**Appendix 7 Capability Framework**

**Capability Framework for on call CAMHS Clinicians**

**Section A: Introduction and Overview**

The purpose of this framework is to ensure that clinician’s taking part in the CAMHS out of hours clinician’s rota have undertaken the necessary development and training to enable them to undertake this role.

This framework includes the following:

* Section A: Introduction and Overview
* Section B: supervision plan and agreement
* Section C: Shadowing and development towards independent working
* Section D: Training and documentation
* Section E: Competency Framework
* Section F: Sign off sheet.

In addition to using this framework the following will also be of use to the clinician:

* CAMHS out of hours procedure
* Training as identified within this framework (Section D)
* CAMHS out of hours clinician forum (ask clinical lead for further details)
* Supervision as agreed locally.

Each clinician due to commence working on the rota should be assigned an assessor by the CAMHS Team Manager or Clinical Lead who is able to assess the clinician’s progress towards on call as per this framework.

The clinician and the assessor should work through this framework and sign off each section as appropriate. Once all sections have been completed, section F should be sent to the Team Manager who can then confirm that the clinician can work on the CAMHS on call rota independently.

This is aimed to be a supportive measure to support clinicians to practice safely on the out of hours rota and any concerns around performance, capability or conduct should be discussed with the Team Manager so that this can be addressed accordingly.

**Section B: supervision plan and agreement:**

Experience to date relevant to CAMHS on call:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Identified Learning needs or areas for developments:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Action Plan to meet needs:

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Agreed plan for assessment of competency (include frequency of meetings with assessor, use of supervision and plan for doing this):

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Clinician:**

Signed…………………………….…

Name and designation ………………………………... Date …………..….

**Assessor:**

Signed…………………………..…..

Name and designation…………………………….….. Date …………….

**Section C: Shadowing and development towards independent working**

|  |  |  |
| --- | --- | --- |
| **Shadowing and Development:** | **Date Completed:** | **Agreed by Clinician and Assessor (Sign and Date)** |
| Shadowing on the on-call rota has been completed for agreed duration |  |  |
| Acting as first on call with second on call available has been completed for the agreed duration |  |  |
| Able to be independently on the on-call rota |  |  |

**Please note: Once each stage is completed, please ensure that the Crisis Team Manager is informed to ensure that the rota is updated accordingly. A copy will be placed in personal file.**

**Section D: Training and documentation**

|  |  |
| --- | --- |
| **Training to be undertaken** | **Date Undertaken** |
| On Call Training |  |
| Risk assessment and management training |  |
| SystmOne Training |  |
| Healthcare Record Keeping training |  |
| CAMHS Assessment competency framework completed |  |
| **Documentation to be received** | **Date Received** |
| Children and Young People’s Mental Health Service (CAMHS) Out of Hours Service Standard Operating Procedure |  |
| Local resource pack as appropriate |  |
|  |  |

**Section E: Competency Framework**

**Practitioner name –**

| **Competency** | **Outcomes to be achieved** | **Evidence to support competency** | **Signed and dated by assessor** | **Signed and dated by practitioner** |
| --- | --- | --- | --- | --- |
| **Screening of non-urgent and urgent referrals** | Able to identify what meets criteria for urgent and non-urgent referrals.Able to request additional information to facilitate decision making process.Able to document and share information as required |  |  |  |
| **Responding to urgent and non-urgent referrals appropriately** | Understands process for undertaking urgent assessments.Able to arrange and coordinate urgent assessments and follow ups.Able to redirect non urgent referrals to Single Point of Access (SPA) or other agencies as required |  |  |  |
| **Use of supervision and de brief** | Understands use of supervision and de brief and how to access this |  |  |  |
| **Assessment Process** | Competency framework for CAMHS assessment completed.(Includes risk assessment) |  |  |  |
| **After assessment** | Understands process for follow up and case management after undertaking assessment |  |  |  |

**Section F: Sign off sheet**

1. **Has the clinician achieved all areas of Section C: Shadowing and development towards independent working?**

Yes/ No (delete as appropriate)

Has the clinician achieved all areas of Section D: Training and documentation?

Yes/ No (delete as appropriate)

Has the clinician achieved all areas of Section E: Competency Framework?

Yes/ No (delete as appropriate)

**2. If the answer to any of the above is no please complete the action plan:**

Action to be taken:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

By what date: ………………………………………….

Who to inform: ………………………………………………………………………………………………………………………………….

1. **Please confirm that the Clinician is now deemed competent to practice independently on the CAMHS On Call Rota**

Clinician: Signed: ……………………………………..

Name and designation:………………………………………….. Date:………….

Assessor: Signed: ……………………………………..

Name and designation:……………………………. ……………...Date:………….

**A Copy of this sheet should be given to the team manager upon completion of framework.**