. • 360 degree appraisal. 	

The applicant should provide evidence that they have taken responsibility for, and have effectively led, the MDT with regard to the patients for whom they have taken lead responsibility. This competency should be confirmed by the AC/RC that they are shadowing and/ or who is the RC with actual responsibility for those particular patients.

6.2 Ability to assimilate the (potentially diverse) views and opinions of other professionals, patients and carers, whilst maintaining an independent view.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> • CV. • JD. • CPD. • Anonymised care plans. • 360 degree appraisal. 	

The applicant may wish here to show evidence of having considered potential cross-professional issues and conflicts especially the relevant responsibilities and authority of the you as the RC and that of the medical AC in treatments for which you may not have direct professional competence, but for which you have ultimate responsibility as RC.

6.3 Ability to manage and take responsibility for making decisions in complex cases without the need to refer to supervision in each individual case.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Professional training and experience.	<ul style="list-style-type: none"> • CV. • JD. • CPD. • Anonymised care plans. • 360 degree appraisal. 	

In order to evidence this competency the applicant should take lead clinician responsibility for specific complex cases and have evidence within the portfolio to demonstrate their lead involvement such as anonymised care plans, case note entries, reports etc.

- 6.4** Understanding and recognition of the person’s own skills and an ability to seek other professional views from others to inform a decision, for example through peer review and appraisal.

How the competency was acquired	Evidence for competence	Page number(s) in portfolio
Via supervision and reflective practice.	<ul style="list-style-type: none"> • Evidence of clinical supervision. • 360 degree appraisal. 	

Anonymized examples of reflective practice are *essential* in demonstrating this competency.

7. Equality and Cultural Diversity

- 7.1** Up-to-date knowledge and understanding of relevant equality issues.

How the competency was acquired	Evidence for competence	Page Number(s) in Portfolio
Knowledge of policy and legislation	<ul style="list-style-type: none"> • Attendance at appropriate courses (including mandatory) <ul style="list-style-type: none"> - manager’s training - commissioned (law school) 	

- 7.2** Ability to identify, challenge, and where possible and appropriate redress discrimination and inequality in relation to approved clinician practice.
- 7.3** Understanding of the need to sensitively and actively promote equality and diversity.

7.4 Understanding of how cultural factors and personal values can affect practitioners' judgments and decisions concerning the application of mental health legislation and policy.

How the competency was acquired	Evidence for competence	Page Number(s) in Portfolio
Values-based practice of legal knowledge	<ul style="list-style-type: none"> • JD • Annual job appraisal process • 360 degree appraisal • Practice supervision records • Anonymised correspondence and reports/plans 	

Reflective learning set activities should reflect this area. Evidence of policies and models drawn on should be specific to patient group (e.g. valuing people, normalisation with LD).

The anonymized care plans and reports should also reflect evidence that the applicant has considered and assessed the specific needs of their cases with regard to any protected characteristics as well as any cultural matters.

8. Communication

8.1 Ability to communicate effectively with professionals, patients, carers and others, particularly in relation to decisions taken and the underlying reasons for these.

HOW ACQUIRED	EVIDENCE	Page Number(s) in Portfolio
Professional training and experience	<ul style="list-style-type: none"> • JD • 360 degree appraisal 	

8.2 Ability to keep appropriate records and an awareness of the legal requirements in relation to record keeping, including the processing of all personal data or sensitive personal data (as both terms are defined in the Data Protection Act 1998) in accordance with that Act.

HOW ACQUIRED	EVIDENCE	Page Number(s) in Portfolio
Knowledge of law and policy	<ul style="list-style-type: none"> • CPD log 	

Evidence of NHS or independent employer Information Governance training.

8.3 Understanding of, and ability to manage, the competing requirements of confidentiality and effective information sharing, to the benefit of the patient and other stakeholders.

HOW ACQUIRED	EVIDENCE	Page Number(s) in Portfolio
Professional training and experience	<ul style="list-style-type: none"> • JD • Professional requirements • Knowledge of Trust policy • Reports/ care plans/ recorded entries to notes 	

8.4 Ability to compile and complete statutory documentation and to provide written reports as required of an approved clinician.

HOW ACQUIRED	EVIDENCE	Page Number(s) in Portfolio
Professional experience Formal AC training Shadowing AC//RC/AMHP	<ul style="list-style-type: none"> • Anonymised reports • Certificate • Testimonial/log 	

Anonymised example reports for First Tier (Mental Health) Tribunals and Hospital Managers' Reviews of detention, example completed anonymised T2 Forms (where relevant), anonymised completed example H5 Forms, anonymised completed example completed s17 leave forms and anonymised example completed CTO1 Forms, should be available in the portfolio.

8.5 Ability to present evidence to courts and tribunals.

HOW ACQUIRED	EVIDENCE	Page Number(s) in Portfolio
Professional experience	<ul style="list-style-type: none"> • CV • Anonymised reports 	
Specialist course attendance (FTTs; court work) Shadowing and actual presenting of evidence (under supervision) at relevant hearings	<ul style="list-style-type: none"> • Certificate • Testimonial/log Anonymized transcripts of Managers Hearings and FTTs where the applicant's evidence has been accepted.	

DRAFT FOR Department of Health (Prepared by BT Gillmer: 07/10/2015)

The reports to First Tier Tribunals and Hospital Managers reviews above will evidence elements of this competency. See 12.4 of the Guidance in this regard.

Apart from 8.4 and 8.5 the seniority of most eligible applicants should ensure competency.

APPENDIX B

Approved Clinician Preparation

Testimony of Demonstration of Competencies

1. Applicant's name , designation and work base

2. Competency number¹ and brief description

3. Date(s) and description of how the competency has been demonstrated²

4. Testimony of demonstration of competency

I can confirm that I have observed the above named carrying out the duties described in section 3 above and that in doing so sound decision making abilities were employed; using appropriate and good clinical judgment and risk assessment skills.³

5. Further comments (as required):

<i>Name of Mentor/Supervisor (print):</i>	<i>Signature:</i>
<i>Designation:</i>	<i>Approved Clinician? Y/N</i>

1.For a full description of the competencies see **Instructions with respect to the Exercise of Approval Functions 2015**. Also this Guidance p 6-7 for the nature and weighting of competencies.

2. Where key decisions reserved for the RC are demonstrated, these should be specified, eg Renewal or Discharge from Section; Granting of S17 leave; Application for CTO.

3. Although the Applicant may not be able to actually implement a decision, being not Approved, their capability to do so may be inferred from reflective practice under supervision.

APPENDIX C

CONTINUING PROFESSIONAL DEVELOPMENT

Some practitioners choose not to be registered with their professional body in order to maintain Continuing Professional Development (CPD). However they must actively participate in some recognised CPD programme, which may be local to the area. In order for the Regional Panel to accept local CPD sign-off, they require the local CPD scheme to meet the minimum standards set by the Royal College of Psychiatrists.

Please note for all medical applicants that there is a requirement of 50 hours CPD evidence

Applicants from other eligible professions will be required to provide evidence of CPD appropriate to their professional role.

It is expected that employing / host organisations will have some form of quality control to ensure confidence in local CPD schemes. Practitioners must provide CPD evidence in order to gain either initial or renewal approval for Section 12(2) and/or Approved Clinician purposes, to meet the standards set out in the Instructions from the Secretary of State for these functions.

The Department of Health has devised this form which should be completed to ensure a recognised format is adhered to in order to submit local CPD activity, which must be signed off by a local peer group.

It is the practitioner's responsibility to participate in CPD and to provide the peer group with the appropriate evidence. It is the peer group's responsibility to scrutinise evidence such as training certificates and check the number of hours the practitioner has participated in for each CPD activity.

This activity must be appropriate for their role and be linked to the practitioner's personal development plan identified in their annual appraisal.

Activity must be signed off and dated by at least two peer group members confirming they are satisfied with the evidence provided.

CPD of: (name of practitioner)

Period covered for this CPD activity:

FROM	TO

It is expected that the local peer group (or whatever arrangement is required or recommended by your professional or regulatory body) will scrutinise the practitioner’s CPD activity for the previous year to ensure that there is fresh evidence for the following year.

Date	CPD Activity	No of Hours

Total Number of Hours = (Please complete)

Signed by two members of your peer group

Declaration that practitioner has participated in the above CPD for the stated period.

Name & Registration No.	Signature	Date
Name & Registration No.	Signature	Date

APPENDIX D:

CHECKLIST WHEN CONSIDERING APPLYING FOR APPROVED CLINICIAN STATUS

- 1. I am eligible to apply for AC status and comply with the requirements set out in the statutory Instructions for the Exercise of Approval Functions (2014), especially Schedule 1 Part 2 and Schedule 2.
- 2. I have an understanding of the role of the AC and RC.
- 3. I have carefully considered why I am thinking of applying to become an AC.
- 4. I am a senior clinician who is sufficiently experienced to capably, and with authority, exercise the autonomous decision-making required of an AC
- 5. I have discussed this with my employer (professional/ line manager/ appropriate Clinical Director) and a current AC and have ascertained that they believe that I have the competencies required to successfully apply to become an AC.
- 6. In doing so, I have considered whether I need to acquire additional skills, knowledge and experience through continuing professional development (CPD) and by undertaking further appropriate training before I will be eligible to apply for AC status.
- 7. I have consulted my employer's policies, procedures and selection criteria for approval as an AC (if available).

- 8. I have organizational support from my line manager and we have a plan for my envisaged deployment as an AC/RC.
- 9. I have also ensured that my application for approval and these plans have the support of my Medical or other relevant Clinical Director.
- 10. I have identified at least one mentor who is an AC and who is prepared to support me in my preparation.

Name	Designation	Base

- 11. In doing so, my mentor/s and I have considered potential cross-professional issues and conflicts especially the relevant responsibilities and authority of the responsible clinician and medical AC in treatments for which I may not have direct competence.
- 12. I have consulted local policy guidance or practice notes in regard to 11 above. Where these are not available I and my mentor/s will endeavor to initiate the development of these as deemed necessary.
- 13. I have access to the documents listed in the Guidance Essential Reading and have familiarized myself with these as appropriate to my circumstances.

Name:

Signature:

Date:

This signed and dated checklist should be submitted as part of your Portfolio.