

Multi-Professional Approved/ Responsible Clinician: Implementation Guide



Purpose

This document provides guidance to NHS organisations and partner agencies looking to implement multi-professional approved (AC) and responsible clinician (RC) roles.

For clarity, definitions of the roles laid out in this guidance are as follows:

Approved clinician: A mental health professional approved by the secretary of state or a person or body exercising the approval function of the secretary of state. Some decisions under the Mental Health Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

Responsible clinician: The responsible clinician is the approved clinician with overall responsibility for the case. Certain decisions (such as renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the responsible clinician.

The 2007 amendments to the Mental Health Act 1983 introduced the roles of approved clinician and responsible clinician, enabling mental health professionals other than psychiatrists to carry out duties previously performed by psychiatrists. The introduction of these roles was intended to deliver enhanced quality of care while also ensuring the best use of our skilled and professionally diverse workforce. It is therefore important to ensure the approved clinician is the clinician with the right set of skills to address the patient's main treatment needs. The adoption of this role will allow patients to benefit from the unique perspectives of nurses, social workers, occupational therapists and psychologists.

This guide is particularly aimed at workforce planners, NHS trust executives and local authorities looking to transform their workforce to meet the diverse needs of patients and service users. In the first section, it will provide you with further background on the role, then move onto the practical considerations around implementing the role. This will allow you to successfully plan and deploy the role while ensuring appropriate clinical and governance arrangements are in place.

The guide is meant to be used interactively. Throughout the guide there are links that signpost you to further information and other documents to consider. The guide contains an overview of the responsible/approved clinician role, an independent review of the role, professional case studies and a list of core competencies. It should be read in conjunction with the [Mental Health Act Code of Practice](#) and [Reference Guide to the Mental Health Act](#).

Purpose	1
Overview and context	3
Background	4
What is an approved clinician?	4
Implementation	5
Implementation focus	11
Introduction	12
Methodology	13
Qualitative data collection	13
Findings from secondary data and routinely collected data	14
Quantitative data provided by trusts	16
Findings from qualitative interviews	18
Discussion and conclusion	27
Acknowledgements	29
References	29
Appendix A	30
Professional focus	34
Professional case study examples	35
Approved clinician core competencies	43
Expert advisory group membership list	45

Overview and context



Background	4
What is an approved clinician?	4
Implementation	5

Background

In recognition of the benefits to patient choice and experience, clinical and professional career progression and national workforce challenges, including in psychiatry, Health Education England (HEE) commissioned the National Workforce Skills Development Unit (NWSDU) to produce this guidance. A further key driver for this work is providing an opportunity to keep senior clinicians in clinical practice and providing direct patient care. The NWSDU is hosted by the Tavistock and Portman NHS Foundation Trust.

The NWSDU convened an expert advisory group (EAG) consisting of approved clinicians from the four eligible professions, and representatives

of mental health trusts across England and professional bodies. The Child Outcomes Research Consortium (CORC) was commissioned to analyse available research, review literature and draw on the experiences of early implementers. The full CORC report (independent review of multi-professional responsible clinical provision in England) can be found at the 'Implementation Focus' section of this document.

The National Workforce Skills Development Unit focuses on a range of national mental health workforce issues and is a service commissioned from the Tavistock and Portman NHS Foundation Trust by Health Education England.

What is an approved clinician?

An approved clinician (AC) is "a person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act 1983" while a responsible clinician is the "AC who has been given overall responsibility for a patient's case".¹

The Mental Health Act 2007 identifies the following as eligible to act as approved clinicians in England:

- practitioner psychologists listed on the register maintained by the Health and Care Professions Council (HCPC)

- first level nurses with a field of practice in mental health or learning disability
- occupational therapists registered by the HCPC
- social workers registered by Social Work England.²

Despite legislation in 2007, low numbers of multi-professional approved clinicians are actually employed in the NHS. The independent review identified that in July 2019 out of a total of over 6,500 approved clinicians (including psychiatrists) only 63 came from multi professional backgrounds. See [here](#) for further details.

1. National Institute for Mental Health in England. (2008). Mental Health Act 2007 new roles: Guidance for approving authorities and employers on approved mental health professionals and approved clinicians. Accessed at: https://webarchive.nationalarchives.gov.uk/20120503145456/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106654.pdf

2. Social Work England only regulates social workers in England. In Wales social workers are regulated by Social Care Wales. The Mental Health Act 2007 covers England and Wales, and we would expect it to also cover the social worker regulators in Wales, Scotland (the Scottish Social Services Council) and Northern Ireland (the Northern Ireland Social Care Council). Social workers in England moved to a new regulator (Social Work England) from the Health and Care Professions Council on 2 December 2019.

Implementation



The implementation of this role offers substantial positive opportunities for service user outcomes and professional development. But this role can be challenging for the organisation, individual clinicians undertaking the role, and the services around them. However, it is important to note the opportunities the diverse nature of different professional backgrounds offers in delivering more personalised care with a clear psychosocial model of care to complement the established medical model. Robust planning, communications, systems and governance need to be in place to roll this out effectively, as well as a clear consideration of equality, diversity and inclusion. A number of current multi-professional approved clinicians have commented on the level of culture change required to make the role work – this applies to both medical and multi-professional colleagues – while organisational support, particularly at board level, is key.

This guide sets out five steps organisations should consider when planning to implement the role:

1. **Workforce planning**
2. **Consultation and engagement**
3. **Support structures**
4. **Selection of candidates**
5. **Monitoring and evaluation**

1. Workforce planning

Role design: Careful role design and a good understanding of organisational need are key.³ Workforce gaps and patient need should be considered carefully. Ethnic and cultural context is an important area for consideration, as is an understanding of the wider health and social care system.

Equality, diversity and inclusion: A disproportionate number of people from Black, Asian and Minority Ethnic (BAME) backgrounds are detained under the Mental Health Act.⁴ This is an opportunity to support a development pathway for people with BAME backgrounds to take on these roles to better meet the needs of patients. The 2018 independent review of the Mental Health Act 1983 set out recommendation for the NHS to develop an organisational competence framework, the Patient and Carers Race Equality Framework (PCREF), which would act as a practical tool to help mental health providers understand the steps they need to take to improve patient experience for individuals of diverse ethnic background.⁵

Scope of practice: The key functions of an approved clinician are set out, and there are clear legal requirements that form a core element of the role that should be taken into account. Approved clinicians will need regular continuing professional development (CPD) time and supervision to ensure they are up to date with the latest legal requirements.⁵

3. Imison, C., Castle-Clarke, S. and Watson, R. 2016. Reshaping the workforce to deliver the care patients need. Accessed at: <https://www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need>

4. The abandoned illness – A report by the Schizophrenia Commission. 2012. Accessed at: <https://www.rethink.org/media/2637/the-abandoned-illness-final.pdf>

5. Modernising the Mental Health Act: Increasing choice, reducing compulsion – Final report of the independent review of the Mental Health Act 1983. 2018. Accessed at: <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>

Workforce impact: It is important to consider the implications that extending or changing the roles of your existing workforce may have. For example, the work carried out by the professional as an approved clinician will likely mean they have less, or no, time to function as they did previously. This will have an impact on your existing workforce and service, meaning backfill arrangements and/or service reconfiguration should be an important consideration. A number of organisations, for example, NHS trusts and local authorities will also need to work together within an Integrated Care system ICS workforce strategy.



Supervision: While in preparation to become approved clinicians, supervision and mentoring is required, which will have a further impact on your existing workforce. Much of this is likely to fall on existing consultant psychiatrists at this time, but further support from senior managers, professional leads and clinical/medical directors will also be required. This will all have an impact on capacity available for these staff members to perform their traditional roles and this needs to be acknowledged, supported and backfilled where necessary.

Deployment: This should be informed by specific areas of need within the organisation. The clinical service area to which an individual is being deployed should be discussed and agreed in advance of approval. There are good examples around the country of successful implementation of these roles. Further details on deployment approaches can be found [here](#).

2. Consultation and engagement

Planning: Any service change requires a clear and understood communications plan. This plan needs to identify and engage with the appropriate stakeholders. It is expected that your organisation has an existing communications team that can assist with this and NHS England/Improvement has produced a [helpful toolkit for communications and engagement teams in service change programmes](#). Any communications plan should clearly set out the following:

- Objective – what are you trying to achieve?
- Audience – who are you trying to engage?
- Timescales – when is change happening?
- Key messages – what do you need to tell people? This may be different for different stakeholders.
- Channels – how are you going to communicate your messages? What existing channels do you have? Do you need new ones?
- Queries and feedback – how can stakeholders respond?

Co-production: The development of the approved clinician role should be seen as having a positive impact on patient choice and experience due to the unique insights and perspectives the eligible multi-professional workforce can bring. Organisations can engage with patients, their families and others through existing patient participation groups, but as patients are often best placed to advise about what support and services will make a positive difference to their lives, genuine co-production and patient

3. Imison, C., Castle-Clarke, S. and Watson, R. 2016. Reshaping the workforce to deliver the care patients need. Accessed at: <https://www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need>

4. The abandoned illness – A report by the Schizophrenia Commission. 2012. Accessed at: <https://www.rethink.org/media/2637/the-abandoned-illness-final.pdf>

leadership is strongly encouraged. NHS England/Improvement has a [suite of tools](#) that can help organisations to do this and local authorities have established the principles of strength-based working under the Care Act 2014. At a minimum, organisations should make clear the impact any changes are likely to have on care and should engage in a way that is clear and avoids confusing or corporate terminology.

Motivation: The three main motivations for implementing this role are as follows. The first is to enhance patient choice and experience. Workforce challenges and clinical career progression are also key drivers. Encroachment of professional boundaries, changes to service structures and levels of responsibility may be encountered. Being clear and open about this should help to address potential disengagement.

Dialogue: It is important that anxieties are heard, acknowledged, and answered. You should have already identified channels for feedback as part of your communications plan; however, acting on that feedback is just as important. It is likely that clinicians will have a better understanding of the impact of any service change.

3. Support structures

Clinical: The adoption and development of a new role may have an impact on existing clinical governance structures, and it is essential that these are understood and accounted for appropriately. Good clinical governance should underpin the design and process of implementing the role,



including all clinical policies and processes. Consideration should be given to clinical training needs to prepare for approval.

Managerial: Boards, local authorities and their executive teams need to recognise and understand the value of the role and the time required for preparation and approval. It is equally important that this support is made explicit to managers to support successful implementation.

Professional: There should be clear lines of professional accountability for responsible clinician activity, within professional supervision lines. The responsibility for professional practice of an approved clinician will lie with the professional lead for their discipline.

Development: The approved clinical competencies outline the need for a detailed knowledge of relevant legislation and national and local policies. Courses such as those that lead to a postgraduate certificate in professional practice in mental health law are available from higher education institutions (HEIs). These courses can assist with the legal aspects of the role and provide helpful support networks.

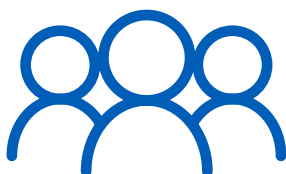
Informal: Action learning sets⁶ are strongly recommended within trusts and/or across localities. Other support networks can also be helpful. A good example of a network open to all multi-professional approved clinicians is the British Psychological Society's Approved Clinicians Forum where clinicians can come together to hear about latest developments and share experiences.

6. McGill, I. and Brockbank, A. 2003. The action learning handbook. Accessed at: <https://doi.org/10.4324/9780203416334>

4. Selection of candidates

Identifying candidates:

Eligible professionals wishing to apply for approval are nominated by their employer based on having the necessary competencies for the role. The Department of Health guidance for those seeking approved clinician status via the portfolio⁷ requires that an applicant should be “a senior professional who is sufficiently experienced to capably, and with authority, exercise the autonomous decision-making”. The eight core competencies required for approval can be found [here](#).



It is important to establish robust and equitable selection processes that are linked to service need and overseen by professional leads from all eligible disciplines.

Candidates should be senior clinicians and professionals who are highly experienced and able to demonstrate clear leadership responsibilities in their current roles. Organisations should develop processes and policies defining these elements. Two examples of these are available from [Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust](#) and [Devon Partnership NHS Trust](#).

Gaining approval: There are statutory requirements (covered by the Department of Health guidance) outlining what evidence applicants must include in their portfolio. These include evidence of completed tasks reserved as statutory functions of a responsible clinician.

There is no set amount of time required for preparation for approval, although it typically takes one to two years to complete the portfolio requirements. Organisations will need to be flexible to allow sufficient time for academic study and to gain appropriate clinical experience. The North of England Approval Panel has developed a useful [pack](#) that is applicable across all area panels to support applicants through the approval process. When this pack was developed we were aware of supporting education programmes offered by Northumbria University and University College London, others may become available.

5. Monitoring and evaluation

Change management: Any change management or service change process should be regularly and cyclically monitored and evaluated. NHS England/Improvement has provided an example of a [change model](#) that may be helpful, but there are numerous processes and tools available across the NHS and it is likely that your organisation already has a favoured way of doing this.



Quality of service: Organisations should collect patient outcomes and experience data and compare these over periods of time. Outcome data should provide indications of improvements or challenges. This could provide an opportunity to demonstrate organisational good practice in relation to developing these roles, for example in Care Quality Commission (CQC) inspections.

7. Department of Health. 2017. Guidance for seeking Approved Clinician status via the portfolio route. Accessed at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652073/Guidance_for_Seeking_Approved_Clinician_Status_via_the_Portfolio_Route.pdf. See page 5.

Impact on workforce: It may be helpful to look at proxy workforce indicators, such as staff retention and sickness rates and productivity levels. It may also be useful to look at clinical indicators such as discharge rates, patient flows and continuity of care as well as patient experience indicators such as the NHS Friends and Family Test results and complaints. There may be further indicators of impact on workforce to be found in key performance indicators, budgets and recruitment.

Consultant-level practice

Once approved, the expectation is that the approved clinician is functioning at consultant level and will continue to demonstrate the competencies required.

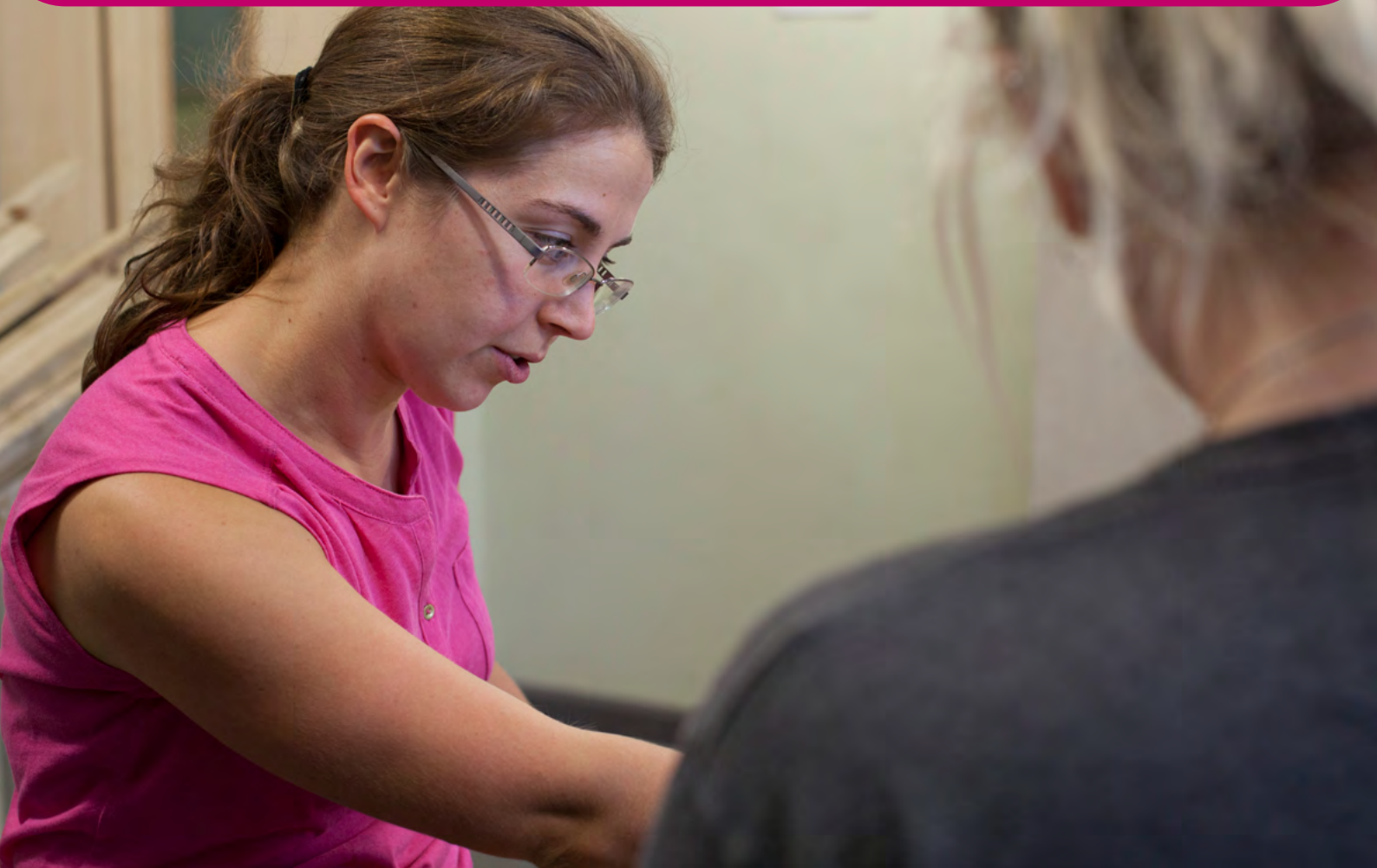
In addition to being expert clinicians, consultant practitioners are expected to lead strategic clinical developments and advance clinical practice and service quality through education, research and evaluation.⁸

Those working towards approval are expected to be in direct clinical practice at an advanced clinical (or consultant) level and are supported by the organisation on a clear development pathway in order to transition into consultant-level practitioners on completion.

Local authorities are often the employers or authorising bodies for approved mental health professionals and social workers or occupational therapists who may be working in integrated arrangements within NHS mental health trusts and so they need to be signed up to these principles and expectations.

8. Adapted from Hardy M and Nightingale J (2014) Conceptualizing the transition from advanced to consultant practitioner: career promotion or significant life event?. Available at <https://shura.shu.ac.uk/22082/1/Nightingale-Paper1ConceptualizingTheTransition%28AM%29.pdf> (accessed Aug 2020)

Implementation focus



Introduction	12
Methodology	13
Qualitative data collection	13
Findings from secondary data and routinely collected data	14
Quantitative data provided by trusts	16
Findings from qualitative interviews	18
Discussion and conclusion	27
Acknowledgements	29
References	29
Appendix A	30

1. Introduction

Following amendments to the Mental Health Act in 2007, a broader range of multi-disciplinary professionals are now able to be approved as a responsible clinician (RC), a role previously performed by responsible medical officers and solely reserved for consultant psychiatrists. Multi-disciplinary professionals now eligible for the role of responsible clinician are:

- registered social workers
- registered occupational therapists
- registered psychologists
- registered nurses.

A key driver for the legislative changes, and associated developments in ways of working, according to work carried out by the National Workforce Skills Development Unit (NWSDU) and stated in the 'request for quote' for this work, was to support the sector to:

- deliver more personalised care with a stronger psychosocial aspect alongside the medical focus
- alleviate current workforce pressures in mental health services and create capacity for consultant psychiatrists to focus on more complex cases that specifically require psychiatric skills
- create more viable senior clinical career pathway opportunities for non-medical clinicians in an effort to improve recruitment and retention rates in the mental health profession as set out in the NHS Long Term Plan.

Research, according to the NWSDU, shows that although the legislation was amended over a decade ago, the introduction of multi-disciplinary professionals as responsible clinicians has been slow in many parts of the country, and that some providers are not taking up this opportunity.

This research has been commissioned by the NWSDU to:

- confirm the number of mental health trusts that have implemented the role across England
- investigate the protected characteristics profiles of multi-disciplinary responsible clinicians approved across the country, where data is available
- gather and review evidence using the learning from early implementers, and others, to provide a robust evaluation of the effectiveness and added value of the role
- draw on the knowledge of the early implementers to provide practice examples of what has already proved successful and unsuccessful
- identify potential barriers or risks in developing these roles, at individual and organisational level.

1.1. A note on language

Numbers/quantities of respondents

Interviews were conducted confidentially. To maintain the anonymity of participants when reporting, the use of numbers to quantify remarks or findings has been avoided and the following terms have been used:

15	= All
<15, ≥10	= Most
<10, ≥5	= Several
<5, >0	= Some
0	= None

Differentiating between psychiatrist RCs and those from other professional backgrounds

The use of the term 'multi-professional RC', for the purpose of this report, explicitly refers to those responsible clinicians from a professional background other than psychiatry, which are:

- registered social workers
- registered occupational therapists
- registered psychologists
- registered nurses.

The term 'psychiatrist RC' refers only to responsible clinicians who are psychiatrists.

1.2. A note on quotations

All quotations are taken directly from interviews conducted as part of this review. Where required, words and phrases have been removed or rephrased to protect the anonymity of participants.

2. Methodology

The Child Outcomes Research Consortium (CORC) used the following methodology to address research objectives.

Accessing data held by statutory bodies

This methodology was used to investigate the number of mental health trusts that have implemented the multi-disciplinary responsible clinician role across England, and the protected characteristics profile of this group.

CORC approached area approval panels (AAPs) to gather the following information:

- up-to-date numbers of approved responsible clinicians, broken down by profession
- approved clinicians by trust

- protected characteristics (such as ethnicity, gender and age) of multi-professional responsible clinicians.

Trusts identified as 'early implementers' by the NWSDU were asked to provide any data they had collected and analysed to investigate the impact on patients of extending the responsible clinician roles to other professional backgrounds. It was anticipated that this could include readmissions to mental health or general hospitals, accident and emergency department treatment, engagement in meaningful occupations, serious untoward incidents, and police investigations. The data that was received is discussed in subsequent sections.

3. Qualitative data collection

To address the remaining research objectives, CORC conducted confidential semi-structured phone interviews with staff from a range of trusts and backgrounds. Initially, contact was

made by the NWSDU to ask permission to share their details and then those details were passed to CORC. A list of potential trusts was also provided by the area approval process, based on

where responsible clinicians had been employed at the time of approval; CORC sent exploratory emails through their front desk enquiry systems. Interviews were then conducted over an eight-week period and included representatives of the following stakeholder groups:

- current RCs from different professional backgrounds (currently in a post)
- current RCs from different professional backgrounds (not currently in a post)
- team members working with RCs from different professional backgrounds
- RCs in training
- area approval panel members.

Interviews were conducted on the phone, lasted 30 to 45 minutes, and explored the following areas:

- impact on quality of service: patient outcomes, service user experience, personalisation of care
- impact on workforce: teams and team members, career pathways
- impact on organisations: recruitment, retention, key performance indicators (KPIs), budgets
- barriers, enablers and risks in implementing the approach
- identification of best practice.

4. Findings from secondary data and routinely collected data

4.1. The number and the characteristics of multi-professional responsible clinicians

Secondary data collected from the four England area approved panels (AAPs) sets out the number of RCs, as shown in Figure 1.

AC approval panel area	Psychologists	Nurses	Occupational therapists	Social workers	Total multi-professionals	Total number ACs (including psychiatrists)
North of England	21	12	0	0	32	1,755
Midlands and East England	5	6	0	3	15	1,785
London	3	0	1	0	4	1,538
Winterhead (S. East/S. West)	7	5	0	0	12	1,504
TOTAL	36	23	1	3	63	6,582

Figure 1: Number of multi-disciplinary and medically qualified RCs (as of July 2019)

Data recorded by the AAPs includes details of the trusts where a multi-professional RC was in post at the time of being approved. These trusts are recorded below:

- 2gether NHS Foundation Trust (now Gloucestershire Health and Care NHS Foundation Trust)
- Avon And Wiltshire Mental Health Partnership NHS Trust
- Cornwall Partnership NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust (now North Cumbria Integrated Care NHS Foundation Trust)
- Kent And Medway NHS and Social Care Partnership Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Oxleas NHS Foundation Trust

- Pennine Care NHS Foundation Trust
- Somerset NHS Foundation Trust
- St Andrew's Healthcare
- Sussex Partnership NHS Foundation Trust.

It should be noted that records are not maintained as to where responsible clinicians are placed or moved to subsequent to approval and so the above is not a conclusive list.

The research team also established that information about protected characteristics of professionals in these roles are variously:

- not gathered at all by the AAP
- not recorded in a consistent format that would enable that data to be extracted from records
- related to small numbers of staff, on the basis of which individuals could be identified.

In seeking to address this gap, research by Oates et al in 2017 (see References) was identified, which gathers demographics data. Oates et al carried out a survey of multi-professional RCs across England and Wales, and 39 responses (approximately 70% of those approved at that time) provided the data reproduced in Figure 2.

Participant demographics		
London	Male	51.28% (n20)
	Female	48.72% (n19)
Ethnicity	White British	89.74% (n35)
	Mixed	2.7% (n1)
	Other	8.11% (n3)
Education	Doctorate	64.10% (n25)
	Postgrad degree	30.77% (n12)
	First degree	5.13% (n2)
Professional background	Psychologist	64.86% (n24)
	Nurse	24.32% (n9)
	Social worker	8.11% (n3)
	Occupational therapist	2.7% (n1)
	Profession not given	5% (n2)

Figure 2: Demographic results from survey conducted by Oates et al (2017)

5. Quantitative data provided by trusts

The amount of quantitative data available to support the hypothesis that multi-professional RCs have tangible benefits is limited for the following reasons:

- The role has not been operational long enough to be able to see changes in traditional key performance indicators (KPIs). Trusts have also not started to look at their data this way.
- No formal 'outcome measurement', as is used in other areas of adult and children's mental health, is being used.
- Where measurement is in place, no differentiation is made between RCs with differing professional expertise.

Despite the difficulties, quantitative data was gathered from pilot projects in Norfolk and Suffolk NHS Foundation Trust (NSFT), Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). The results are summarised below:

5.1. Norfolk and Suffolk NHS Foundation Trust (NSFT) pilot results

The NSFT pilot took place between October 2013 and March 2015 with 15 patients in central Norfolk who had community treatment orders. All of the patients acted as their own pre and post control, comparing their data from before they fell under the care of the non-medical RC.

Number of bed days

Before the pilot, the 15 patients had in total used 2,065 bed days, which is an average of 137.7 days per patient. During the pilot period those 15 patients used a total of 85 bed days, which is an average of 5.7 days per patient.

Number of readmissions, revocations and recalls

Before the pilot, 14 out of the 15 patients had been readmitted, some more than once, therefore totalling 20 readmissions. During the pilot, one patient was readmitted on one occasion. There were two revocations and eight recalls before the pilot and none occurred during the pilot. The two revocations were for two patients and they used 50 bed days in total (included in the 85 bed days as stated above).

Accident and Emergency (A&E) treatment and admissions to general hospital

None of the patients visited A&E or was admitted to general hospital during the pilot. Before the pilot, five of the patients had visited A&E, totalling six times, and two were admitted, totalling three inpatient days.

Meaningful occupational activities

Before the pilot only one of the patients was undertaking meaningful activities for an average of 10–11 hours per week, compared to nine patients during the pilot for an average of over 12 hours per week.

5.2. Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) pilot results

In 2011 a multi-professional RC approach was piloted on a CNTW locked rehabilitation unit for males with learning difficulties. There were 18 beds on the unit and the multi-professional RC was responsible for nine out of 18 patients (the first cohort). A discharge pathway protocol was developed and implemented, the details of which are described in a 2017 study by Taylor et al (see References). The pilot then expanded the discharge pathway to all patients and over

a four-year period (2011–2015) the results were compared to the previous four years (2006–2010).

Discharges from hospital

Eight out of nine patients were discharged from the original cohort during the first 18 months of the pilot. Going forward across the four-year pilot, 37 discharges were made compared to 12 in the four years pre-pilot. Of those 37 discharges, three were readmitted compared to seven out of 12 discharges during the four years pre-pilot.

Mean length of stay

Of the original cohort, mean length of stay at the unit was nine and a half years. By the end of the four-year pilot the mean length of stay reduced to one year.

Incident rates

There were 262 incidents of PRN 'when required' medication being used during the four years pre-pilot compared to 160 incidents during the four-year pilot. There were 77 restraint incidents during the four years pre-pilot compared to 40 during the four-year pilot.

5.3. Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) pilot results

In 2016 a multi-professional RC role was implemented on a TEWV psychiatric intensive care ward. The ward had a high turnover of staff and patients reported feeling 'unsafe'. KPIs were

monitored between May 2016 and September 2017, and regression analysis was conducted to show trends over time, with the following results.

Incident rates

Incidents fluctuated from month to month, with the highest number happening in August 2016 (45) and the lowest occurring in May 2017 (nine). Regression showed an overall reduction from 41 to 11.

Feelings of being safe

Regression showed an overall improvement in patients feeling safe. However, the lowest points did occur after the start of the pilot (25% in November 2016) but this was following the months when incident rates had been highest. Feeling safe then increased to 100% of patients and remained at this level throughout the last 10 months of the pilot (March through December 2017) and was still 100% at a follow-up in February 2018.

Discharges

The number of discharges actually decreased. However, the number of transfers in and admissions also decreased. Therefore, the improvement was seen in occupancy, which reduced from approximately 80% to approximately 50%.

6. Findings from qualitative interviews

Qualitative interviews took place over an eight-week period. The 15 people who participated had a range of roles, including:

- current RCs from different professional backgrounds (currently in a post)
- current RCs from different professional backgrounds (not currently in a post)
- team members working with RCs from different professional backgrounds
- RCs in training
- area approval panel members.

The professional backgrounds of interviewees included registered nurse, registered psychologist, registered social worker and registered occupational therapist.

Interviewees were employed at the following trusts:

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Midlands Partnership NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Oxleas NHS Foundation Trust
- St Andrew's Healthcare
- Tees, Esk and Wear Valleys NHS Foundation Trust.

All participants were currently working in, or had a background in, forensic mental health, adult acute mental health or learning disability. There was a mixture of both community and secure facility experiences. None was currently working in child and adolescent mental health.

A number of key themes were identified by

respondents in relation to success factors, barriers, facilitators and effectiveness of the roles.

6.1. Characteristics of the careers of multi-professional RCs

Study participants were asked about the route they had taken to becoming a responsible clinician. Interviews explored participants' experience and background beyond the basic requirements of registration in their substantive profession and tenure in that profession.

The longevity and seniority of respondents' careers suggested multi-professional RCs tend to be experienced and well established in their profession. All respondents had been qualified/registered to practice in their chosen profession for at least 12 years before starting the approval process, and some had been qualified/registered for more than 20 years.

Some participants had master's degrees in their relevant fields of work or had taken on further education as part of their continuing professional development and stated that they felt that this gave them an advantage in certain skills required for a portfolio approach, such as self-reflection and evidence gathering. An example of this was a master's in mental health studies.

All participants had held at least one, or more commonly several, senior role/s in their relevant profession for at least seven years. Examples of these roles were service managers, ward managers, service leads and consultant or clinical level practitioners. In some instances, this was across more than one trust, or a mixture of community and secure facilities.

Some study participants were also qualified prescribers. They stated that, while not a necessity of the RC role, this was a benefit to

them in their role as an RC. Other respondents who could not prescribe felt this was a barrier. Interviewees explained that in situations when patients did require medication, the inability of an RC to prescribe could result in delays in the chain of decision making. For example, one stated: *“I’m not currently a prescriber. I have the support of a junior doctor and a consultant psychiatrist. If someone needs a medication review, I’ll request that. But sometimes that can take several weeks...I wish I could just get on and do that side of the job as well.”*

6.2. Motivations and drivers at a personal/individual level

Participants identified a range of drivers that might result in professionals outside of the psychiatry profession taking up the role of responsible clinician.

Increase pay and responsibility

Participants said that they were motivated by the opportunity to move into a higher banded position with more responsibility and saw this as a contribution to their ongoing professional development. One stated: *“It’s helped to reinvigorate my passion for what I do. It’s been a real positive step for me and my career.”*

Maintaining clinical identity

A key benefit identified by some participants was the opportunity to *“maintain [their] professional identity while being in a more senior position”*. They felt that traditionally more senior roles could involve practitioners becoming more removed from patients, taking up more managerial responsibilities and less ‘clinical’ responsibilities. For example, one interviewee said: *“When you work for so long, you get to a point where the kind of only opportunities are management...I wanted to get back to the clinical work. This has given me a real opportunity without having to go*

back to where I started. It’s another step up but it’s getting back to clinical work...I don’t manage anybody anymore...I just work with patients.”

It is therefore clear that this route offers both intrinsic and extrinsic rewards, such as job satisfaction and better remuneration, to those who do not want to pursue more traditional management roles.

6.3. Motivations and drivers at the trust level

The interviews were used to explore the factors informing trusts’ decisions to open the position of RC to practitioners who are not from a psychiatry background. Several interviewees had been instrumental in developing the multi-professional RC role within a trust, for example identifying a need for this role, structuring the position, or being the first to occupy the post. Other participants had taken up the role at a later stage. This allowed for multiple perspectives on organisational drivers.

An opportunity to improve the model of care

In some contexts, participants reported that a senior colleague (for example, a clinical psychologist, clinical psychiatrist, clinical lead, senior medic or director) had identified a gap in current provision or an opportunity to improve the model of care. Some participants referred to a motivation to become more patient-centred and to fully adhere to the Mental Health Act code of practice, which states that a trust must ensure that patients have an RC with the appropriate skills and knowledge to meet their treatment needs: it was suggested that where this was not being supported, the trust had an obligation to consider the potential contribution of other professionalisms. As one participant explained: *“The responsible clinician for any detained patient should be the responsible clinician who has the appropriate set of skills to meet the patient’s main treatment needs. [Trusts] should have a*

pool of approved clinicians, from a range of professions, and each patient should be thought of by their particular presentation, treatment and need – and then, as best as possible, match a patient presenting difficulties with the RC who has the most appropriate skills. For example, someone who is presenting with predominantly psychological needs would be matched to a psychologist, while someone with rehabilitation needs would have an occupational therapist.”

Challenges recruiting psychiatrists

The majority of interviewees felt that there was a national shortage of psychiatrists, with the impact of this considered to be more acute in some regions. Participants said that where there were challenges locally in recruiting psychiatrist RC roles, the opening of the role to other professional groups provided an opportunity to broaden the potential recruitment pool. Participants stated that “there is a lack of psychiatrists and plenty of work to go around” and “we were all thinking on our feet a little bit and looking at more creative ways that we could bridge gaps”.

Budget pressures

Participants also stated that in some trusts introducing a wider range of professionals to the RC role was a response to demand pressures and budget constraints. One participant said that “in some ways, a shortage of money was a driver for my post”. This environment raised a need to deploy resources differently. A view was taken by some that services could employ more multi-professional RCs (for example, two full-time equivalents) for the cost of one psychiatrist RC. One interviewee said: “If there was a way in which the operational aspect of an organisation saw they have a workforce problem that can, in part, be resolved by new roles, that would be good...For example if we don't have enough consultant psychiatrists [ask] what part of the job

could be shared with someone else...there's an aspect that a psychologist could do...an aspect that a nurse can do.”

6.4. Advantages and disadvantages of different implementation strategies

Once the need had been identified and the decision to extend the RC role to multi-professionals was made, different approaches to implementing that strategy were developed. The approaches used fell broadly into three types. Participants' responses suggested each had varying benefits and disbenefits. More detail on each of these approaches has been attached as case studies in Appendix A.

Approach 1: Generating a bank of RCs

In this approach, a pool of people from within the trust with different professional backgrounds were supported and funded to become RCs. Participants described how they were able to build their portfolios and attend relevant training, but added that, once they had achieved approved status, there was not necessarily a post to go into. Therefore, the trust had built up a potential ‘bank’ of employees with the relevant skills, ready to occupy posts when they were created.

This approach was described as having two main advantages. Firstly, it built up a pool of relevantly skilled individuals, ready to be deployed as the need was identified. Secondly, the larger numbers recruited onto the cohort to begin with compensated for any attrition throughout the approval process. In one example shared by an interviewee, of 20 people who began the journey to approval, two had been approved to date, and others had pulled back from the process. In another example, of six people who had started training, two had been approved and four had stopped working towards approval.

A disadvantage of the approach was considered

to be the delay in putting people into post. As one participant said: *“So I’ve got my approval and now we are thinking ‘Where am I going to be?’”* This delay prevents new RCs being able to apply their experiences while still fresh from gathering evidence and increases the risk of these staff leaving for already established multi-professional RC roles if they became available in other Trusts.

Approach 2: Recruiting directly to a multi-professional RC role (with development ‘in role’)

Participants described how trusts taking this approach had in some cases created a role and recruited someone directly into it who already held the qualification, or in others allowed someone to ‘train up’ once appointed to the role.

An interviewee recruited through this route explained: *“I am employed in my role now [as a non-medical RC in training], so I’m not doing this on top of a different role. [I’ve been allowed] to start and dedicate my time to developing the competencies and working in a way that will be expected later on, down the line.”*

Another participant who was not operating under this model shared a view as to its advantage. They said: *“It would be better if this was a training and development post...where someone was doing that full time and could concentrate on things and actually see the patient journey through from start to finish while being under supervision, it would be so much better and so much safer.”*

Another echoed this view, saying: *“[We] might think about doing it a different way around in the future, where [we] identify the need first and set up more of a training role so it makes the deployment more streamlined.”*

A further benefit identified in having a dedicated role, and recruiting or training someone straight into it, was that the process is potentially quicker due to the focus they can bring to it.

A practitioner explained that *“to complete a portfolio as a busy [practitioner] in a busy team is going to take you eighteen months to two years to do when you are doing it part time and in your own time”*.

Approach 3: Piloting the role

In these instances, trusts have tested the role in a small area as a ‘pilot’ or ‘feasibility’ study. This has been done ‘without prejudice’ so that the role could be trialled without making fundamental changes to terms and conditions, allowing both the trust and the individuals occupying the role to return to original ways of working if the study was not a success. One representative of such a trust where this has happened said that *“just because it works in one part of the organisation, in one service area with one particular client group or patient population does not mean it is going to work in another part of the organisation...you have a rolling programme of field tests. You build momentum”*. They also explained that it helps all parties, sceptics included, to be involved and have a say in the end result: *“If you’ve got people on the ground who are wary, you can say to them...part of the field test is we will evaluate benefits. Pros and cons. If you and others...feel this isn’t beneficial, that will be taken into account as part of the evaluation.”*

6.5. Key enablers and barriers to implementing a multi-professional RC role

Examples given previously around the different approaches demonstrate that there is sometimes attrition between the start of the approval process and the point of completing and becoming approved as an RC. The reasons for attrition are varied, with influencing factors both in and outside the control of the trust. Interviewees indicated that successful implementation of the multi-professional RC role also presented challenges. Interviews explored factors that had

helped or challenged participants both in the approval process and in role, as well as their suggestions as to how these might be addressed, and processes improved.

Enabler: Support of senior managers

All participants reported that support at a senior level (at board or director level or in the form of a senior clinical lead) was a crucial success factor. This support was needed for:

- funding for training and to complete the approval process to be released (either at a trust budget level or at a local team/directorate level)
- a strategic-level deployment plan to be developed, taking into consideration the need across wide geographical and directorate areas
- easing the path to obtaining buy-in from other colleagues across the trust, cutting through lower-level debates and potential arguments about roles and responsibilities. Examples are given further in this section.

One participant emphasised this, saying: *“It was very new...there were a lot of central [trust] processes that it had to pass through...There is a lot of change of personnel in a trust, which holds things up, so you get different opinions from different senior people.”*

Enabler: Access to a mentor

A key requirement in meeting the approval criteria is being able to shadow and receive mentorship from a current RC to gain experience, knowledge and understanding of the role. In most trusts there were either limited or no other multi-professional RCs available and so the main mentor would be in the form of a psychiatrist RC. This is a time commitment that the current RC needs to make, very much like taking on an apprentice, as they will have to explain rationale for decisions, provide guidance and feedback, write testimonials and produce paperwork to support the application.

Where this had happened well, interviewees described how this support and guidance had been a major enabler. One interviewee explained that *“you are going to be working alongside consultant psychiatrists. Their knowledge and skills are absolutely critical to me in terms of having people I can speak to and have supervision with”*. Conversely, where this hadn't happened it became a barrier. For example, in one trust, several people who started the journey had to suspend their pursuit of approval because they could not find anyone willing to mentor them.

Some participants said that challenges in identifying a mentor were caused by limited capacity among current RCs. In other cases, participants felt that current RCs had reservations about the role being taken up by staff from outside psychiatry and had concerns about the potential implications for the profession.

When asked to expand on the reasons for not being able to find a mentor, the answers included capacity issues but also alluded to those with the capability to support not agreeing with people from different professional backgrounds being able to hold the position of RC; they were potentially fearful of what this could mean for their own profession. A participant hypothesised that *“[it] potentially has implications for some of the existing roles. People get a bit nervous about that”*.

Barrier: Time

In order to collect the evidence against each of the competencies, there is a time commitment that needs to be considered. There was a mixture across the interviewees of those who had been given time away from their substantive posts to gather this evidence (for example, shadowing in another team) and those who had incorporated addressing these requirements into or around their current role. The responses showed that, where time had been given by the trust, this

was seen as more of an enabler and not doing so could prolong the process. One participant commented on the length of time taken to complete the approval process and said that "... you've got to do it alongside your day job...I can't imagine anyone doing it in less than two years. Eighteen months if you really slogged it...I did it in my own time".

Another stated what impact it had on their working hours: *"I think it was definitely, definitely time. Because I was still working in my substantive role, and trying to submit this as quickly as possible, which was my choice, but I was probably working 75 to 80-hour weeks."*

Enabler: Clarity on what is required as part of the portfolio

A common theme from interviews with those who had completed the approval process was the work involved in building the portfolio of evidence required for accreditation. Participants commented that more evidence is required from those from a multi-professional background than is required from psychiatrists. This was also recognised among participants who had been through the process and now sit on approval panels. This is not necessarily a bad thing, but it perhaps does give an idea of why it can take up to three years to gather that evidence (it was noted that anything older than three years cannot be submitted and so three years really is the longest it could take).

Interviewees also reported a lack of clarity around expectations when submitting the portfolio of evidence. One stated: *"It was a bit of a scatter gun approach...it's like knowing the sort of things that are required but not knowing exactly the sufficient depth and breadth of evidence that was required...If I were to do it again now, less than half of the amount because I know what is required."* The same interviewee commented on the process of collecting evidence and how

burdensome it can be during times of austerity; *"it's about what you can achieve in a post austerity workplace...and how we can pull out evidence from the work we are already doing..."*

An enabler to this is that the people who have been trailblazers for their profession in becoming an RC have a wealth of experience around the portfolios and have made it slightly easier for those now following because there is a benchmark for others to work to. One such person, who was the first in their profession to become approved said: *"I think it would be very different because I sit on the panel now and I think [regulatory body] would most likely come to me and ask me to have an overview of the portfolio. They'd also have some baseline to work from. I think the difficulty was there just wasn't that baseline to measure me against."*

Enabler: Support of staff from the wider team

Staff being aware and supportive of having an individual with a different professional background in the RC role was identified as an enabler by participants, both during the approval process, and even more importantly once the RC was in role, to facilitate efficient and effective working practices.

It was acknowledged that these roles cannot work in isolation and need to be part of a collaborative approach that factors in opinions and expertise from wider team members. Ensuring the teams work cohesively seemed to be aimed at reducing frictions around decisions and ensuring those decisions would be actioned; it was described like this: *"Having a relationship with other members of the team is actually really important...we need to be able to discuss and share ideas. A lot of the things we are discussing and agreeing and talking about need to be actioned on the shop floor...having the team on side is quite vital really."* Another participant said

that *“if you want to be taken seriously and you want people to respect your decision making, you have to invest time in building relationships”*.

Barrier: Lack of understanding of the RC role by colleagues

A lack of understanding from other staff members was identified by participants as both a cause for frustration and an area of potential risk. There is robust legislation around the role of RC and any erosion or subversion of its responsibilities risks breaching this legislation. Examples of where this had happened were given, such as a consultant psychiatrist, who was not an RC, superseding the decision of the appointed RC by revoking the patient's community treatment order as they believed their authority was higher. Another example demonstrated where the lack of understanding had affected the ability of the RC to fulfil their role and was described as follows: *“Something else I've learnt more recently...the automatic behaviour is always to revert back to the psychiatrist. That's been an interesting learning experience for me, because what I was finding was, as soon as there was any problem, [the care coordinator] would go straight to the psychiatrist...so I've had to sit down and almost educate [them] and to say, I need this information, you can't bypass me because I need to decide whether I'm going to recall [the patient] to the hospital, it's not the psychiatrist's decision to make, it's mine. Without throwing my weight around, but it's just about educating other colleagues you're working with.”* One participant explained how it affected their capacity *“...because it's new, I don't think a lot of senior colleagues know what it is either...the [team member] still sees me as the ward manager or as an extension to the ward manager post, so almost thinking I will pick up things that the ward manager [would], when actually I don't have the capacity to do that”*.

Barrier: Lack of financial incentive

A personal driver identified by interviewees in pursuing the role of RC was the ability to achieve a higher banded pay. Others identified that practitioners already working at a consultant/senior level may not be driven by this as they are already achieving the highest banded salary possible. In these cases, participants suggested that taking on the extra responsibility and risk associate with being an RC would not be appealing. One stated that *“if there is no financial incentive why take [extra responsibility] on?”* while another echoed that view, *“if you are talking to people who are already consultant grade they will say ‘Why would I do this when I am already paid XXX. Why would I take on that additional responsibility?’ There is no motivation to do it”*.

The potential to overcome the issue of pay, by changing employment terms and conditions at the consulting/senior level was explained by one participant, *“this is part of a consultant level job, it should be part of a consultant job description ultimately, which it is now. Any new appointments at consultant grade, it says in their job description [that they are] expected to undertake the preparation for [approval] and be deployed as such”*.

Barrier: Lack of support from regulatory bodies

The nature of the role of RC means that there is a level of professional risk associated with the decisions being made about the patient's care. It was stated that the regulatory bodies for non-psychological or medical professions – such as the Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) – are not as aware of, or do not have an understanding of, the RC role to degree that the General Medical Council (GMC) does, and so do not offer as much support. Participants explained that this may be a

barrier and cause reluctance to take on the extra risks required by the role because individuals do not feel like they would be supported by their regulatory body should they make a mistake or a wrong decision. A participant explained how this lack of understanding slowed down the approval process: *“I think it was predominantly because I was the first...there was a bit of uncertainty from [my professional regulatory body], it wasn’t something that they were terribly familiar with. The [approval panel] went to my professional body to ask for their endorsement...It was just unfamiliar territory, really. There was some anxiety about them endorsing me.”* Another explained their own anxieties around this lack of support: *“I do worry that the NMC would not provide the same protection as the GMC provides for doctors. As an RC you are expected to make some really big decisions and you’re taking on a huge amount of responsibility. I worry that the NMC does not support nurses as the Medical Council does...That’s a big worry...”*

Barrier: Lack of recognition from supporting/ professional bodies

There was discussion by most participants about the lack of knowledge of the RC role held by the organisations and bodies that supported their substantive career path (such as the Royal College of Nursing and Royal College of Occupational Therapists). It was explained that this reduced the possibility of others pursuing the career as an RC because this career trajectory is not clearly demarcated and so people are not aware the roles exist. Someone who now holds the position of RC mentioned that they became aware of the possibility through discussion with medical colleagues later in their career and they retrospectively thought it had affected their development: *“I think, looking back at my career, if I was made aware earlier of different opportunities where I could be clinical expert/consult or whatever, I think it does change your professional development activities.”* Someone

else went on to say it is also a hinderance because, once individuals are aware, they are not sure how to start the process. Someone who isn’t currently an RC said: *“It would have been something I would look at, consider in the future doing but I wouldn’t know where to start to look...how to commence on a course, how long it takes, what funding is available, I wouldn’t know where to look. I haven’t seen this advertised anywhere.”*

6.6. Benefits to patients in having a multi-professional RC

Participants previously identified that one of the drivers for implementing multi-professional RC roles is to improve the care received by the patients. Interviewees were asked to identify and describe perceived benefits to patients.

Views varied during the interviews about how much of a tangible benefit there should be because to expect this is potentially inferring that the traditional approach to the RC role is inferior (or vice versa). It was suggested that, as the ultimate purpose of extending the roles is to be able to provide patients with the most appropriate skills to meet their treatment needs, the ultimate measure of this is whether the patient’s needs have been met.

Participants perceived the role to confer the following benefits.

Enhancing the collaborative approach

Multi-professional RCs are not introduced to replace or be better than psychiatrist RCs. Every profession has strengths and limitations and so, from a patient perspective, any RC position works better when part of a collaborative approach. An example of this was explained like this: *“Myself and medical colleagues, we have a very different way of looking at things. I’m better at thinking about the more holistic approach to someone’s*

care...having an emotional intelligence. Whereas medical colleagues have their own skills, not just around diagnosis but the capacity for recall and thinking through the process is just amazing. I think that's good, I think that's something that should be celebrated."

More personalised care plans

It was also elucidated that the diverse nature of the different professional backgrounds resulted in more personalised care plans and treatment. As one participant said: *"I've got a lot of experience in terms of care management so I can think about the bigger picture. It's not just about medication. It's more about the management of the whole person."* Another said: *"just from the training that [my profession has]...the focus is very much on positive risk taking and...on people's recovery. The extent of their recovery might be somewhat limited but it's about working with people and especially with carers and families."* A third confirmed this thinking by saying: *"I think we are able to talk beyond the diagnosis...looking at ways that we can perhaps more laterally benefit patients, kind of through activity coordination, through looking at family and carer involvement further down the line."*

Patients do not perceive a difference in the care they receive

Finally, several of the participants held the view that patients don't differentiate between the people in the role as long as it is meeting their needs; they don't feel like they are getting second best even when it is explained that they are not seeing a 'doctor'. One explained how the patients will use generic terms and not differentiate: *"The communication has been a bit of a difficulty. Certainly, in the first instance...a lot of patients...automatically referred to me as doctor."*

6.7. Benefits to the wider team members

The mix of interviewees meant that the perspectives of both the RC in post and those who are working alongside the RC were represented. The view of all was that there are benefits to team members as well as patients. Specific benefits identified include the following.

An increase in resource

They felt that having a multi-professional RC was an increase in resource and a better use of everyone's time. *"It frees up the ward consultant to consult...in terms of the more complex medication and physical health issues, [they are] able to think about more."*

Better collaborative working

The multi-professional RC role was viewed as improving collaborative working; team members felt more listened to and perceived to have a better power balance. One participant explained that listening to each other made practices safe: *"The fact that junior staff are able to be more supported and have more of a shared decision making in terms of risk management means that practices are safer. [They] have a point of contact that's available pretty much every day of the week."* Another, who is not an RC, but works alongside them, stated: *"The approachability...there's a lesser power imbalance...there's more of a collaborative spirit along the way."*

Highlights different career pathways

The majority commented how the role helps to demonstrate there is a different career path and those who are interested feel more motivated to develop professionally as there is something at the end of it. Someone stated: *"Once there are three or four of us [in post] particularly as we're coming from different disciplines and working in different areas and in different ways...it will instil a little bit more confidence in people that are interested in applying for the course but don't necessarily want to be stuck behind their laptops...think there is nothing at the end of it."*

7. Discussion and conclusion

CORC has considered the findings from both the qualitative data gathered from secondary sources and the qualitative data gathered through the interviews and has drawn the following conclusions and points of discussion.

Number of approved RCs

Data about the current number of multi-professional RCs was sourced from the four England area approval panels (AAPs) and demonstrated that the proportion of multi-professional RCs remains low in comparison to the proportion of psychiatrist RCs (at less than 1% of the total RC workforce). Of those who have made it through the process to approval, the majority are registered psychologists (57%), followed by registered nurses (37%), while a very small number are registered social workers and occupational therapists (OTs). This highlights that, even within the multi-professional RC grouping, there are some inequalities that may need to be addressed.

Results from quantitative studies

The research explored quantitative data collected by trusts that have extended the RC role to a multi-professional workforce, reviewing the available evidence to consider the impact of the approach on efficiency, experience of care and outcomes for organisations, staff and patients.

The data located was relatively sparse and originated in a small number of trusts and is not yet able to conclusively demonstrate value added by this approach. Findings from qualitative interviews with practitioners from those trusts also suggested that individual skills – namely working collaboratively and a person-centred approach – play as important a role in accruing these benefits as the professional background of RCs.

The quantitative data provided by the three trusts shows positive improvements in KPIs and suggests significant benefit to the patients, yet from a research and review perspective, there are some caveats or cautions that CORC recommends be considered alongside this data.

Predefined vs retrospective metrics

In all cases, it was not made clear if the metrics were agreed before the pilot began or whether they were gathered retrospectively once the pilot/feasibility study had ended. This is an important distinction as there can be a tendency to look for those metrics that report favourably, and those that do not meet the hypothesis could be overlooked.

Wider metrics

No wider metrics have been looked at to explore if improvements in these KPIs (such as discharge rates) have caused any dispersed effects in other areas of the trust, or even secondary services. These effects could be positive or negative.

External evaluation

It appears that the analysis of results or evaluation has been carried out by staff internal to the trust and even internal to the team where the pilot happened. Robust evaluation is often carried out by an external body; this has the benefit of making the results more objective.

Causal links

There does not appear to be a clear causal link between the introduction of specifically a multi-professional RC and the improvements. For example, was it because the role was multi-professional or was it because it was a much-needed extra resource? Or was it because the role was multi-professional or because general processes and procedures had been improved?

Qualitative findings

The qualitative interviews, which took place over eight weeks and gathered views from a sample of 15 participants (including current multi-professional RCs, AAP members and fellow colleagues), highlighted three approaches taken by trusts in introducing the multi-professional RC role (see case studies at Appendix A), and explored the enablers and barriers that can influence the success of implementation.

Enablers and barriers

Once all interviews were synthesised and common themes identified, more barriers were highlighted than enablers.

The enablers identified centred on practical support, including allowing time to gather evidence and having the support of a mentor and colleagues. The barriers identified extended to cultural and historical factors, highlighting the impact of the embedded attitudes and behaviours and knowledge base of internal and external stakeholders such as fellow psychiatrist RCs or supporting bodies such as the Royal College of Nursing. By the nature of those barriers they are much more difficult to change and therefore drivers at a national policy level should be looked at; for example, working with Health Education England to get this on its agenda for change.

Language used around the role

During the interviews, the terms 'non-medic responsible clinician' and 'medic responsible clinician' were used. It was highlighted in later interviews that the use of these terms, in and of themselves, maintains the myth that there is a difference, be it positive or negative, between multi-professional and psychiatric RC roles. The perceived differences seem to be very much rooted in the traditional feelings that the 'medic' is still the highest authority. Certainly, from a patient perspective, to explain the role in such a

term may lead them to the assumption that they are getting a lesser service in some way. Status, or the perception of status, can lead to unhelpful behaviours in both staff and patients.

Key traits of the individual in the RC role

It was clear that approachability and collaborative spirit were key ingredients to the role being accepted and seen as beneficial by team members. However, it is not clear if this was because of the professional background and having a multi-professional approach, or down to the skills and personality of the individual occupying the post.

7.1. Strengths and limitations

The strengths of this study lie in its systematic collection and analysis of rich, in-depth qualitative data, by an independent evaluation team outside of the services concerned, about the experiences and perspectives of professionals

However, the findings of the study should also be considered within the context of the following limitations. Participants were those who volunteered to participate in the research, and direct approaches were made to interviewees with a relevant perspective who were known to the NWSDU. By the nature of how they were engaged, and due to being in those trusts where the multi-professional RC role has been implemented, it is possible these interviewees were predisposed to be more engaged and to have specific perspectives. Therefore, the degree of transferability of the findings of the evaluation to other multi-professional RCs, or to other trusts, is unknown. Limitations and variations in the quantity and quality of data collected about the characteristics of RCs, and about service impact, has also limited the extent to which generalisable conclusions can be drawn in this area.

The study has not been able to access and take

into account the views of service users due to the limited timeframe of the study. In a future evaluation, it could be of value to access the views of patients, and in this light, it is noted

that some interview respondents felt that alerting patients to differences in the professional backgrounds of RCs would need to be carefully handled to avoid causing unnecessary concerns.

8. Acknowledgements

CORC would like to thank those who took part in the interviews and gave us their thoughtful, detailed and interesting responses to the questions. There was a mixture of staff based within trusts and those who hold positions on area approval panels. A list of those trusts where staff took part is as follows:

- Avon and Wiltshire Mental Health Partnership NHS Trust Midlands Partnership NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

- Nottinghamshire Healthcare NHS Foundation Trust
- Oxleas NHS Foundation Trust
- St Andrew's Healthcare
- Tees, Esk and Wear Valleys NHS Foundation Trust.

CORC would also like to thank the area approval panels for providing us with the data around current approval figures. This was extremely helpful to us being able to identify trusts to engage with as well.

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Appendix A: Case studies of different approaches

Approach 1: Nottinghamshire Healthcare NHS Foundation Trust – encouraging a cohort of approved clinicians

About the trust

Nottinghamshire Healthcare NHS Foundation Trust is a major provider of mental health, intellectual disability and community healthcare services for the people of Nottinghamshire. It sees about 190,000 people every year, employs around 9,000 staff and has an annual budget of over £400 million. With that the trust provides services across the county for people with mental health needs, with needs relating to drug or alcohol dependency, mental and physical health services for people with intellectual disabilities, and community physical healthcare. It also provides secure mental health services.

The approach

In October 2017, a strategic decision was made by the trust to fund up to 20 practitioners from across different teams, and within agency partners, to attend a five-day course delivered by Northumbria University and gain a postgraduate certificate in mental health law. Staff who were working at a senior level (band 8a upwards) were asked to submit an expression of interest to a panel and attend an interview. As part of the process, candidates had to detail how they would gain the evidence needed to complete the portfolio and have agreed support from a colleague to mentor them, and also give thought to how they would be deployed in their area. The trust had not, at that time, created any positions where the multi-professional RCs would be deployed but wanted to have a cohort approved and ready to go into position when the opportunity arose.

Once the cohort was agreed and they attained the postgraduate certificate, they could then begin to collect their evidence for demonstrating the eight competencies. There were different approaches to this and while some were released from their role for an agreed period each week (for example two days), some had to gather their evidence in their own time. For example, one person spent six hours a week, on top of their substantive role, attending the wards and shadowing the doctor who was their mentor.

The outcome

Out of the 20 people who were recruited to this cohort, there was some attrition; two people have achieved approved status so far and another three are on track to submit their portfolio to the approval panel. Fifteen have not gone on to complete their portfolio and will not become approved. This has happened for many reasons, some outside the control of the trust (such as moves out of the area and personal reasons), but also included: struggling to secure a mentor; plans falling through with the agreed mentor; and not having the capacity or time to obtain the necessary evidence.

Of the two people who attained approval, one was tasked with creating a post, has piloted the role in a locked rehabilitation unit and was in post February 2020. The other is awaiting suitable deployment and a potential position has been identified in another area of the trust. Both received approval within 18 months of attending the Northumbria University course.

Learning

The main learning from this approach can be summarised in three areas.

Being given time

The time required to collect evidence appears to be a potential barrier. Although some people have been successful while taking time to do so on top of their substantive role, the person who was supported to gather evidence as part of the working week felt this was a preferred approach, as it made it much more manageable and lead to a better work–life balance.

Having a mentor

Having a mentor in a suitable position and who has the capacity to support is essential; a mentor should be identified before a candidate's entry onto the formal postgraduate certificate course as this is a potential waste of a resource should that person not be able to go on and be mentored.

Having a position to go into

Not having a position for someone to go into once approved was described as “messy”. With the next cohort, clinical directors are considering identifying the need first, and then setting up a training role to develop someone into the position.

Approach 2: Avon and Wiltshire Mental Health Partnership NHS Trust – creating a non-medic RC in a training role

About the trust

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) provides inpatient and community-based mental health care for people living in Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. It also provides specialist services extending throughout the south west.

It employs over 4,000 members of staff who deliver services from more than 90 locations, working in approximately 150 teams across a geographical region of 2,200 miles, for a population of approximately 1.8 million people.

The approach

There is currently one multi-professional RC working at AWP, as part of the secure services directorate; this post was developed locally by secure services and was not part of an overarching trust strategy. However, the role is felt to have been successful, with staff reporting benefits to both patients and fellow staff in taking a multi-disciplinary approach. Because of this, a real interest has been shown by other areas and now a trainee position has been created within one of the psychiatric intensive care units.

The creation of this role was led by the consultant psychiatrist on the ward, who recognised that there was a need to have complementary skill set to work alongside the psychiatry element and look more at care management. The recruitment to this role was through a competitive process; candidates were asked to lead a focus group of stakeholders from across the site (including senior nurses from both community and inpatient settings), and they then attended a formal panel interview.

The role was designed to be a development position and therefore the successful candidate would hold that position as their only role. There is no expectation on timescales to reach approved status.

Outcome

The successful candidate is a mental health nurse and has worked in psychiatric intensive care for over 13 years. They have been in post since March 2019 and they are also working towards achieving their medical prescribing qualification as this has also been written into the job description.

At present, they are hoping to have gained approved status within 12 months (by March 2020) and feel that this is realistic due to the support and time given by AWP and in particular their consultant psychiatrist mentor.

Learning

While this role is ongoing and approved status has not yet been reached, there is already some learning to be shared from this approach:

Relationships and support are crucial

Having the right support and relationships in place is critical. In this case, the relationship with the ward manager and the consultant psychiatrist has made almost a “triumvirate” that role models a good approach to senior clinical decision making. Another trainee role was developed elsewhere in the trust, but this was abandoned as there wasn’t the support network (such as consistent access to a consultant psychiatrist), leaving the post very isolated and vulnerable.

Linking up with those already in the multi-professional RC role

Being able to link to and be supervised by a multi-professional RC already in post has been incredibly helpful. One of the difficulties of the ‘non-medic’ RC position is that there is sometimes confusion around what the role can and can’t do and it’s only once someone starts the journey that it gains clarity. Having someone who has already been through the approval process, and is working in that new way, helps to manage expectations and offer guidance on the best approaches.

Other staff’s understanding

Other people not understanding the role is a risk. If staff are unclear on the purpose of the role, they may try to pull the RC back into other tasks, leading to frustrations for all parties. This can be overcome by building relations with wider team members and ensuring there is a collaborative approach to decision making around care management.

Approach 3: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) – taking a feasibility study approach

About the trust

The trust works from more than 60 sites across Northumberland, Newcastle upon Tyne, North Tyneside, Gateshead, South Tyneside and Sunderland. It also runs a number of regional and national specialist services. The trust has more than 6,000 staff and a budget of over £300 million. The services are divided into four sections, which are organised geographically into ‘locality care groups’. These are known as North, Central, and South and North Cumbria.

The approach

CNTW had among the first individuals in the country to secure approval as RCs from a multi-professional background. Their work on gathering evidence and demonstrating the competencies as set out in the legislation became the new roles format and developed the approach so that all responsible clinicians, whether psychiatry or multi-professional based, have to provide the same evidence.

Those same individuals, once approved, wanted to prove that the multi-professional RC role could work and so wanted to trial the approach in one area of the trust. They considered which population it was most likely to work for, where psychologists and nurses had more power, and where it was not going to intrude too much on psychiatry colleagues’ responsibilities.

They chose an 18-bed locked rehabilitation unit, located in the forensic unit, which was a specialist secure unit for supporting males with intellectual disabilities (ID).

All of the staff who took part took on the extra responsibilities of the RC role ‘without prejudice’. This meant that human resources (HR) did not

need to be involved in amending terms and conditions and that, should the feasibility study not work as planned, everyone could return to business as usual with no consequences.

Key performance indicators (KPIs) such as discharges, mean length of stay and incidents were monitored over four years between 2011 and 2015.

Outcome

The feasibility study proved to be a success and there were some measurable improvements on the ward. For example, discharge rates increased, readmissions after discharge decreased, mean length of stay decreased, and the number of medication and restraint incidents reduced.

Because of this success, the board endorsed other areas of the trust to implement the role of multi-professional RCs. Teams make a case for their own need and also find the funding within their own budgets for the training and development into the roles. However, terms and conditions more generally across the trust have been changed at the consultant level as now it is in their job description that the person is expected to undertake the preparation to become an RC and to be deployed as such.

According to the AAP data, there are currently 19 multi-professional RCs within CNTW.

Learning

There has been some tangible learning from taking a feasibility study approach, which other trusts may consider.

Board-level support

Having buy-in at board level was crucial to the success of the pilot. Where resistance may have been found in the field, having the high-level support could cut through that and make it less of an 'us vs them' scenario.

Test and learn approach

What works for one area of the trust may not work in another area of the trust. With the diverse nature of the services and care models, it is important to test the approach in every new area to see that it works before committing to that way of working. Being able to measure any improvements during the feasibility stage helps to make the decision at the end.

Having a 'without prejudice' clause

Taking on the RC role 'without prejudice' meant that it was a win-win situation for everyone involved. If the study did not work, individuals could walk away from it and return to normal practice and substantive roles; there was no risk of redundancy or drops in pay. Not getting HR involved early meant avoiding potentially lengthy processes; they could get on with delivering the feasibility, seeing if it worked, and then amending terms and conditions once it did. The only caveat to this is that everyone involved needs that understanding and needs to be comfortable with that approach.

Professional focus



Professional case study examples	35
Approved clinician core competencies	43
Expert advisory group membership list	45

Professional case study examples

Good practice case study questionnaire

Job title	Clinical Psychologist
Service worked in/Department	Adult Mental Health Services

Please provide a summary of the example of good practice you believe has supported you in obtaining and retaining Approved /Responsible Clinician status

- The most significant factor in enabling me to achieve my AC approval was the desire the Trust showed to support this initiative and increase the number of multi-disciplinary ACs within the Trust. This falls in line with several other ongoing Trust initiatives including the development of more trauma-informed services. This desire meant that senior managers supported the development and funding was identified to enable several cohorts to access training courses relevant to the AC role.
- I was supported to undertake my training to become an Approved Clinician by my line manager, senior managers within the Trust and several local Consultant Psychiatrists (one attached to the inpatient ward, one attached to the local mental health team, one attached to the crisis team). This enabled me to get a wider experience of the Mental Health Act in practice than my current role would have allowed. Gaining this experience relied on the positive relationships I had with Consultant Psychiatrists in my locality and the willingness of these professional to support me. This was achieved through spending time explaining the role and how this would fit alongside existing AC provision (rather than replace this) as a way of promoting patient choice and wider multidisciplinary perspectives for challenging patient groups. These conversations clarified the benefits of multi-professional ACs for effective care pathways and enabling professional experience to be used and directed most effectively.
- I was released for two days per week for 18 months to develop my AC competencies, which helped me to gain broader experience than I would otherwise have been able to, and also enabled me to develop my portfolio (although I still worked on this in my own time).

Professional case study examples

Good practice case study questionnaire *continued*

What have been the key enablers in you becoming an Approved Clinician?

- Support, engagement with, and working collaboratively with my line manager, senior managers, and the lead Consultant Psychiatrist in the area, who also supported the other Consultant Psychiatrists to offer me experiences, supervision and mentoring. This collaboration utilised the existing positive working relationships I had developed over many years.
- Having time released from my day job to focus on this training and portfolio development was key. Although my time was not backfilled, adjustments were made in light of this training that were supported by my line manager.
- Seeking out and range of experiences (e.g. visits to the Mental Health Act office, shadowing AMPHs and Consultant Psychiatrists on initial detention assessments, community and inpatient work experience opportunities) to demonstrate a depth of applied knowledge was helpful.
- Mapping my skills, knowledge, and role responsibilities against the Agenda for Change Consultant Psychologist skills and knowledge framework enabled me to demonstrate the level I was working at as this was not reflected by my out-of-date job description.
- Using the BPS peer scrutiny process to help identify areas that may be lacking or need additional evidence before submitting my portfolio to the approvals panel was helpful as I included this review in the portfolio and explicitly identified how I had addressed the issues raised.
- Attending an AC workshop delivered by the regional approvals panel to inform the structure and content of my portfolio (in addition to the AC Induction mandatory training I attended) helped me to clarify how to structure the content of my portfolio and what to consider.
- Accessing mentoring sessions with a psychologist AC who had been through this process several years before me also helped me to consider the content and structure of my portfolio.

What have been the key challenges in you becoming an Approved Clinician?

- Not holding a post as a Consultant Psychologist (as these posts have been cut within the Directorate) and so trying to demonstrate the consultant-level working I have been doing in ways other than through my job description. Explicitly referring to how additional roles and duties link with the Agenda for Change Consultant Psychologist profile helped with this.
- The Trust not having a clear picture of how to effectively deploy Non-Medic AC roles has meant that discussions around additional resources that are required in order for the roles to be deployed effectively have needed to take place post my approval. Although this has delayed deployment, the Trust have demonstrated a desire to ensure resources and support is available to enable these posts to be successful and have been keen to consider various models of deployment.

Professional case study examples

Good practice case study questionnaire *continued*

What advice might you have for aspirant Approved Clinicians, both locally and nationally?

- Before starting on this journey, consider what you will need in place to enable you to develop your competencies and portfolio. This could include identifying a supervisor and / or mentor and considering the time you will need available to you to dedicate to this training. Negotiating time to focus on this training and development is important.
- Consider how you can get a range of experience (inpatient and community, observations of initial detentions, renewals etc) so that you can cover the duties you would be required to perform as an AC in your evidence for competencies is helpful. It may be helpful to review the competencies outlined in the BPS documents available in order to clarify what experience you already bring and what areas you need to strengthen.

Do you have a statement of support from CEO / Medical Director / Director of Nursing?

- I gained two statements of support from Clinical Directors overseeing this development within the Trust. The development of these roles has also been supported by the Medical Director and Director of Nursing within the Trust.

Do you have a statement of support from a Medical Consultant?

- I have four statements of support from Consultant Psychiatrists I worked with over the course of developing my competencies and portfolio. I also sought a reference form the AMHP I spent time shadowing.

Professional case study examples

Good practice case study questionnaire

Job title	Consultant Nurse, Approved Clinician and Responsible Clinician
Service worked in/Department	Wickham Low Secure Hospital

Please provide a summary of the example of good practice you believe has supported you in obtaining and retaining Approved /Responsible Clinician status

- I think that my background prior to taking on this training role was extremely important to me obtaining the AC status. I have been qualified for 22 years, 12 of which have been in a forensic service. I have also completed a 2-year consultant practitioner training programme which included attainment of a master's degree in MH studies and gave me experience in keeping a portfolio. Past roles such as the matron role and the service manager role helped me evidence leadership skills. In a nutshell, these roles should be undertaken by highly experienced clinicians.
- Once in role I was supported to develop the competencies to become and AC by being allowed to be effectively supernumerary. An initial timescale was set at 1 year. During this time, I was supported to complete all training I needed, to shadow colleagues, develop my portfolio and nominally take on the role of AC/RC under supervision. This support in conjunction with my past experience in fact led to be gaining AC status within 10 months, working part time at 20 hours per week.

What have been the key enablers in you becoming an Approved Clinician?

- Personal motivation
- Support of my consultant psychiatrist colleagues
- Support of the service
- Previous experience- clinical, leadership and development of a portfolio
- Support of management
- Acceptance by the patient, carers and staff group on the ward.
- Trust from others
- Opportunities to access training
- Robust supervision arrangements from my mentor.
- Clear deployment plans to the role of RC

Professional case study examples

Good practice case study questionnaire *continued*

What have been the key challenges in you becoming an Approved Clinician?

- Trust Policies- need amending to include non-medical RC's
- Lack of joined up working with the nursing and quality directorate as this role was developed in isolation. I would value and benefit from some nurse led supervision.
- I am not yet a prescriber which means I have to delegate this aspect of the role to another AC. I find this personally frustrating but plan to do my independent prescribing course.
- IT systems- it took ages to get this changed so that I could be put as RC on the system as it only allowed this to be a doctor.
- Training budgets- medics all have training budgets, it is not the same in nursing and it was difficult and complex to get funding approved for essential training

What advice might you have for aspirant Approved Clinicians, both locally and nationally?

- Ensure you have plenty of experience before undertaking this as otherwise you will struggle to evidence that you have the correct competencies. Reflection is key to a good portfolio. Ensure you have the support of Consultant Psychiatrist colleagues as they will be paramount to your training. Don't lose sight of your profession and ensure you are linked into this. Try and have a trust wide strategy for developing these posts to ensure that preparation is done in advance. If possible, timetable time to work on your portfolio- it is best to write things up as you go along.

Do you have a statement of support from CEO / Medical Director / Director of Nursing?

- My statement of support came from the Medical lead for our service as it was not a requirement at the time to have the CEO/medical director/DoN. However, in retrospect it would have been better if these individuals were linked into this process from the earliest opportunity. Whilst they were fully aware of the post, they were not involved in the development of it as it was created locally.

Do you have a statement of support from a Medical Consultant?

- Yes- my mentor was a Consultant Psychiatrist who gave me a statement of support which was included in my portfolio.

Professional case study examples

Good practice case study questionnaire	
Job title	Social Worker / Responsible Clinician
Service worked in/Department	Rehab and Recovery Ward
Please provide a summary of the example of good practice you believe has supported you in obtaining and retaining Approved /Responsible Clinician status	
<ul style="list-style-type: none"> • Engaging with the training fully, attending all work experiences offered and using initiative. • Having the competence to transfer skills and experience to the role from previous work experience in mental health, particularly, leadership, care planning, communication skills, decision making, legal framework • Being conscientious in all aspects of the work undertaken, having robust evidence for Portfolio and diverse and vast range of work experiences covering all the competencies in detail. 	
What have been the key enablers in you becoming an Approved Clinician?	
<ul style="list-style-type: none"> • My family • Support from board level within the organisation • My own motivation to professional develops • Cross roads in my career and turning point out of senior management and increase clinical role with service. 	
What have been the key challenges in you becoming an Approved Clinician?	
<ul style="list-style-type: none"> • Length of course and training juggling a full-time lead SW role alongside having a small caseload of service users. Long days of up to 16 hours on occasions, particularly towards the end of the training pulling everything together. 	
What advice might you have for aspirant Approved Clinicians, both locally and nationally?	
<ul style="list-style-type: none"> • To plan well in advance, it takes from 18 months to 24 months. Take time to shadow AC/RC's. Peruse the AC mental health law course in Northumbria. Look at the role completely and how this would fit within your organisation. Is there a current working model of non-medical AC's being supported in with your organisation? Look at portfolio's and relate all your work to the competencies. Compile your portfolio as you progress, don't leave it until late on! Above all completely understand as to what you are embarking on in advance and the responsibilities attached. 	
Do you have a statement of support from CEO / Medical Director / Director of Nursing?	
<ul style="list-style-type: none"> • Yes, from Chief Medical Exec 	
Do you have a statement of support from a Medical Consultant?	
<ul style="list-style-type: none"> • Yes, x5 testimonials 	

Professional case study examples

Good practice case study questionnaire	
Job title	Lead Occupational Therapist
Service worked in/Department	Community Mental Health Rehabilitation
Please provide a summary of the example of good practice you believe has supported you in obtaining and retaining Approved /Responsible Clinician status	
<ul style="list-style-type: none"> • Support to attend the Northumbria course, which supported my learning and completion of my portfolio. • Peer Support supervision was already established, and I was encouraged to attend, even before being approved. This was a useful opportunity to reflect on my learning and learn from ACs already undertaking the role as RC. 	
What have been the key enablers in you becoming an Approved Clinician?	
<ul style="list-style-type: none"> • Support from my Director of Therapies. • Support from a local Consultant Psychiatrist and his willingness to mentor me through the process. • Peer support and supervision from other non-medical ACs/RCs. • Shadowing opportunities. 	
What have been the key challenges in you becoming an Approved Clinician?	
<ul style="list-style-type: none"> • Finding the time and opportunities to shadow staff or relevant activities, such as Tribunals. • Pockets of resistance or a disinterest in development of non-medical staff working towards AC status. • Length of time between submitting portfolio and being approved, which was possibly unique to my case due to being the first Occupational Therapist, in England, seeking approval. 	

Professional case study examples

Good practice case study questionnaire *continued*

What advice might you have for aspirant Approved Clinicians, both locally and nationally?

- Ensure you have organisational support in the first instance. Find a mentor as early on as possible and create as many learning opportunities as possible, drawing on your networks and the relationships you have within your organisation.
- Maintain a good record of any learning opportunities throughout the process as this makes it easier to reflect on the evidence needed when addressing the AC competencies and identifying potential gaps in your learning.
- Have a clear deployment plan from the start.
- Use the support of other non-medical ACs/RCs in your local area. Set up a peer support network/group if your organisation doesn't already have one, or find an already established peer group which can support your learning and development as an AC or aspiring AC.

Do you have a statement of support from CEO / Medical Director / Director of Nursing?

- My Director of Therapies provided me with a statement of support.

Do you have a statement of support from a Medical Consultant?

- My Mentor (Consultant Psychiatrist) provided a statement of support.

Approved clinician core competencies

Summary of Competencies required for AC Approval as outlined in the Department of Health 'Guidance for seeking Approved Clinician status via the portfolio route'.⁹

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.
2	Legal and policy framework
2a	Applied knowledge of the Mental Health Act, Mental Capacity Act and the Human Rights Act and related codes of practice and national and local policy and guidelines.
2b	Applied knowledge of other relevant legislation, codes of practice, national and local policy guidance; in particular, relevant parts of the Human Rights Act 1998, the Mental Capacity Act 2005, and the Children Acts 1989 and 2004.
2c	Applied knowledge of relevant guidance issued by the National Institute for Health and Care Excellence (NICE). 'Relevant' means relevant to the decisions likely to be taken by you as an approved clinician or responsible clinician. Where such guidance is not available the applicant should use other evidence-based sources relevant to the patient group likely to be subject to their decisions.
3	Assessment
3.1	Demonstrated ability to: <ul style="list-style-type: none"> a. identify the presence of mental disorder; b. identify the severity of the disorder; and c. determine whether the disorder is of the kind or degree warranting compulsory confinement.
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.
3.3	Demonstrated ability to undertake mental health assessments incorporating biological, psychological, cultural and social perspectives.
4	Treatment
4.1	An understanding of: <ul style="list-style-type: none"> a. mental health related treatments, i.e. physical, psychological and social interventions; b. different treatment approaches and their applicability to different patients. c. 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.

9. <https://www.gov.uk/government/publications/mental-health-act-exercise-of-approval-instructions-2013>

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 for 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
	Demonstrated ability to manage and develop care plans which combine health, social services, and other resources 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 the (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	Understands and recognises the limits of their own skills and recognises when to seek other professional views to inform a decision.
7	Equality and cultural diversity
7.1	Up to date knowledge and understanding of equality issues, including those concerning race, disability, sexual orientation and gender.
7.2	Ability to identify, challenge, and where possible and appropriate redress discrimination and inequality in relation to approved clinician practice.
7.3	Understands the need to sensitively and actively promote equality and diversity.
7.4	Understanding of how cultural factors and personal values can affect practitioners' judgements and decisions in 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 the legal requirements with respect to record keeping.
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.

Expert advisory group membership list

Surname	Forename	Organisation name
Abraham	Neena	Rotherham Doncaster & South Humber NHS Foundation Trust
Bhutani	Gita E	Lancashire & South Cumbria NHS Foundation Trust
Bickerton	Laurence	The Tavistock & Portman NHS Foundation Trust
Bird	Olivia	The Health and Care Professions Council
Blofield	Alison	Midlands Partnership NHS Foundation Trust
Bradbury	Natalie	Midlands Partnership NHS Foundation Trust
Burn	Wendy	Royal College of Psychiatrists and co-chair of the Physician Associate Group
Burrell	Carole	Northumbria University, Newcastle upon Tyne
Caldwell	Chris	The Tavistock & Portman NHS Foundation Trust
Cape	John	University College London
Chapman	David	Somerset NHS Foundation Trust (formerly Somerset Partnership NHS Foundation Trust)
Clough	Amanda	Mersey Care NHS Foundation Trust
Cochrane	Nikki	Co-chair of the HEE New Roles in Mental Health Physician Associate Group
Coombes	Melanie	co-chair of the Nursing & Nursing Associate Groups
Dudley	Jane	Avon & Wiltshire Mental Health Partnership NHS Trust
Dugmore	Paul	The Tavistock & Portman NHS Foundation Trust
Eagles	Hilary	Winterhead Ltd
Fellows	Andrew	Social Work England
France	Miles	Miles France Associates Limited

Expert advisory group membership list *continued*

Surname	Forename	Organisation name
Fung	Nicole Karen	Birmingham Women's & Children's NHS Foundation Trust
Gamble	Catherine	Royal College of Nursing
Gillmer	Bruce	Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust/British Psychological Society
Gray	Abigail	Sussex Partnership NHS Foundation Trust
Hardy	Rob	The Tavistock & Portman NHS Foundation Trust
Hatton	Sue	Health Education England
Hilder	Debbie	Health Education England
Kearney	Thomas	NHS England and NHS Improvement
Lees	Matthew	Department of Health & Social Care
MacDonald	Hannah	Avon & Wiltshire Mental Health Partnership NHS Trust
Maher	Sharon	St Andrew's Healthcare
Massey	Alexandra	Tees, Esk and Wear Valleys NHS Foundation Trust
Merchant	Karen	The Tavistock & Portman NHS Foundation Trust
Millar	Kerry	Winterhead Ltd
Reeves	Paul	Co-chair of the Nursing & Nursing Associate Groups
Sheeran	Anne	Kent & Medway NHS and Social Care Partnership Trust
Smith	Samuel	St Andrew's Healthcare
Stewart	Luisa	co-chair of the Psychological Professions Group
Stone	Kevin	The University of the West of England, Bristol

Expert advisory group membership list *continued*

Surname	Forename	Organisation name
Taylor	John	Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
Tegerdine	Ian	The Tavistock & Portman NHS Foundation Trust
Thompson-Boy	Donvé	Oxleas NHS Foundation Trust
Trewin	Mark	Chair HEE New Roles in Mental Health Social Work Group
Tunncliffe	Tom	Midlands Partnership NHS Foundation Trust
Veitch	Paul	Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
Vicary	Sarah	The Open University
Walker	Clare	Nottinghamshire Healthcare NHS Foundation Trust
Walker	Susan	UCL Division of Psychiatry/Great Ormond Street Institute of Child Health
Whittington	Adrian	co-chair of the Psychological Professions Group
Wild	Amanda	Tees, Esk and Wear Valleys NHS Foundation Trust
Witney	Michael	Oxleas NHS Foundation Trust
Wood	Sarah	Secure Services LDU
Woodcock	Nigel	St Andrew's Healthcare