



Tees, Esk and Wear Valleys
NHS Foundation Trust

NORTH OF ENGLAND APPROVALS PANEL

**APPROVED CLINICIAN MENTORS PACK:
GUIDANCE FOR AC / RC MENTORS**

SUPPORTING

**APPLICANTS SEEKING AC STATUS VIA THE
PORTFOLIO ROUTE**

NORTH OF ENGLAND APPROVAL PANEL

APPROVED CLINICIAN MENTORS PACK: GUIDANCE FOR AC / RC MENTORS SUPPORTING APPLICANTS SEEKING AC STATUS VIA THE PORTFOLIO ROUTE

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1. Introduction

The content of this pack is based upon the Department of Health (2017) AC Portfolio guidance, and related feedback received from NEAP's multi professional panel who are directly involved with AC benchmarking and approval.

2. Using the AC Mentors support pack

The AC Mentors Pack was developed as a consultative reference guide to address the arising queries of Approved Clinician / Responsible Clinician mentors providing support to AC applicants seeking approval via the portfolio route.

Every AC Portfolio applicant requires the support of at least one named AC / RC mentor. Being a mentor will inevitably involve providing a level of guidance and supervision, while applicants must also be given the opportunity to actively shadow RC functions. Ultimately a mentor is required to testify as to an applicant's capability to execute requisite RC decisions and to judge whether an applicant has demonstrated AC competency.

The appendices of this pack duplicate a number of documents which NEAP supplies to applying AC portfolio applicants, and also includes documents that are pertinent to role of the AC Mentor. Appendix i outlines the skill base requirements of prospect AC applicants. Appendix ii presents the required format of the AC portfolio. Appendix iii sets out the detailed competency requirements of AC approval which the applicant must demonstrate, and which necessitates confirming mentor testimony as outlined in Appendix iv. Finally Appendix v replicates DH's recommended reading list for AC applicants.

3. The purpose of the AC Portfolio

All AC applicants are required to demonstrate an overall comprehensive understanding of the AC role and competency in performing the key legal functions of the RC. Eligible professionals not on the GMC Specialist Register for psychiatry must complete an AC Portfolio as part of an initial application for AC approval.

The purpose of the AC Portfolio is to enable applicants to submit evidence that demonstrates the 8 AC competencies as specified in the Secretary of States (2015) Instructions (c.f. content of Appendix iii). The summary headings of the competencies are:

- The role of the Approved Clinician and Responsible Clinician
- Legal and policy framework
- Assessment
- Treatment
- Care Planning
- Leadership and multi-disciplinary team working
- Equality and cultural diversity
- Communication

Applicants seeking approval via the portfolio route must compile a structured file of reflective practice that demonstrates applied skills and knowledge which evidences competency to autonomously perform the key functions reserved only to the RC role. To be approved as an AC there is an expectation that an applicant will be professionally deployed as a RC.

Prior to commencing AC preparation applicants should familiarise themselves with the DH *Guidance for seeking Approved Clinician status via the portfolio route* (2017). This guidance includes an initial check list for all prospective applicants to consider prior to commencing AC preparation and mentor shadowing (Appendix i). The check list emphasises the following essential requirements for prospect AC applicants:

- they should already possess an advance level of knowledge and applied skill;
- be practising at a senior level;
- and will require the professional backing of their employing organisation.

In effect only applicants who can demonstrate the necessary professional acumen to autonomously perform the legal duties and responsibilities of a RC will be approved as ACs.

4. Professional eligibility to seek AC approval

The introduction of the Mental Health Act 2007 amended the Mental Health Act 1983, and the former role of the Responsible Medical Officer was replaced by that of the Responsible Clinician. Under the MHA a RC is an AC who has been given overall responsibility for a patient's care. All patients subject to compulsion under the Act must have an appointed RC.

MHA secondary legislation set out in the Secretary of States (2015) AC Instructions provides direction to delegated authorities (S12(2) & AC Regional Approval Panels) to approve a range of qualified professionals:

- Registered medical practitioner;
- Psychologist registered in Part 14 of the register maintained by the Health and Care Professions Council;
- First level nurse, whose field of practice is mental health or learning disabilities;
- Registered occupational therapist; or
- Registered social worker.

The *Mental Health Act 2007 New Roles* (NIME 2008) document summarises the legislative rationale for extending this statutory role to non-medical personnel. The effect of this legal development was to open up eligibility to a spectrum of professionals, bring a broader perspective and a wider range of expertise to interventions in mental health care, treatment and management.

“A patient’s responsible clinician should be the available AC with the most appropriate expertise to meet the patient’s main treatment needs”

(NIME, 2008 p. 21)

The choice of RC should be based on the individual needs of a patient. There may be circumstances where the appointed RC is qualified with respect to the patient's main assessment and treatment needs but is not appropriately qualified to be in charge of subsidiary treatment requirements e.g. medication which the RC is not qualified to prescribe. In such circumstances the RC will maintain their overarching responsibility for the patient's care, but another appropriately qualified AC would take responsibility for a specific treatment or intervention. Conversely where psychological therapies are the main basis of the patient's treatment it may in some circumstances be more appropriate for an AC psychologist or other non-medical AC to act as the designated RC.

5. Role of the AC Mentor and RC shadowing

As noted every AC Portfolio applicant requires the support and guidance of at least one named AC / RC mentor. Being a mentor will inevitably involve providing a level of guidance and supervision, while applicants must also be given the opportunity to actively shadow RC functions.

5.1 Active Applicant RC shadowing

Applicant RC shadowing should include a sequence of observing the work of a RC; participating in RC decision making; and being actively observed by AC / RC mentors. Ultimately a mentor is required to testify as to an applicant's capability to execute requisite RC decisions and to judge whether an applicant has demonstrated AC competency.

5.2 Validating / signing off examples of completed RC work

Within the specified content of the portfolio (Appendix ii) applicants must submit examples of completed tasks that are solely reserved as the statutory functions of the RC. Such completed decision making / assessment documentation should be accompanied and supported by brief explanatory narratives / reflections of applied use.

Required portfolio evidence includes: examples of completed statutory forms and related documentation i.e. H5 (S20), T2 (S58), S17, S23, examples of CTO use, SOAD request, and completion of two statutory 1st Tier Tribunal / Hospital Managers Hearing reports. Although applicants cannot legally implement these statutory actions / decisions (which would be based on such assessments), they must obtain written confirmation from their shadowing RC mentor/s that they have demonstrated sound skills in understanding these pre-decision assessments and have applied the relevant legal criteria to complete such statutory tasks.

To ensure that effective AC / RC shadowing has been undertaken, and related competency witnessed (either directly or through discussion) mentors are required to countersign submitted examples of RC practice.

Where exposure to certain legal decisions (e.g. application for CTO) are not readily available within an applicant's current deployed service area, the applicant (with the support of their mentor) should try to access other learning opportunities within other

service areas of their employing organisation. To enable an applicant to gain and demonstrate requested AC competency in specific areas, this may entail shadowing other RCs who are engaged in such work. All applicants are required to have considered, on more than one occasion, each of the following decisions:

- Renewal of detention;
- Discharge from detention;
- Granting of S17 leave; &
- Application for CTO

In addition where an applicant is a medical practitioner or nurse prescriber they should also demonstrate, on more than one occasion, consideration of the decisions/s around consent to treatment specific to S58 MHA.

5.3 Supporting AC applicants to work within professional competency boundaries

With the introduction of amendments to the MHA in 2008 the former role of the RMO was replaced by that of RC, and a broader range of professionals became eligible for approval. Irrespective of professional background ACs who are allocated as RCs will undertake the majority of the functions previously performed by RMOs.

All eligible professionals must evidence an ability to execute the key functions of a RC and demonstrate the 8 areas of competency to achieve AC approval. All approved ACs must work within the remit of their own professional competency, as legally AC / RCs can only authorise decisions for which they are suitably qualified. As such the applicant's submitted evidence must demonstrate a clear understanding as to the competency boundaries of their own profession.

All AC applicants must demonstrate an ability to formulate, review and appropriately lead on treatment options within the remit of their own professional competency, and within the context of a multi-disciplinary team. As such applicants may choose to submit evidence of having considered potential cross-professional issues and conflicts. For example a consideration of the respective responsibilities and authority of the designated RC as compared to that of a responsible AC in charge of treatment. Although a non-prescribing RC may not have direct professional competence to prescribe or change medication, they hold ultimate responsibility for the care of the patient as the RC. In such circumstances where the AC in charge of a particular treatment is not the patient's RC, the AC in charge of treatment must ensure that the RC is kept informed about considered treatment options, and that treatment decisions are fully discussed with the RC within the context of the patient's overall care.

To enhance knowledge and experiential learning it is advantageous for AC applicants to receive shadowing support from more than one mentor. Specifically having access to an AC / RC mentor from a different professional background will consolidate applied understanding of MDT relationships, and can often directly enable aspects of applied learning which otherwise would prove difficult to achieve. For non-prescribers it can be highly instructive to shadow an AC / RC mentors who are qualified medical doctors or nurse prescribers, while for medical applicants

exposure to RCs from other professional backgrounds can enhance understanding of talking therapies and other holistic interventions that are not medication based.

The relative seniority of many applicants, irrespective of professional background, should ensure a high degree of existing competency in assessment, but evidence of shadowing AMHPs and working with S12 doctors (including RCs conducting CTO assessments) may also be necessary for many applicants. Such shadowing can be of particular value for non-medical applicants who may not have had substantial or any direct experience of engaging in community based MHA assessments. This exposure may help consolidate an applicant's understanding of the legal criteria for detention and of the emotional / social impact of admission into hospital under compulsion. Such experiential opportunities may also enhance applied understanding of legal criteria and the statutory basis for making decisions reserved for RCs e.g. S20 renewal of detention, S5(2) holding powers and the use of CTO statutory powers in the community.

5.4 Completion of Testimonial Forms

Within section B5 of the AC Portfolio applicants are required to submit at least one full completed copy of the '*Competency Testimony (ies)*' document (c.f. Appendix iv). This documentation should be completed by an applicant's mentor/s, and must provide testimonial confirmation of the applicant's AC competence across each of the 8 AC competency areas. Included testimony should evidence that an applicant has demonstrated sound decision making and assessment skills across a range of RC specific functions / tasks.

Testimonial evidence should be in the form of written confirmation compiled by the applicant's nominated mentor, who may also be the designated RC for the patients the applicant has worked with. In circumstances where an applicant does not have a designated mentor an applicant can seek testimonial statements from AC / RCs who have on more than one occasion observed the applicant participating in prescribed tasks of an AC / RC, and who can verify that the applicant has demonstrated the 'capability' to independently undertake such work.

The term capability is used within the testimonial documentation as it may not always be possible for an acting mentor to directly observe an applicant undertaking specific RC activities. However when making affirmative testimonial statements a mentor should have sufficient knowledge of the applicant to confidently infer that their skills, knowledge and experience would readily transfer across a particular competency parameter.

Ideally an applicant's designated AC / RC mentor should be able to provide a testimony statement for each competency area. Where this is not possible other eligible mentors whom have observed the practice of the applicant, can contribute to the completion of the full Competency Testimony document. Specific written examples of observed or discussed practice should be included within the Evidence / Testimony sections of the form (ref. to examples within Appendix iv). To affirm an applicant's demonstrated competence the mentor should also note (by means of

ticking the provided box on the form) whether the '*Applicant meets Standard*' and whether '*Observed Practice*' occurred.

6. Evidence of applied knowledge and skills

The purpose of the AC Portfolio is to enable applicants to submit evidence that demonstrates the 8 AC competencies. To clearly present such applied knowledge and skills within the portfolio an applicant must submit evidence which effectively illustrates their understanding of the AC / RC role and reflectively demonstrates their ability to autonomously perform the key legal functions of the RC.

6.1 Background Reading

The AC competency of *Legal and Policy Framework* specifies that applicants should have an understanding of relevant legislation including an applied knowledge of the MHA Code of Practice, and of other pertinent national and local policies. The AC Instructions also notes that applicants should also be aware of NICE guidance relevant to the decisions likely to be taken by an AC or RC.

The DH AC Portfolio guidance includes an 'essential reading list' (Appendix v). The DH guide also notes that for applicants fulfilling duties related to children and young people, familiarity with child care legislation and safeguarding should be regarded as mandatory.

In line with prescribed national practice NEAP and other regional Approving Panels are very conscious of the requirements of the October 2013 *First-Tier Tribunal Practice Direction*. There is an expectation that both Tribunal and Managers' Hearing reports will adhere to the outlined RC report structures as contained within the Direction. Any deviation within the statutory reports' content should be noted and explained in accompanied reflections.

6.2 Reflective practice and the Two anonymised Case Commentaries

Reflective practice is a key component of the AC Portfolio and should illustrate an applicant's: underpinning skill base; knowledge of legislation; and their application of the AC / RC role. To effectively demonstrate such evidence the DH recommends that applicants make reference to their own profession's respective guidance on reflective practice.

The use of reflective practice is an essential requirement of the narration of the two Case Commentaries. As noted in British Psychological Society guidance (2016, p.10) relating to the case commentaries:

"This is the most taxing but by far the most convincing evidence of applied knowledge and skill across all competencies."

The commentaries should be reflective in style and need to demonstrate an applicant's ability to operate as a RC with patients subject to the MHA. An applicant's narratives should focus on a patient's period of detention (subject to compulsory powers) over a protracted period, and outline the key clinical decisions and actions that they would make and lead on as the patient's acting RC. When

preparing to write the reflective case commentaries, and in so doing reviewing a detained patient's journey, the applicant should consider the potential range of RC interventions that did or could arise. To illustrate an applicant's breadth of knowledge and applied skills as a preparing RC these summaries could be hypothetical case composites of patients the applicant has worked with, rather than based on two specific cases.

In effect the focus of these commentaries is about an applicant's clinical judgements, interventions and learning as a preparing acting RC under the supervision of a mentor. The narrative should include an outline of how the applicant formulated their own decisions and should provide explicit examples of specific RC decisions made. Such examples should include reference to MDT work and related leadership. In addition the applicants use and awareness of NICE Guidance, the MHA Code of Practice etc. should also be referenced.

6.3 Compliance with current Data Protection legislation

The submission should be compliant with current Data Protection legislation, and all unique patient identifiable information should to be anonymised. Names, addresses and other identifying data such as NHS numbers or dates of birth of patients, or identifiable data related to familiar others e.g. family, carers or acquaintances etc. should be removed or effectively obscured. Personal identifiable information that has been covered by means of marker pen or Tippex / correction fluid or tape should be photocopied to ensure full anonymity of obscured data.

AC Portfolios that breach confidentiality will not be submitted for AC Benchmarking by the NEAP panel, while significant breaches will be brought to the attention of an applicant's Medical Director / employing organisation.

APPENDICES i – v

Appendix i

CHECKLIST WHEN CONSIDERING APPLYING FOR APPROVED CLINICIAN STATUS

Please tick ✓

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 (2015), especially Schedule 1 and Schedule 2 on pages 7 – 9.
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 organisational 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 Director or other relevant Clinical Director.
10. I have access to the documents listed in the Guidance Essential Reading section and have familiarised myself with these as appropriate to my circumstances.
11. I have identified at least one mentor who is an AC and who is prepared to support me in my preparation.

Name	Designation	Base

The next 2 questions are for non-medic AC applicants only:

Please tick ✓
 Yes N/A

12. 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.

13. I have consulted local policy guidance or practise notes in regard to 11 above. Where these are not available I and my mentor(s) will endeavour to initiate the development of these as deemed necessary.

All applicants to complete:

Name:

GMC / PRN:

Signature:

Date:

Appendix ii

NEAP PORTFOLIO CONTENTS LIST – EXPLANATORY NOTES & RELATED GUIDANCE FOR AC PORTFOLIO COMPLETION

Your submitted AC Portfolio practice based evidence should be clearly presented in an ordered ring binder folder, which is numbered in accordance with NEAP’s “Portfolio Contents List – Front Sheet”. Relevant guidance as to the content of Section A – E is provided in the explanatory index template below.

The contents of your submission must be your own genuine work and not a copy of reports produced by anyone else. All submitted examples of practiced based clinical work must be relatively contemporaneous and should have been undertaken within two years of the portfolio submission. You must also ensure that your evidence is supported and signed off by AC / RC mentor(s) you have shadowed and / or who have undertaken observational shadowing of your preparatory RC work.

The Relevance of Reflective practice within the AC Portfolio

The purpose of the AC Portfolio is to enable applicants to submit evidence that demonstrates the 8 AC competencies as specified in the Secretary of States Instructions. For further information you should refer to DH AC Instructions 2015 and DH (2017) ‘*Guidance for seeking Approved Clinician status via the portfolio route*’.

Reflective practice is a key component of the AC portfolio and should illustrate an applicant’s: underpinning skill base; knowledge of legislation; and their application of the AC / RC role. To effectively demonstrate such evidence DH recommends that applicants make reference to their own profession’s guidance on reflective practice.

Compliance with current Data Protection legislation

Any included case materials and associated patient identifiable information must be anonymised and compliant with current Data Protection legislation and regulation. AC Portfolios that breach confidentiality will not be submitted for AC benchmarking by the NEAP Panel, while significant breaches will be brought to the attention of an applicant’s Medical Director / employing organisation.

Names, addresses and other unique identifying data such as NHS numbers or dates of birth of patients, or identifiable data related to familiar others e.g. family, carers or acquaintances etc. should be removed or effectively obscured. Personal identifiable information that has been covered by means of marker pen or Tippex / correction fluid or tape should be photocopied to ensure full anonymity of obscured data.

SECTION A – Index headings and content guidance

A1	<p>AC APPLICATION FORM This must include 2 identified referees who meet the AC Instructions 2015 requirements.</p>
A2	<p>DECLARATION FROM MEDICAL DIRECTOR – (Form included in AC application pack) Include a completed declaration from your Medical Director or a person of equivalent status, which is signed off on behalf of their organisation and indicates supports of your AC application.</p>
A3	<p>COMPLETETED PORTFOLIO CHECKLIST – (Form included in AC application pack & in Appendix D of DH Guidance)</p>
A4	<p>PERSONALISED STATEMENT Within this statement you should reflect on how you have prepared for AC status. You should include any periods of shadowing and the name(s) of the Responsible Clinician(s) you have shadowed.</p> <p>“Shadowing” – this includes a sequence of observing, participating in, and being observed to have demonstrated capability for the relevant AC competencies and for executing any requisite RC decisions.</p> <p>Medics should also reference and include periods of on call work and the nature of the work that was undertaken.</p>
A5	<p>PROFESSIONAL QUALIFICATION AND PROFESSIONAL REGISTRATION</p>
A6	<p>JOB DESCRIPTION AND JOB PLAN Applicants currently employed in a role in which they will be unable to utilise their future AC approval to operate as a RC should also include a planned / envisaged RC deployment plan.</p>
A7	<p>RELEVANT TRAINING COURSE CERTIFICATES (current / valid):</p> <ul style="list-style-type: none"> - AC Induction - Information Governance - Equality and Diversity (at Leadership Level) - Professional Practice in Mental Health Law Postgraduate Certificate, relevant to those applicants who have attended this optional AC preparation course

SECTION B – Index headings and content guidance

B1	<p>CURRICULIUM VITAE</p>
B2	<p>CPD i.e. Royal College of Psychiatrists Certificate of Good Standing, or Peer Group CPD form, or CPD Log (non-medical AC applicants)</p>
B3	<p>360 DEGREE APPRAISAL AND REFLECTION The reflection should consider the outcome of the 360 Appraisal and how such skills will be transferable to your future AC / RC role.</p>

B4	<p>COMPETENCY TESTIMONY / TESTIMONIES</p> <p>This form is included in the AC application pack and must be completed by the ACs / RCs you have shadowed and / or who have shadowed your preparatory RC work.</p> <p>Included testimony should confirm that an applicant has demonstrated sound decision making and assessment skills across a range of AC / RC specific functions / tasks. All areas of competency must be commented upon, and clearly demonstrate that all the required AC competencies have been met.</p> <p>As noted on the Competency Testimonial form (and in keeping with general AC reference requirements) only AC / RCs who have had a professional working relationship with an applicant of at least a period of three months should complete such testimonials. The three month minimum period is required to ensure that testifying signing off mentor(s) have a minimum level of acquaintance with an applicant's practice skills and applied knowledge.</p>
B5	<p>BRITISH PSYCHOLOGICAL SOCIETY (BPS) ADVICE NOTE – (Optional)</p> <p>Psychologists preparing to submit a portfolio for approval should refer to the BPS document entitled '<i>Guidance for Registered Psychologists in making applications to the BPS Approved Clinician Peer Review Panel</i>' (Gillmer and Taylor, September 2016). This is accessible on the BPS website.</p> <p>Submission to the BPS for pre-approval scrutiny is open to all psychologists. Although it is not a requirement of the process of approval, it is considered good practice. Following recent developments and in keeping with the 2008 NIMHIE '<i>New Roles</i>' guidance document, the BPS peer review service is now open to all non-medical professional groups eligible to be ACs. The reviewing panel includes representatives of all eligible non-medical professions and the process is the same for all applicants.</p> <p>The BPS pre-approval scrutiny panel is made up of experienced ACs who review the portfolio against a set of standards. The aims of the process are to scrutinise the applicant's portfolio to ensure:</p> <ul style="list-style-type: none"> - That the evidence submitted is coherent - That the applicant's claims of competency and the contents of the portfolio are generally consistent with their declared skills, knowledge and experience. - To determine whether the applicant possesses the relevant competencies for the AC role. <p>For employers this is a quality assurance function as to the professionally verified weight of evidence submitted by applicants. For regional panels this constitutes evidential advice as to the professional probity of the applicant's submission. If the BPS process finds the portfolio to be above the level then the Advice Note will state that view as a recommendation to the regional panel and provide grounds for that finding as an evaluative summary. It must be noted, however, that the final adjudication of competency and approval is strictly and solely that of the regional panel.</p>

SECTION C – Index headings and content guidance

N.B* Across the portfolio applicants must include clear evidence that demonstrated their ability to make all the key decisions reserved to the RC on more than one occasion. Submitted examples of anonymised statutory forms and reports should be countersigned by ACs / RCs mentors you have shadowed and / or who have shadowed your preparatory RC work. Your included reflections should demonstrate knowledge of associated legislation and illustrate your application of such powers.

C1	<p>TWO STATUTORY REPORTS I.E. FIRST TIER MENTAL HEALTH TRIBUNAL REPORT / HOSPITAL MANAGERS HEARING REPORT*</p> <p>Included statutory reports should be succinct and anonymised. These may be hypothetical (i.e. prepared solely for the purposes of the AC portfolio application), but must be based on actual personal contact and knowledge of patient(s) you have worked with.</p> <p>There is an expectation that both Tribunal and Managers’ Hearing reports will adhere to the outlined RC report structures as contained within the current ‘<i>First-Tier Tribunal Practice Direction.</i>’ Any deviation within the statutory reports’ content should be noted and explained in accompanied reflections.</p>
C2	<p>TWO ANONYMISED REFLECTIVE CASE COMMENTARIES</p> <p>Your submitted commentaries should illustrate RC competence to enable you to be approved as an AC. As such your reflective narratives should focus upon the rationale / formulation of specific RC decisions you were actively engaged with. Such reflections should include reference to MDT work and related leadership, while your use and awareness of NICE Guidance and the MHA Code of Practice etc. should also be referenced.</p> <p>The case commentaries should be relevant, concise and practice reflective in style. They should focus on a patient’s period of detention (subject to compulsory powers), and outline the key clinical decisions and actions <u>that you made and lead on</u> as the patient’s acting RC whilst being shadowed by a RC mentor.</p> <p>When preparing to write the reflective case commentaries (and in so doing reviewing a detained patient’s journey) you should consider the potential range of RC interventions that did or could arise. To illustrate your breadth of knowledge and applied skills as a future RC these summaries could be hypothetical case amalgamation of patients that you have worked with, rather than based on two specific cases.</p>
C3	<p>RENEWAL OF DETENTION (SECTION 20) STATUTORY FORMS AND REFLECTIONS*</p>
C4	<p>SECTION 17 LEAVE STATUTORY FORMS AND REFLECTIONS*</p>
C5	<p>DISCHARGE FROM DETENTION STATUTORY FORMS AND REFLECTIONS*</p>

C6	<p>COMMUNITY TREATMENT ORDER STATUTORY FORMS AND REFLECTIONS*</p> <p>To demonstrate underpinning knowledge of legislation associated with CTO processes you must include a range of examples of CTO applications e.g. renewal, recall and revocation. Your related reflection should demonstrate understanding of underpinning legislation and associated statutory best practice guidance as outlined in the MHA Code of Practice.</p>
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SECTION D – Index headings and content guidance

D1	<p>CARE PLANS. MDT WORKING AND LEADERSHIP</p> <p>Include anonymised examples of clinical documentation that illustrates your level of MDT work, role in care planning and associated MDT leadership.</p>
D2	<p>CONSENT TO TREATMENT (SECTION 58A AND REFLECTION – (*NB above)</p>
D3	<p>SOAD REFERRAL AND STATUTORY FORM AND REFLECTION</p>
D4	<p>MENTAL CAPACITY ASSESSMENTS</p> <p>Include an example of a completed MCA assessment form, and a related reflection outlining the underpinning legislative structure, stages and outcome of the included assessment.</p>
D5	<p>UNDERSTANDING OF AMHP ROLE AND REFLECTION</p>
D6	<p>RISK ASSESSMENT AND RISK MANAGEMENT TOOLS</p> <p>Include anonymised examples of clinical documentation that illustrates your use of risk assessment and risk management tools.</p>

SECTION E

E	<p>ADDITIONAL SUPPORTING EVIDENCE - (Optional)</p> <p>Within this section you can include any other information you believe illustrates AC / RC competence and is relevant and supportive of your AC application. For example complex MHA assessments, court reports, reflective case logs, or knowledge of evidence based practice relevant to specific patient groups.</p>
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Appendix iii

Summary of Approved Clinician Competencies as outlined in the Secretary of States AC Instructions (2015)

- 1. The Role of the Approved Clinician and Responsible Clinician**
 - 1.1 A comprehensive understanding of the role, legal responsibilities and key functions of the AC and RC
- 2. Legal and Policy Framework**
 - 2.1 Applied knowledge of –
 - a. mental health legalisation, related codes of practice and national and local policy and guidance;
 - b. other relevant legislation, codes of practice and national and local policy guidance, in particular, relevant parts of the Human Rights Act 1998, the Mental Capacity Act 2005, the Children’s Act 1989 and Children Act 2004; and
 - c. ‘relevant’ guidance issued by the National Institute for Health and Clinical Excellence.
 - 2.2. In the above paragraph ‘relevant’ means relevant to decisions likely to be taken by an approved clinician or responsible clinician.
- 3. Assessment**
 - 3.1 Ability to -
 - a. Identify the presence of mental disorder;
 - b. Identify the severity of the mental disorder; and
 - c. determine whether the mental disorder is of a nature or degree warranting compulsory detention.
 - 3.2 Ability to access 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.
 - 3.3 An ability to undertake mental health assessment incorporating biological, psychological, cultural and social perspectives.

4. Treatment

4.1 Understanding of -

- a. mental health related treatments, which include physical, psychological and social interventions.
- b. different evidenced based treatment approaches and their applicability to different patients; and
- c. 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.

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

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.

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

5. Care Planning

5.1 Ability to manage and develop care plans which combine health (including measures relating 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.

6. Leadership and Multi-Disciplinary Team Working

6.1 Ability to effectively lead a multi-disciplinary team

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

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.

6.4 Understanding and recognise the limits of person's own skills and an ability to seek other professionals' views from others to inform a decision, for example, through peer review and appraisal.

7. Equality and Diversity

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

7.2 Ability to identify, challenge and where possible and appropriate redress discrimination and inequality in relation to approved clinical 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 practitioner's judgements and decisions concerning the application of mental health legislation and policy.

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.
- 8.2 Ability to keep appropriate records and an awareness of legal requirements with respect to record keeping, including the processing of all personal data or sensitive personal data in accordance with the Data Protection Act 1998.
- 8.3 Understanding of, and ability to manage, the competency requirements of confidentiality and effective information sharing, to the benefit of the patient and other stakeholders.
- 8.4 Ability to compile and complete statutory documentation and to provide written reports as required of an approved clinician.
- 8.5 Ability to present evidence to courts and tribunals.

Appendix iv

N.B For illustrative purposes the following document is truncated and includes examples of two completed competency domain statements. The full document covers the full 8 AC competency areas and includes an additional domain which covers Comprehensive Understanding.

North of England Approvals Panel Competency Testimony (REQUIRES COMPLETION BY AC / RC MENTORS)

Applicant Name

Professional Registration Number

Guidance Notes

Applicants seeking Approved Clinician status who are not included on the GMC Specialist Register require support to provide evidence for their portfolio to demonstrate competencies.

This will include periods of shadowing Responsible Clinician(s) (RC) which may take place in a variety of services. A demonstration of the use and understanding of the Mental Health Act should be included for the various responsibilities they undertake. An RC must have known the applicant for a minimum of period of three months.

You have been approached by an applicant who is in preparation for Approved Clinician status. Your role is to provide an appraisal of their competency and capability across a range of parameters that have been identified as central to the role of Approved Clinician under the Mental Health Act 1983, (as amended 2007). The term 'capability' is used because, although you may not have directly observed a specific activity, you have sufficient knowledge of the applicant to be able to confidently infer that their skills, knowledge and experience would or would not transfer readily to a particular parameter.

Based on your knowledge of the applicant you are asked to consider all aspects, to confirm whether you feel the applicant has appropriate/sufficient knowledge. You must complete the evidence / testimony for each competency.

1. The Role of the Approved Clinician and Responsible Clinician

- 1.1 A comprehensive understanding of the role, legal responsibilities and key functions of the AC and RC
- 1.2 Shadowing of the AC/RC in order to demonstrate this competency must include clear evidence of the applicant having demonstrated the ability to make all the key decisions reserved to the RC. They should have considered, on more than one occasion, each of the following decisions:
- Renewal of detention,
 - Discharge from detention,
 - Granting of Section 17 leave; and
 - Application for CTO

Where the applicant is a doctor or Nurse Prescriber they should also demonstrate, on more than one occasion, consideration of the decision/s around consent to treatment specific to S58 MHA.

- 1.3 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.

Applicant Meets Standard Yes No

Observed practice Yes No

Evidence / Testimony

Dr XXXXX has demonstrated a comprehensive understanding of her role as a locum consultant and the legal responsibilities and key functions relevant and specific to the AC / RC role. I have observed such practice from 12/09/16 to 07/03/18 on a general acute adult psychiatry ward and adult PICU. - Over this period she has regularly shadowed my RC practice, attending CTO assessments and Tribunals / Managers Hearings with me. She has completed Tribunal reports, T2 Consent to Treatment forms and SOAD requests for me, which subsequently I scrutinised and authorised as the patients' designated RC.

During her AC preparation we have had periodic supervisions during which she has produced MHA related work and we have discussed complex case scenarios. In advance of such sessions she would prepare mock up completed forms i.e. examples of various CTO forms, S23 discharge and S17 documentation, all of which I scrutinise and found to be completed competently. I found her readily willing to acknowledge areas for further learning and development, and found her to be proactive in addressing such gaps in her knowledge, all of which has consolidated her understanding and application of the RC role.

Dr XXXXX and I have attended many MDT meetings together. Her advice and team steer in directing patient care has proved effective, particularly when considering presenting risk factors for the purpose of renewing detentions and the use of S17 leave. In complex situations she has always sought my advice, and in general has always kept me informed of proposed changes to detained patients treatment plans.

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.
- 8.2 Ability to keep appropriate records and an awareness of legal requirements with respect to record keeping, including the processing of all personal data or sensitive personal data (as both terms are defined in the Data Protection Act 2018) in accordance with that Act.
- 8.3 Demonstrates an understanding of and has the ability to manage the competency requirements of confidentiality and effective information sharing to the benefit of the patient and other stakeholders.
- 8.4 Ability to compile and complete statutory documentation and to provide written reports as required of an Approved Clinician.
- 8.5 Ability to present evidence to courts and tribunals

Applicant Meets Standard Yes No

Observed practice Yes No

Evidence / Testimony

During her period as an inpatient doctor she has completed all written reports relevant to her own cases, while she has also prepared a number of Tribunal Reports and related RC documentation under my supervision. I can confirm that these reports were well written, detailed, informative, and demonstrated relevant RC competency.

In my presence and my absence she has presented Tribunal reports on my behalf. Her articulation of the salient presenting factors were clearly conveyed as witnessed by myself, but also confirmed in the Tribunal summary feedback I have read.

In MDT settings Dr XXXXX has a concise and precise approach to articulating patient assessment summaries, and in presenting salient risk factors and related risk management plans. Her style of communication has instilled confidence within the MDT team and has enabled her to effectively manage strained team dynamics and disagreements regarding the direction of patient care.

During my period of mentoring Dr XXXXX I have found her general communication style to be clear and concise, while she has demonstrated great empathy and patience in her interactions with patients and carers.

There have been no concerns regarding confidentiality and inappropriate information sharing. She is fully compliant and knowledgeable with the MH Trust's IG training.

Sign Off

I confirm that all information provided within this testimony is factual to the best of my knowledge.

Print Name

Professional Registration Number

Role

Organisation Worked For

Date

Signature

Appendix v

Department of Health Essential Reading

N.B. The following extracts are from of DH ‘Guidance for seeking Approved Clinician status via the portfolio route’ (October 2017 pp. 6 – 7).

DH recommends that applicants have a good knowledge of the following documents:

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, how to attain them and sources of evidence.

Mental Health Act 1983 Instructions with respect to the Exercise of Approval Functions in Relation to Approved Clinician 2015 (came into force as from 05/01/2016). These Instructions supersede elements of the New Roles Guidance.

Mental Health Act Code of Practice (came into force 01/04/2015)

Mental Health Act 1983 as amended by Mental Health Act 2007

Practice Direction: First-tier Tribunal Health Education and Social Care Chamber: Statements and Reports in Mental Health Cases (came into force on 23/10/2013)

Mental Capacity Act (MCA) 2005

If an applicant’s AC/RC responsibilities are in regard to other specific groups such as Older Adults and Learning Disabilities, then they should have a particular familiarity with the Mental Capacity Act and relevant policies and guidance, as well as relevant NICE guidance.

MCA 2005 and the Deprivation of Liberty Safeguards (DOLS).

<https://www.gov.uk/government/statistics/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-2015-to-2016>

And other relevant sites such as:

RadcliffesLeBrasseur website, especially their mental health law briefings under Publications <http://www.rib-law.com/briefings/mental-health-law/>

<http://www.mentalhealthlaw.co.uk>

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

<http://www.39essex.com/>

Child care legislation

If it is anticipated that if an applicant 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).

British Psychological Society Guidance

Psychologists considering preparation for approval are encouraged to consult the BPS Guidance for Registered Psychologists in Making Applications to the British Psychological Society Approved Clinician Peer Review Panel (September, 2016).

<http://www.bps.org.uk/system/files/Public%20files/Policy/INF263%20Clinical%20peer%20review%20ID704%20WEB.pdf>

The BPS 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 and has now been extended to other professional groups seeking AC approval via the portfolio route.

Additional Recommended reading

Applicants should read their own Trust's and local social services Policy document on safeguarding vulnerable adults and children.

Children Act 1989

Care Act 2014

CQC website re [role of the CQC including SOAD](#).