



GRADUATE CERTIFICATE
in Consolidation of Social Work Practice
LEVEL 6 - 60 Credits

LEARNER PORTFOLIO
(PORTH AGORED and UWTSD)

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WALES ACADEMY for PROFESSIONAL PRACTICE and APPLIED
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Section 1

Graduate Certificate in Consolidation of Social Work Practice - Learner Portfolio

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Section 2

Developmental Review

Guidance: This section should be completed by taking into account the work that you will have done since qualifying, and discussions with your mentor and supervisor/line manager as part of your First Three Years of Practice Individual Plan.

Based on your experience in practice identify and justify your agreed learning needs for the following outcomes:

- Working Collaboratively with service users & carers
Working Collaboratively with Other Professionals
- Applying analysis in assessment to inform interventions
- Intervention and application of professional judgement in increasingly complex situations

500 words (+/- 10%: include your actual word count at the end of each section)

As a newly qualified social worker, the first few years in practice is a valuable time as practice experience and academic learning is combined to enable professional development to grow, (Galpin, Bigmore and Parker, 2011). Since qualifying I have been working in Adult Community Mental Health Team, a field in which I have found fascinating and interesting since a young age. This has helped me identify outcomes for further learning, as I believe mental health is an incredibly broad spectrum of knowledge that is needed when working in psychiatric services. Furthermore, I am interested in developing my knowledge further around the Mental Health Act 1983 and how professionals use this appropriately in different contexts. In supervision I have identified this as a learning need, as the Mental Health Act 1983 is a key piece of legislation that underpins the team and with my manager's support I wish to shadow experienced staff where appropriate where they support service users with complex needs and require detainment under the Act. This would help me develop critical analysis skills to inform interventions.

Since I joined the team I have worked collaboratively with other professionals such as nurses, psychiatrists and occupational therapists using each other's expertise to identify the best outcomes for individuals. This integrated way of working with other professionals has been

very valuable to me, it has helped me to challenge my own thought process behind decision making, enabling me to make judgements confidentially and developing my own professional identity, (Rutter and Brown, 2011). Working collaboratively with individuals on a case management basis has enabled me to build therapeutic relationship with service users which is reciprocal. Additionally, I want to build upon this in all areas of my practice, including partner agencies and non-statutory organisations.

Supervision has been a helpful tool in allowing me to critically reflect upon my case's and use constructive advice to move forward with cases in an outcomes focused approach. It has allowed me to use it as a reflective process, much like (Kolb 1984) Kolb's learning model and also allows me to evaluate my own knowledge base, helping me to identify areas that I want to improve upon. Another learning need that I have identified and agreed with my manager is to have more complex cases to help me develop my knowledge pool and decision making skills. (Bailin et al. 1999) would agree that knowledge is power in any given situation. Since qualifying my enthusiasm has not changed and managing complex cases will also build my confidence in relation to decision making. These experiences will also help me further when I wish to progress in the future into the emergency duty team, as the role requires supporting both adult and children in crisis situations.

I believe these learning needs will enable me to critically reflect upon my practice, thus allowing me to engage in learning that will further my professional development.

Word Count – 484 words

Section 3

Observation from an individual using services, their family and carers

Observation SumSU3

Please include name of the expert witness observing in section 8.

Date of observation: 19th December 2019

To be completed by learner

Set out the social work objectives and give a brief description of the situation including geographical and legislative contexts and any relevant cultural, and language issues.

300 words (+/- 10%: include your actual word count at the end of each section)

The observation will be of direct work with service user 1 (SU1) as part of an assessment. SU1 is a 22 year old individual with a diagnosis of Anorexia Nervosa living in a rural and socially deprived area of Wales at her family home, where both her and her parents are Jehovah's witnesses. At present, SU1's mental and physical health appears relatively stable, however, The Welsh Health Survey (2015) have indicated more adults in this locality are being treated for a mental health than the rest of Wales.

The main piece of legislation that informs my practice with SU1 is The Mental Health Measure Wales (2010). Being relatively new, this framework has allowed me to practice in a person-centred way, promoting SU1's confidence and recovery. The measure also provides SU1 the right to Care and Treatment Plan and a Care Coordinator, allowing her to set achievable goals such as increasing work hours and living independently. The plan will help to ensure that services are coordinated to promote recovery, and prevent relapse.

As SU1 lives in a rural part of Wales I am beginning to appreciate some of the demographic challenges that individuals experience such as transport, geography and demographics. Wood (2011) has indicated that people in Wales travel further distances to access appropriate treatment. In 2018 SU1 had to travel to England to spend 3 months as an inpatient due to the

lack of appropriate services in Wales and expressed that her relationship with family had become strained from this.

On my initial meeting with SU1 I took appropriate steps to identify her language need and asking about the language she uses at home and work. SU1 indicated that English is her language need and although she reported no issues with language I am mindful to use 'plain language' avoiding acronyms and jargon to ensure my communication is understood, (Mavrogenes, Hanson & Winkley, 1977).

Word Count – 314

Section 3

Critically reflect on your communication methods and skills during the observation including how you identified whether you had the necessary communication skills to work with the individual using services, their family or carers. Show how you adhered to social work values using a person-centred approach, Code of Professional Practice for Social Care Workers, culturally sensitive practice, language needs including the **“Active Offer” principle**, and ethical practice.

1300 (+/- 10%: include your actual word count at the end of each section)

As previously mentioned, the observation will be of direct work with SU1 as part of gathering information for my initial assessment. The reason for the assessment is to gather the appropriate and relevant information to inform her care plan and to also help build a therapeutic relationship. This involved aiming to get an understanding of SU1's childhood, relationships, and her mental health history. I also aimed to gain a better understanding of any challenges she has had to address and overcome, including societal and demographic challenges. I am aware that SU1 lives in a socially deprived area of Wales and has faced demographic challenges whilst in recovery and seeking treatment for her anorexia. Further research I found from the Public Policy Institute for Wales (2016) indicated that Wales has a large rural population and levels of poverty are higher in Wales than the UK average, and public transport being more expensive in rural parts.

Fortunately, SU1 is able to drive and owns a car which has allowed her to choose to attend the observation at my team's base. If SU1 was unable to drive, I'm aware that I may have had to choose another time and place for the observation to help SU1 avoid becoming more societally oppressed because of where she lives. As SU1 can drive, I invited her to my team's base where there was a suitable room for the observation.

On arrival to the suite I introduced SU1 to my mentor, gently reminding her of the observation she agreed to do on my previous visit with her. I explained to SU1 that I would like to complete a timeline exercise to help me understand how she got to the point of where she is at present. This exercise was a useful tool that I learnt as a student which enabled me to gather relevant information and help individuals feel involved, listened to and valued. SU1 agreed to do the

exercise and I took a person centred approach by handing her felt pens and paper to help her feel that this was her piece of work.

I felt the ice was broken when SU1 chuckled at me expressing that my mentor was only assessing myself and that I was going to pretend that she wasn't there. To me interpersonal skills are a key part of communicating, especially when wanting to put an individual at ease. I used these skills throughout the observation and was mindful of the language I used.

As I was aware of the Active Offer Principle I gave SU2 the choice of English or Welsh, SU2 choose English. I spoke to SU2, being mindful of my language, for example I asked, 'Do you see your friends much?' Instead of, 'Do you have contact with friends?' I find conversations run much smoother, using 'plain language' instead of formal language. I was also mindful not to use abbreviations and jargon such as 'assessment' 'CTP' 'MDT' or 'review'. For example, in the language I used, I asked, 'Have you had cognitive behavioural therapy before?' Instead of, 'Have you had CBT before?' Reflecting back on this observation I can see that language is an important part of social work practice, it's important to match the language style of an individual as it ensures clear communication, and helps to build a therapeutic relationship. I am pleased that I have the communication and interpersonal skills to do this, although I do find that using plain language comes naturally to me, likely because it's the language I use most of the time away from work. However, I have now noticed that my time as a student focused heavily on developing my academic language and formal report writing, more so than the actual language needs of service users. It is clear that using plain language enables me to follow Section 2.2 of the Professional Code of Practice.

Reflecting back on my communication method, I have noticed that I adopted a relaxed approach that was still person centred which invited SU1 into discussions about significant events in her life. SU1 began discussing her early childhood and took the lead in the timeline activity I set up using the felt pens to write her events on the timeline. She went on to discuss briefly that she was in an abusive relationship and quickly went on to discuss the triggers for her anorexia. At this point, I began to reflect in action on whether I should have pressed to discuss the domestic abuse. I was aware that the locality of where SU1 lives has the highest number of domestic abuse related calls to the police than any other local authority in Wales, linked to deprivation and social isolation, (Joseph Rowtree Foundation 2018). After SU1 discussed her anorexia openly, I then asked her, 'Is it okay if we go back to when you said you

were in a relationship? I felt that this language gave her the opportunity to say if it was too distressing to discuss, or the opportunity to tell me more. SU1 discussed that she was a controlling relationship and that she found being in a relationship difficult as her parents are both Jehovah's witnesses. I responded by saying, 'That must have been a tough time for you.' I have noticed here that I empathised with SU1 using Carl Rogers (1961) core values which are empathy, congruence and a non-judgement approach. I agree with both Carl Rogers (1961) and Bereford (2012) who highlight that being non-judgemental and using a person-centred approach is at the heart of social work practice. Prior to being a student social worker, I completed a BSc degree in Counselling where I took a person centred perspective, and I am pleased to see that this approach is still a central part of my practice.

I believe that using the core values enables me to uphold public trust and confidence in the social care, adhering to Section 2 of the Professional Code of Practice for Social Workers, (SCW, 2017).

SU1 expressed that she is also a Jehovah's Witness stating that her faith is very important to and at the moment she is enjoying working part time in a Jehovah's Witness's nursing home. When SU1 stated this I was surprised as I did not perceive SU1 to be religious, however, I was mindful that this is part of SU1's identity and I was also mindful that I work with SU1 in a culturally appropriate manner, for example I need to be aware of the possible challenges or prejudice she may have faced growing up or when seeking treatment. I feel confident that I've noticed in this observation that I adhered to the BASW 2012 Code of Ethics and Principles by recognising diversity, being respectful, culturally appropriate, and by also identifying SU1's strengths such as working part time to aid her recovery and maturity as a young woman. I am aware that between the years 2018 to 2019, the amount of people who were unemployed in this locality was 4.2% which is higher than the national average for the UK which is 3.8% according to the BBC, 2020)

Nearing the end of the observation, I reminded SU1 the plan of action that we planned together in our last meeting where I agreed to attend another assessment with her and consulting with another professional involved with SU1. At the time I thought I was simply summarizing the meeting and preparing SU1 for the next plan of action.

Although through reflection, I have identified that I have acted as an accountable practitioner, working person centred ensuring SU1 is involved in the care plan and upholding public trust and confidence in line with the Professional Code of Practice (2017), S.1, S.2 and S.5.

This also gives me confidence that SU1 can see the work I am doing with and that I am interested and committed to my role. To me it makes sense that Gaiswinkler and Roessler (2009) argued that individuals who believe that social workers as competent, are far more likely achieve change than those who believe they are incompetent.

Word count -1334

Section 3

Feedback and comments from an individual using services, their family or carers

This section of the Observation should not be done in the presence of the learner.

Some or all of these questions may be used by the observer (who should re-phrase and add explanations and prompts as required). Alternatively, the learner is able to design their own method of obtaining information for the Observer to use if this is more suited to the needs of the individual. The observer should record responses below or by using the alternative method from the individual using services, their family or carers.

Before asking the questions, the observer must explain to the individual using services that their comments will be shared with the learner. It may be useful to explain that it is used as a learning tool for the learner to develop their own practice.

If the observer is unable to gain feedback, they should briefly say why.

Was the social worker on time? Or if delayed did he or she contact you?	SU1 stated that Sarah Thomas (Social Worker) was on time. She mentioned that Sarah is always on time, that she keeps to the plans they have made and that Sarah's communication is always excellent.
Did the social worker get your permission in advance for the observer to be present? Did they explain why they were being observed?	SU1 informed that Sarah obtained permission in advance to use this learning experience as a direct observation and that she explained that it would involve me attending and observing Sarah. SU1 said she was aware that this was part of Sarah's training. At the beginning of the observation, Sarah checked with SU1 that she was still in agreement for me to observe the session. Sarah asked if SU1 would be happy to provide feedback at the end of the session and explained

	that she would leave the room at this time. SU1 was happy to provide feedback.
Were you clear why the social worker met with you today?	SU1 said that she is clear why Sarah met with her today, telling me that it was a way to get to know each other and start gathering information for the plan. Sarah outlined the aim and purpose of the session, ensuring that SU1 was fully aware what to expect. Sarah used a large sheet of paper and collaboratively with SU1 created a timeline documenting positive influences in SU1's life, negative and positive experiences, focusing on family life, health, employment and education. The session provided a pen picture in SU1's own words. Sarah informed that the information gathered would be included in the assessment document and be used to start the Care and Treatment Plan. Sarah ensured that SU1 was clear that it will be her plan and that she will be an integral part to its creation.
How well prepared do you think, the social worker was for his or her meeting with you?	SU1 said Sarah had a good plan for today, stating that she seems very organized. Sarah had clearly planned well for this visit and started by recapping on her last visit to SU1 and confirming the progress of actions noted during the last visit. Sarah clarified the time of SU1's Personal Independent Payments assessment and offered support to attend the appointment. Sarah discussed the planned referral to platform, explained the process and provided a clear picture of what SU1 could expect. Sarah confirmed the date and time of SU1's outpatient appointment with the Consultant Psychiatrist and offered to attend with SU1. Sarah established a good rapport with SU1 by showing respect and that she had listened during the last session. Due to the preparation made by Sarah, the session was easy to follow, had a clear purpose and was focussed on collaboration, ensuring the SU1 was central to the discussion. Sarah had clearly thought about the session plan, using the coloured pens she had brought and allowing

	SU1 to draw her own timeline made the session relaxed and interactive, which allowed for difficult topics to be raised and discussed.
How has the social worker listened to you and respected your views and wishes?	SU1 said that when Sarah came in, she remembered everything they had spoken about during the last session, noting “even the little things”. SU1 told me that Sarah listens and respects her wishes and her views. Sarah considered the welsh context by acknowledging that SU1 lives in a rural area, that there may be potential difficulties travelling and showed empathy when SU1 talked about having to travel far to access eating disorder services previously. Sarah respected SU1’s religious beliefs, incorporating this into the assessment. SU1 talked about the eating disorder services. Sarah explored linking in with other agencies/professionals also supporting SU1 to ensure they are working towards the same goals. Sarah asked SU1 if she is happy for Sarah to contact other agencies, in doing so showed respect to SU1 by asking for her consent to discuss her with other professionals. Sarah showed at this time that she was working in SU1’s best interest by ensure she values and includes the specialist knowledge of all professional involved in the care and support provided for SU1. Sarah asked SU1 whether she had any questions, allowing her time to go over anything SU1 may not have understood. Sarah’s positive and effective working relationship with SU1 was evident in the feedback. Sarah evidenced listening by repeating back and asking more about the topic or situation, i.e. when talking about low self-esteem, Sarah asked when this started, she showed understanding and empathy, asked how this affected SU1’s mental health and explored the information shared in more detail. When SU1 talked about when the eating disorder started, Sarah asked about services and support at the

	time. This enabled SU1 to talk about what support she had received from CAMHS, family therapy and eating disorder services and what she felt was helpful or not. This allowed Sarah to be aware of what had been tried in the past, anything that worked well and anything SU1 did not wish to try again. Sarah also used silences, allowing SU1 the time to talk, prompted when needed and then allowed SU1 more time to talk. Sarah actively listened by picking up on slight comments and exploring these further.
Did the social worker talk to you in a way that you understood? Did you understand the language they used?	SU1 said that she understood what Sarah was saying and understood the language used. Sarah used common language ensuring to avoid social work jargon. Sarah worked in a person centred way and explained what the session would entail. Sarah prompted SU1 where needed when completing the timeline (i.e. where you were born, siblings, what was it like growing up, where her parents worked, how was school). Sarah allowed time and respected pauses, allowing the conversation to flow. This worked well and enabled SU1 to tell her story SU1 while allowing SU1 to lead. Sarah clarified meaning of terms used by SU1, i.e. "bad behaviours", Sarah did not assume the answer, allowing SU1 to explain that the meant purging and self-harm by burning.
How has the social worker's involvement met your expectations for this visit?	SU1 reported that Sarah is going above her expectations, that she sees Sarah more than previous workers and that she now knows about Personal Independence Payments which has really helped her. Sarah sat next to SU1, side by side without directly facing SU1. This worked well, allowing Sarah to encourage collaboration in the gathering of information about SU1 and her history. Sarah guided SU1 through the task and was clearly very skilled in her approach, evidencing patience by working at SU1's pace. Sarah took her time

	and did not rush SU1 in her responses. Sarah ensured a person centred approach throughout the session.
Are there any other comments or suggestions that you would like to make?	SU1 stated that she thinks Sarah is “nice, warm and makes me feel relaxed”. SU1 said she feels comfortable taking to Sarah, that she could tell her anything and that it’s worth telling her things. Sarah allowed SU1 to tell her story at her own pace, evidencing that she was actively listening and went back to a difficult topic at a later stage ensuring that she asked difficult questions where needed to assess risk. By going back to topics that SU1 had briefly mentioned, SU1 opened up further allowing deeper exploration of the issue. Sarah checked the legal status when SU1 talked about admission to an eating disorder unit, placing importance on ensuring she has all the services legally required under the Mental Health Act 1983. Sarah also asked about any other services SU1 is accessing support from at present. Sarah evidenced her willingness to work with other professionals and showed respect to SU1 by asking permission to contact other services for information. Sarah explained why she would be speaking to other services, being open and honest about her reason which included introducing herself and to ensure they are working towards the same goals, not against each other. Sarah ensured a holistic approach by covering all areas of SU1’s life and demonstrated good skills by using a guide to measure when SU1 said she was struggling, i.e. asked how much spend on food in a bad week. Sarah praised SU1 and pointed out where she has identified her own goals, which SU1 did not appear to have noticed herself and smiled when acknowledging this. By focusing on the positives, Sarah empowered SU1, helping improve her confidence and reminding her of her importance in her care and treatment planning. Sarah was clear

	what was going to happen next, checked risk and asked if safe SU1 felt she could keep herself safe at home. Sarah clearly explained the actions/tasks identified and who was responsible for the individual tasks.
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Section 4

Safeguarding and working in complex situations – Case Study

Complete a critically reflective case study based on an assessment, undertaken with others **(in your own area of work)** concerning the safeguarding of either an adult or a child. Demonstrate how the case relates to safeguarding legislation and your Safeguarding Boards safeguarding policies, strategies and procedures. Ensure that you cover the learning outcomes, National Occupational Standards, legislation (domestic and international), the specific dimensions of working in Wales and relevant social work theories. Please find list of learning outcomes in the handbook

4000 words (+/- 10%: include your actual word count at the end of each section)

This paper will critically reflect upon a case study of an adult within the context of a community mental health team. Firstly, I will briefly touch upon the topic of mental health in respect of defining a mental disorder and those who are likely to develop ill mental health. The case study chosen is based on an assessment and has been anonymised to protect patient confidentiality, and will be referred to as service user three (SU3). I will then briefly discuss the demographic challenges both myself and SU3 have begun to appreciate, from living in a rural part of Wales. I will then give careful consideration to The Mental Health Act 1983 amended 2007, the Mental Health Measure (Wales) 2010, the Social Services and Wellbeing Act (Wales) 2014 The Human Rights Act 1998 and briefly, the European Convention of Human Rights and the Wales Safeguarding procedures (2019) . Safeguarding procedures will also be critically evaluated in the context of contingency planning and the barriers and ethical dilemmas that can come from collaborating with other professionals, will also be critically reflected upon. As social work assessments in general are naturally influenced by various theories, three key theories will be considered in the latter part of the paper. These will be anti-oppressive practice, crisis intervention and person centred. I will use Kolb's (1989) reflective model to allow for a critical analysis of my practice.

Barber, Brown and Martin (2020, p.23) define poor mental health as, 'any disorder or disability of the mind.' In Wales, The Welsh Health Survey (2015) have pointed out that this locality has the highest number of adults being treated for ill mental health than the rest of the country. More recent statistics from the Welsh Government (2017) indicate that one in four people will go on to experience ill mental health at least once in their life time. The

reasons for developing a mental illness can be from a wide range of factors that cannot always be proven, such as, genetics, environmental, situational and biological factors (Richardson, Elliott and Roberts 2013). Teresa, Scheid and Brown (2010) have concluded that those with a mental illness fall into three categories, the first being those who experience acute ill mental health as a reaction to a stressful event or a loss. In the second category, they have described acute ill mental health which is more severe, although the service user's ability to function has not been compromised. In the third category, Teresa, Scheid and Brown (2010) have described service users as presenting with a severe and enduring mental illness that requires treatment and intervention from services, as their ability to function in their normal way of life significantly. It is within this third group that I am working with SU3, under the Mental Health Measure (Wales) 2010. This fairly new piece of legislation has the same legal status as other mental health Acts, however, the measure leans more towards making sure the help is there for those requiring support from mental health services.

Since working in this locality, I have begun to appreciate the demographic challenges service users have to face, due to living in a deprived part of Wales. SU3 is an English middle aged woman, who moved to Wales in her early twenties with her then husband and four children. This is a socially deprived area of Wales, with poor transport links and mental health services being over a forty minute drive away. Wood (2011) has found that people in this area of Wales seem to travel further distances to access appropriate treatment, and this still seems to be the case today. I believe that it could be reasonable to argue that safeguarding the most vulnerable patients in the community who have an enduring mental health illness, can be somewhat difficult due to the lack of services available in the area. Because of this, I ensure I carry out regular home visits and prepare myself for the demographic challenges that can arise from living in a rural area. For example, in the winter months, I am mindful to watch the weather forecasts for ice and snow as SU3 lives up a number of steep hills in an isolated village forty minutes from my place of work. I am also mindful to take into account a service user's means of travel when arranging meetings, as there are poor transport links in this locality. As a care coordinator, I have been working with SU3 in a person centred way, involving her in the care plan, working together to identify outcomes such as practising coping skills and increasing her productivity. This is in line with key role two and three under the National Occupational Standards set out by Social Care Wales (2011).

SU3 has a long history of depression, anxiety, self-harm, suicidal ideation and sporadic patterns of non-engagement with treatment. She now lives at home with her three adult children who have all experienced poor mental health. Unemployment in this locality is at 4.8% according to Stats Wales (2020) and SU3 feels unable to work, however, has worked in the past. Further to this, Pickett, Oliver, & Wilkinson, (2006) point out that unemployment and poverty factors are associated with poor mental health. Link and Phlelan (1995) also note that inequalities such as wealth and prestige can also significantly impact a person's mental health. SU3 appears to hold a critical perception of herself and feels overwhelmed with emotions of guilt and shame, which she strongly links to her role as a mother in particular. She is also a survivor of domestic violence and has often described herself as a 'failure' as a wife and a mother. Ferrari et al (2016) argue that women who have experienced domestic abuse are likely to develop depression and anxiety, and this seems to be a contributing factor to SU3's mental health. There is also a higher number of referrals in this locality that include domestic violence, than any other area in Wales (Davies, 2013). SU3 has also discussed with me on previous visits that she is also a survivor of childhood sexual abuse and I'm aware that those who have experienced this type of harm/abuse are at a higher risk of developing a mental illness and are at an increased risk of suicide, (Roberts, Connor, Dunn & Golding 2014).

On a particular home visit, SU3 disclosed to me that she intended to end her life in the upcoming days. Her presentation to me, indicated that she was very low in mood, she was teary, and there was minimal eye contact and some evidence of self-neglect. SU3 answered most of my questions about self-harm, hearing voices and how she was feeling, she used the words, 'it doesn't matter anymore.' I was assessing SU3's mental state to allow me to make a professional judgement if she was at a significant risk of harm to herself. I was also mindful of her history and the current research as mentioned earlier about survivors of abuse. In the year 2014, suicide was the leading cause of death among women in Wales aged between 20 and 40 years old. Her self-harm was also concerning me, as she had often told me she cuts herself when feeling very low. Carroll, R., Metcalfe, C., & Gunnell, D. (2014) have argued that self-harm is a strong risk factor for suicide, especially if service users have been admitted to hospital for a form of deliberate self-harm. SU3 would not show me her wounds when I asked to see them, and this further escalated my concerns. Despite not being able to see them, I advised her to seek medical attention and to see her GP at the earliest opportunity.

I found gathering information from SU3 somewhat challenging as she was vague when answering my questions. When assessing her, my person centred approach became more pronounced. I tried to empathize and see the world from her view, and told her that there is no judgment from me and I that I wanted to listen to her. I informed her that I was very concerned about her and Carl Rogers (1961) has argued that these three conditions are needed for a therapeutic relationship and this was what I was trying to create. However, SU3 continued to give me vague answers.

Despite this, my knowledge of mental distress informed my assessment and lead me to collaborate with other professionals to initiate safeguarding procedures. To determine the risk, I took into account her mood, her presentation, the words that she spoke to me and her history. I also took into account my understanding of mental distress and the social model. Barcham (2016) states that a useful way to judge information is to consider risky behaviour in terms of recent events frequency, severity and the context of the situation. I found this a little difficult as SU3 appeared to find it difficult to engage in conversation.

On reflection, I then came to the professional judgement that SU3 was in a crisis and needed intervention from services. I felt that the appropriate next step should be the least restrictive, and this was to make a referral for an assessment with the Crisis Resolution Home Treatment Team (CRHT). However my initial steps to safeguard her lead to more challenges, as she would not give consent for me to make the referral. She also declined to seek support from her GP. I now found myself in what felt like was the beginning of a potential dilemma. To me, SU3 was presenting as suicidal but would not consent to crisis intervention, and my initial thought was that she lacked insight in relation to the risks that she posed to herself.

I explained to her that I had to inform my manager and my team of the situation immediately, and I was open and honest with her explaining that I needed to seek advice, as per section two of the Professional Code of Practice, Social Care Wales (2017).

When initially seeking advice from the CRHT, they seemed to assume that SU3 'could be at a low risk', because she had been 'voicing suicide ideation for many years and has had no previous admissions or known attempts.' I did not accept this assumption. To me, this assumption appeared to be bias, as the team were basing this on previous experience with

SU3, and not her current presentation. I tried to explore options with the CRHT team, such as having a team member attend SU3's home with me, to discuss the role of the CRHT. I felt that if SU3 had reassurance from the CRHT she may make a more informed decision. However, I was informed this wasn't appropriate, and reflecting back I can see that managing her risk was at the forefront of my mind, and perhaps I was not initially balancing this against her human rights, as I continued to challenge the CRHT. My identified learning outcome was to develop my experience of working collaboratively, and I have now begun to experience the challenges and barriers to working with others. Although, my initial thoughts were that this could only be a helpful process but I have now learnt that this is not always the case.

My referral to the CRHT felt like the beginning of a possible conflict. The difference in perspectives between teams became more distinct. The CRHT stated that they will only work with patients who give consent and started to realise that this is SU3's 'right to a private family life' and that her wishes should be respected. This led me to stop and reflect upon my own decision making once again.

I needed to give careful consideration of the Human Rights Act 1998 and this seemed to be the ethos of the CRHT. The Human Rights Act 1998 ensures that public authorities have a duty to act in a way that is in line with the European Convention on Human Rights. In particular the right to a family life, as stated in Article 5 of the Human Rights Act (1998) and the right to expect practitioners to uphold these rights, and of course public trust, (Barcham, 2016). I feel I have started to experience the potential dilemmas working under the Mental Health Act 1983 that many professionals face on a regular basis.

SU3 has the right to decline support offered, the same way she has the right to say no to showing me her wounds. In this situation, it became even more apparent that the risk of harm must be carefully balanced against a person's human rights (Gould, 2010).

For social workers, it is not unusual to face challenges regarding risks and contingencies. I knew I had to ensure safeguards were put in place for SU3, being mindful to balance this with respecting her human rights. I made a professional judgement to go down another path in order to safeguard her, and this was to give consideration to a Mental Health Act assessment under the Mental Health Act 1983 amended 2007. This is the law in both England and Wales that allows individuals with mental ill health to be admitted, detained and treated without

their consent to either protect themselves from harm or others. In 2017 to 2018 there were 1,891 admissions under the Mental Health Act 1983 in Wales, (Welsh Government, 2019). This route is oppressive as it is denying a service users right to freedom, and I was conscious to work in an anti-oppressive way, by informing SU3 of my concerns and considerations in an open and honest way. Laird (2008) states that an anti-oppressive approach can address a multitude of oppressions a service user may face. SU3 may have felt oppressed due to the powers of the Mental Health Act. The Oxford Dictionary of English (2005) defines power as one who has the ability to influence a course of events or the actions of other persons. Smith (2008) points out that power can be a slippery slope for social workers, however, argues that in certain circumstances it is necessary to exert power when they are safeguarding concerns. Nonetheless, this should be a last resort and my focus was on empowering SU3 to make informed choices. Anti-oppressive practice is not just an approach to understand a SU3's situation, but also an approach that seeks to achieve positive outcomes and fairness that's relevant to her, as highlighted by Parrot (2014). An important aspect of anti-oppressive practice is understanding SU3's values. Being a mother was extremely important to her, and her outcomes set out in her care and treatment plan was to develop a better relationship with her children.

Another theory that has been at the heart of this case study is crisis intervention, and although SU3 declined support from the CRHT, I was still able to utilize aspects of this theory with anti-oppressive practice to safeguard her. Ellison (1974) defines a crisis as a reaction to a stressful event where a service user may feel unable to cope or function. It is fair to argue that SU3 was in a crisis, and although she did not verbally say, she seemed to feel no longer able to cope. Golan (1974, as cited in Coulshed and Orme 1998) reports that there are three stages to a crisis intervention approach, such as a beginning, middle and end. Needless to say, the beginning stage is where a crisis has emerged, and SU3's emotional response to this crisis appeared to be sadness and despair. I was confident that SU3 was in the first stage of a crisis. The middle stage is where we will begin to work together identifying coping strategies and start planning long term goals. Lastly, the end stage is where developing an action plan, (Golan, 1974).

With guidance from my manager on the telephone, I gently informed SU3 that I was now considering an assessment under the mental health Act as I felt this was the next appropriate step to safeguard her. I was not sure what her reaction would be, however, the response she gave me was one that I was not expecting. SU3 almost immediately categorically denied that she was suicidal and denied any plans or thoughts to harm herself. She said she was not suicidal and that she had no plan to end her life, and did not want to go down this route. She then stated that her children were home for the weekend and expressed that they were her protective factor, although she had been feeling overwhelmed.

I utilized my counselling skills and empathised with SU3 giving my professional opinion that this must be a difficult time and intense emotions will pass. Roberts (2005) highlighted a framework for crisis intervention that involves person centered practice and developing an action plan. I believe that both of these were needed as this was a crisis that needed to be dealt with sensitively and with a lot of thought and careful consideration of the risks. Counselling skills outlined by Carl Rogers (1961) were needed as they helped me maintain a rapport with SU3 and helped enable her to feel in a safe environment with me (Maclean and Harrison, 2015). I negotiated with SU3 a detailed safety plan, where she expressed that she felt more 'comfortable'. She also acknowledged that my concerns would escalate if she did not follow the safety plan. It was agreed with SU3 that she would answer to 'Out of Hours' telephone calls over the weekend and a call from the duty officer once a day to discuss coping skills, and what she identified was helping. Another part of the action plan was to engage in weekly home visits from myself over the next four weeks, with a plan to review at the end. I also arranged an urgent outpatient appointment with the consultant psychiatrist to review her medication. Crisis intervention has allowed SU3 to feel more in control of her care and treatment, as she was much more accepting of help with this method, than the other avenues of safeguarding I have discussed.

However, if my concerns had remained or escalated then I would have had to contact the AMHP duty line and requested a mental health Act assessment under the Mental Health Act 1983. I would have had to give my rationale behind my request and discuss my concerns. The Approved Mental Health Professional (AMHP) would then gather and evaluate sources of information, and then if they determined there was a safeguarding concern, the AMHP would

coordinator an assessment. The AMHP would arrange for two doctors and I would have likely been involved in this assessment to support SU3 as her care coordinator. The AMHP role is unique, and they will consider the least restrictive options first, such as support from the CRHT. If SU3 would not allow the AMHP or doctors into her home then the AMHP would have to consider obtaining a warrant under section 135.1 of the mental health Act 1983 to gain entry into her home lawfully, (Barcham, 2016). This can be very traumatic for patients as their right to freedom has been lawfully denied. The mental health Act 1983 Code of Practice for Wales (2016) has clear guidance for safeguarding an adult. The code states that all local authorities must establish a safeguarding board. The new Wales Safeguarding Procedures (2019) have built on Part 7 of the Social Services and Well-being Act (Wales) 2014 and provide clear guidance for social workers regarding safeguarding adults at risk. Although this is not a case of investigating abuse, I can still follow the guidance when engaging SU3 in the care planning and her risk management plans. If in the future I have concerns regarding an adult at risk, these procedures will give me guidance on what I must do.

On reflection, I have noticed that the safety plan is of positive risk taking. Interestingly, Kemshall and Pritchard (1997) point out that positive risk taking can often enhance a service user's quality of life. As this was a crisis intervention, the plan to visit SU3 weekly over the next four weeks involved a continuation of assessing the risk. SU3 agreed to this, I felt I was able to work in a person centered way, ensuring she felt listened to and involved in her safety plan. I was also able to continue using the crisis intervention theory, assessing over the next few weeks if SU3 had moved onto the end stage. At this final stage, I would expect her to be using her coping skills, and the need for service intervention to start slowly withdrawing. Crisis intervention will also help me to recognise if the risk has reduced when I review the safety plan.

For this case study I have used Kolb's (1984) experiential learning theory to help me reflect upon my practice. Kolb (1984) developed a learning cycle and argues that people can only truly learn from an experience if they move around the four stages of this circle. The first is the experience, the second stage is reviewing the experience making sense of it. The third stage is reflecting on previous knowledge, so in my case, I believe I was reflecting on SU3's history, the Human Rights Act 1998 and my understanding of mental distress. The fourth and

final stage is the where the person develops a working hypothesis and start to plan what they will do next. For me, I believe that I have moved around the circle. I have noticed that I like to take a step back after an experience and set a time to sit down and reflect. In this case study, reflection was important as I it felt like I had a lot of information to process and I do not think I could have processed that information without Kolb's (1984) reflective model. I could have used Schon's (1987) reflective model, however, I have noticed that I prefer to stand back to take the time to reflect on all the information I have gathered. This way, I feel more confident in my decision making. I believe that I was in the fourth stage of this model when I created the safety plan, and if a new experience develops when I plan to review it, then the learning cycle may start again.

To conclude, this case study required a critical analysis, and I could not have developed this without my knowledge of The Human Rights Act 1998, The Mental Health Act or the Wales Safeguarding Procedures (2019). Without this knowledge, I would have most likely found myself at a loss and may have even put SU3 at a risk of harm. Supervision was also a good opportunity for me to reflect on my critical analysis and professional judgement as set out in the code of ethics by the British Association of Social Workers (BASW) 2012. Supervision allowed for feedback on my decision making and also helped me feel more confident about crisis working. Looking back I can clearly see the importance of using aspects of different theories and how some of them can link in with each other, for example person centred theory, crisis intervention and anti-oppressive practice. Without my knowledge of these theories, I cannot confidently say that SU3 would have been appropriately safeguarded. I needed to use my communication skills and my awareness of how oppression can make a service user feel disempowered. If a plan had not been put in place, she may not have felt supported and further disengaged from services.

Going forward, I think this case study has also prepared me for becoming an Approved Mental Health Professional (AMHP) student. I have been reflecting upon the pertinent role of the Human rights Act 1998, and I'm starting to get firsthand experience of the position of power social workers can find themselves in, and the importance of using power ethically and legally (BASW, 2012). As I look back on this case study, I feel confident that I have explored all options available to safeguard SU3 and feel that my assessment has led to a good defensible decision.

Carson (1996) rightly points out that a decision can be defended if the social worker has shown they have taken all reasonable steps, evaluated all information thoroughly, worked within policies and procedures and all decisions have been recorded accurately. When making difficult decisions, knowledge of this concept has prompted me to question myself, asking, am I being reasonable? Can I confidently justify my actions? I am naturally a reflective person and I have found questioning myself enables me to be critical of my work. Honey and Mumford (2000) designed a learning style questionnaire to help people identify their learning style, and I was not surprised to discover that my learning style was that of a reflector. All of my work and decision making is accurately recorded and the relevant legislative guidance are followed, in line with Section 4, 6.1 and 6.2 of the Code of Professional Practice, Social Care Wales (2017).

4189 words

Section 5

Safeguarding

*Guidance: Social Care Wales require newly qualified social workers to provide evidence of their understanding of safeguarding work with adults **and** children. The assignment below will enable you to show this. **N.B.** if your normal area of work is with children please write about adult safeguarding. If you normally work with adults then write about child safeguarding.*

In an area **that is not your main focus of work** (see guidance above), explain the relevant legislation, and the national, local and organisational policies and procedures for safeguarding.

500 words (+/- 10%: include your actual word count at the end of each section)

The role of a social worker in a children's team is to support and empower families by creating a plan that recognises strengths, priority risks, and achievable outcomes. To ensure Social workers identify risks and safeguard children, they must follow guidance from the Children Act 1989 and the Social Services and Well-being Act (Wales) 2014. More recently, the new All Wales Safeguarding Procedures Wales 2019 has a thorough guide on the safeguarding procedures for practitioners to follow. It has two key principles that practitioners should embed, such as using a child centred approach and an understanding of how to promote a child's wellbeing. It emphasises that everyone has a duty to safeguarding children, not just social workers.

The Children's Act 1989 is also still an important piece of legislation that places duties on local authorities to investigate harm or abuse of children. Section 17 places a duty for all local authorities promote the welfare of children who are either in need of additional support or protection from abuse.

Section 47 of the Act places a duty on local authorities to carry out an investigation where there is reasonable cause that a child is at a significant risk of harm. This investigation involves an assessment of the child, visiting the child alone within 24 hours of the referral and arranging a strategy meeting with all professionals involved to discuss whether and what action needs to be taken. Professionals such as health visitors, police are usually invited and parents/carers are interviewed as part of the assessment. The investigation must be completed within 45 days from the referral date. Some social workers in children's teams can

have numerous section 47 investigations on their caseloads so organisation skills are crucial to a role in children's services.

Another important piece of legislation that is parallel to the children's Act is the United Nations Convention on the Rights of the Child (UNCRC) which states that every child has a the right to be protected from abuse. In Wales, the Welsh Government (2011) has embedded the UNCRC into the Rights of Children and Young Persons (Wales) Measure 2011. This places a duty on local authorities to have due regard to the rights of the children and wales is the first country in the UK to appoint a children's commissioner. Wales seems to be at the forefront of safeguarding with an emphasis on children's welfare and information sharing.

In this local authority the council have produced a ERW Model Child Protection Policy and created the role of an Education Safeguarding Officer (ESO). These officers are now in most schools across the locality and are specifically there to assist with safeguarding concerns, or complex safeguarding needs. They liaise with both families at home, the local authority and children and staff at schools.

463 words

Reflect on the difference between safeguarding in adult and children's work

400 words (+/- 10%: include your actual word count at the end of each section)

Both children and an 'adult at risk' need safeguarding that is proportionate to the needs and risks. However, the approaches to safeguarding in children's and adult social care can be somewhat different. The Social Services and Wellbeing Act 2014 defines an 'an adult at risk' as a person who has needs for care and support and is at risk of experiencing abuse or neglect. When considering safeguarding an 'adult at risk' there are a numbers of factors to consider. Capacity is important, and guidance must be followed from the Mental Capacity Code of Practice and the Mental Capacity Act 2005. Adults who have capacity have the right to make unwise decisions, such as refusing to engage with services, refusing to take medication, refusing to stop drinking alcohol and so on. Adults may also chose not to protect themselves and it is only in certain circumstances that the local authority may need to intervene. For the safeguarding of children, a child's capacity to make decisions is not necessarily a main factor to take into consideration but the child's wishes and feelings should be listened to.

The All Wales Safeguarding Procedures 2019 has replaced the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse 2010 (updated 2013).

When the local authority has concerns for an adult and needs to gain entry into a property or home, the local authority can apply to the courts for 'An Adult Protection and Support Order' (APSO) where an authorised officer can enter the property and speak to the adult to determine if any action needs to be taken to safeguard them.

Similar to a child protection investigation, if the local authority have reason to suspect an adult at risk then a An Adult Protection Conference is to be arranged where the adult is interviewed and professionals share and discuss information to determine an action plan.

Other pieces of legislation that may need consideration regarding the concern of an adult is the Deprivation of Liberty Safeguards Act (2007), The Mental Health Act (MHA) 1983 and The

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. When considering the mental health Act 1983 for children, the process is different for adults and children. Children assessed under the MHA will need an assessment of 'Gillick Competence' to determine their capacity. Moules, Ramsay and Hendrick (1998).

Word count 387

Section Developmental Review (b)

Critically reflect on your development including reference to the training, learning, research and use of supervision since completing section 2. Consider in discussion with your mentor/supervisor/line manager the extent to which those learning needs have been achieved. Identify additional learning needs to support your development in the transition to becoming an experienced practitioner. You will consider here, the feedback you have received from individuals using services, their families and carers, and how this has impacted on your practise.

800 words (+/- 10%: include your actual word count at the end of each section)

On reflection I feel I have had a good year of learning and have developed my self-awareness further. One of my learning outcomes was to develop my knowledge around the Mental Health Act 1983 amended 2007 and I feel that I have achieved this outcome, as noted in Section 4. I had not been in such a complex situation before, and it allowed me to reflect upon my actions and build upon my confidence. Supervision has been very helpful as I can discuss the thought process behind my decision making. I have also enjoyed wider reading behind the Mental Health Act 1983 such as books by Barber, Brown and Martin (2020), Maclean and Harrison, (2015) and Barcham (2016). It has been interesting reading about the recognition the Human Rights Act 1998 needs in regards to safeguarding and implementing the Act. Supervision has been helpful to be as it is where I can seek clarity and ease any anxieties I have about things I am unsure of. It has been helpful as it has allowed me to identify areas I need to improve upon and I have found my own style of practice. With feedback from other professionals, I am confident that my practice is appropriate, approachable and professional. However, I have identified additional learning needs such as developing my knowledge further around children's legislation and managing complex cases that involve children's services.

Another one of my learning outcomes was working collaboratively, and I feel I have gained experience in both the challenges and difficulties this way of working can bring. It has helped me reflect upon my own practice and I am mindful to be open to others expertise and points of view and be assertive when appropriate. I wanted to develop knowledge of how other teams work but did not anticipate that I may face a potential conflict or disagreement. In the future I may come across this many times and I am glad I had the opportunity to reflect upon

this and learn from it using Kolb (1984) reflective model. This has helped take more from my experiences and helped me think about how I would handle situations in the future. I have also been able to develop my critical analysis skills and exercise my professional judgement. I do not think I could have done this without knowledge of relevant theories and a sound knowledge of the key pieces of legislation. The feedback I have received from services users has been positive and I liked that service user 2 felt that I was not 'too formal' which is how I liked to be perceived. I feel this approach is more natural to me and can put patients at ease. I have also reflected upon the Welsh context and I have seen the impact the lack of living in a deprived area can have upon service users. I have noticed that Wales lacks many important services such as inpatient eating disorder clinics and mother and baby mental health units. Service users who are already in crisis have to travel and stay over a 150 miles away for treatment and their mental health is further impacted by this. I did not realise that I would have to take into account all the wider issues from living in a rural area. To give service users the best service, meetings must take into account bus times and childcare services.

I have also researched what other services are available in the third sector who can help services with issues such as housing, substance misuse, self-harm and advocacy support. To be an experience practitioner means to draw upon resources, experience to exercise professional judgement. I feel that I am developing as a practitioner and to continue my professional development I need to take more shadowing opportunities within the team. I have also developed my understanding of various theories and understand more how they inform interventions. I have found a person centred approach to be at the heart of my practice as it helps me build a rapport and establish a therapeutic relationship with patients. I have found crisis intervention an area of interest and I look forward to developing my learning, particularly how to manage conflict and difficult situations that requires quick thinking. I am hopeful that my time as an AMHP student will enable me to develop these skills, and transition into an experienced practitioner.

Words 732

Please record in the table below the dates of each consolidation programme workshop you attended.

Consolidation workshop	Date Attended
1	13 th November 2019
2	27 th February 2020
3	30 th April 2020
4	9 th July 2020

Notes

The COVID 19 pandemic has made restrictions for students to attend consolidation workshops in person so the last two were attended via teams.

It must also be noted that the restrictions have not allowed Sarah to access the university's library.

Mentor's comments
Please comment fully on the learner's development over the duration of the whole programme. Reflect on information provided by the learner in section 2 at the outset of the programme and the later perspective given at section 6. Where you have seen or discussed feedback from individuals using services, families or carers, you are encouraged to comment on this with regard to the learner's development.

Having worked alongside Sarah for a year, prior to her commencement of the CPEL course I was more than happy to take on the role of her mentor. Sarah is knowledgeable, hardworking, organised, motivated and a proactive member of the team. I have enjoyed learning from Sarah, especially the techniques she uses to engage individuals in identifying their care and support needs and formulating their plan. Sarah had clearly put thought into sessions with the individual and tailored her approach to meet their needs. Sarah showed an interest in the families she works with and sought supervision and advice from the multi-disciplinary team when needed. This was evident in relation to an individual where the risk to self-needed to be managed in a safe way, while also respecting the individual's right to make unwise decisions. The individual declined a referral to the crisis team, which we would usual consider in this circumstance as they provide support out of hours as well as in the day. Sarah, however, developed a safety plan with the individual, while utilising the multi-disciplinary support within the Community Mental Health Team. This included bringing the outpatient appointment forward and sharing information about the potential risk with all colleagues on

office duty. This ensured that should the individual call for help, all members of the team had the required information to support the individual at this time. The individual agreed that information can also be shared with the crisis team, allowing her the options to change her mind and seek support out of hours if needed. Sarah is a very competent social worker, has developed effective recovery focussed assessment skills and produces work to a high standard. Sarah manages complex cases for individuals who have a severe mental illness diagnosis and works well with other agencies such as the crisis team and acute hospital ward as needed.

Sarah utilises both formal and informal supervision effectively to reflect on interventions with families and individuals and has open and honest discussions around ways of improving future practice. Having observed Sarah on many occasions undertaking direct work with individuals and families, it is clear that Sarah is methodical, has appropriate professional boundaries and is realistic about what she, individuals and families can achieve. Sarah is reliable, demonstrates compassion and empathy with individuals and carers and works in an anti-discriminatory and anti-oppressive way. Sarah is respectful to individuals, carers and other professionals, also working collaboratively while empowering individuals to make decisions about their care and treatment. Sarah has attended Tribunal Hearings which can be a difficult and challenging experience. Sarah will grow in confidence by attending further hearings and gain a better understanding of the expectations of the other professionals involved. We explored this in supervision and Sarah is aware that they can be challenging even with more than adequate preparation. Due to the complex requirements of our roles, Sarah is aware of the support available within the team when we face challenges at work. Sarah spoke positively about the support in the team and has utilised this appropriately. Sarah has developed by taking on challenges, reflecting on practice and used supervision to develop her learning and professional practice. Sarah demonstrates integrity in all her work.

Sarah discussed as part of her developmental review that she would like to gain further knowledge around the Mental Capacity Act 2005 and the Mental Health Act 1983. Sarah reflects well and seeks supervision after interventions with families and her learning is evident in relation to the Mental Health Act. Her motivation to learn, research, follow legislation and support families in a collaborative and strengths based way has enabled her to gain valuable

work experience and enhance her knowledge of the Mental Health Act. Sarah's current learning needs include further development of her skills around relapse indicators, crisis intervention and conflict management. This could in part be achieved by attending Wales Applied Risk Research Network (WARRN) training and training as an Approved Mental Health Professional. This in turn will lead to further understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (soon to be Liberty Protection Safeguards) and their interface with the Mental Health Act 1983. Sarah raised an important point in her developmental review about the need to continually improve knowledge of children's services. It is essential to keep up to date with the safeguarding referral process and the links between parents struggling with their mental health while ensuring a safe and nurturing home environment for their children.

Section 7

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Section 8

Learner details, Signatures and Line manager verification

It is the learner's responsibility to ensure that their university learner number is correctly inserted wherever requested within the portfolio

Learner Details

(NB it is essential that you inform your Workforce Development/Training Unit and the University of Wales Trinity Saint David if your name or your address for correspondence changes).

1. Name of Learner Sarah Louise Thomas

2. Learner's University Number: 1152222

**Address for Correspondence: Tonna Community Mental Health Team (CMHT)
Tonna Hospital, Tonna Uchaf, SA11 3 LX**

Telephone: 07852310194 OR 01639507310

E-mail: s.l.thomas2@npt.gov.uk

Date of Professional Qualification: 31st July 2018

Date of registration with Social Care Wales: 4th September 2018

3. Name of Learner's Agency: Tonna Community Mental Health Team (CMHT)

Agency Contact details: 01639 507310

Name: *Neelo Farr, Manager*

Address: *Tonna Hospital, Tonna Uchaf, SA11 3 LX*

Telephone Number: 01639507310

E-Mail address: neelofar@npt.gov.uk

4. The evidence I have provided within this portfolio is in:

Welsh only ☐

Welsh and English ☐

English only ☐



Mentor's details

5. Mentor's details: *Rhiannon Roberts, Social Worker, AMHP*

Name: *Rhiannon Roberts*

Address: *The Forge Centre, Forge Road, Port Talbot SA13 1PA*

Telephone Number: 01639 888000

E-Mail address: *r.roberts@npt.gov.uk*

6. Observer details

Name: *Rhiannon Roberts*

Work Address: *The Forge Centre, Forge Road, Port Talbot SA13 1PA*

Professional Qualification and date of qualification: *MsC in Social Worker 2015*

Email and telephone number:

Signatures and Line Manager Verification

CONFIDENTIALITY and PLAGIARISM – to be completed by the learner

All information provided in this portfolio complies with guidance on confidentiality. I confirm that all work apart from comments by others (e.g. mentor, an individual using services, their family or carers) is all my original work and has not been copied. I understand that plagiarism is taken very seriously by the University and the programme.

Signed:  (Learner)

Date: 18.2.2020

Feedback and comments from an individual using services, their family or carers (Section 3) - to be completed by the Observer

I confirm that I am a registered social worker with knowledge of the learner's area of practice and that the observation sumSU3 and the comments from the individual using services, their family or carers and/or carers above are about the same piece of practice that I observed on the date given.

Signed:  (Observer)

Date: 18.2.2020

Line manager verification

Guidance: This section must be completed and signed by the learner's line manager or senior practitioner. He/she should be a registered social worker who is familiar with safeguarding work, can verify that the learner has been involved with the case evidenced in section 4 of the portfolio, and has also met all other required criteria listed.

In this section, please confirm that you have seen sufficient of the learner's work during the period they have been undertaking the Consolidation programme. If necessary, please consult with other managers that the learner has worked for. In signing this section, you are confirming that you are content with the:

- level of supervision and mentoring support received by the learner
- learning and development undertaken
- reading and personal research undertaken

- level of knowledge and skills demonstrated
- understanding shown of the Code of Practice and National Occupational Standards
- core values of the learner
- content of the development plan within the portfolio
- work and commentary referred to within the portfolio, that it is the learner's own work and based on current practice

I confirm that this learner has achieved an appropriate level of professional practice.

LINE MANAGER VERIFICATION:

NAME OF LINE MANAGER:	<u>Neel Far</u>
SIGNATURE OF LINE MANAGER.:	<u>Neel</u>
DATE:	<u>18.2.2020</u>

Section 9

PORTH AGORED and UNIVERSITY OF WALES, TRINITY SAINT DAVID

GRADUATE CERTIFICATE IN CONSOLIDATION OF SOCIAL WORK PRACTICE

LEARNER AND EMPLOYER'S LEARNING AGREEMENT

Name of Learner	Sarah Louise Thomas
Name of Team/Agency	Tonna Community Mental Health Team
Name of Mentor	Rhiannon Roberts
Name of Line Manager	Neelo Far

Study Duty

The learner will undertake all elements of the Graduate Certificate programme diligently, including mandatory attendance at induction, 4 Consolidation workshops, and participation in an evaluation survey or focus group on completion of the programme.

The learner's full and effective participation on the Graduate Certificate is mandatory given that Social Care Wales has made completion of the programme a requirement within the first (three year) period of registration as a Social Worker. .(Qualifying after April 2016)

Study Leave

The employer undertakes to support the learner by providing paid leave in full to attend all agreed induction, Consolidation Workshops, programme evaluation meetings or training agreed as required during the programme. In addition, three additional paid days can be approved by managers as a contribution towards the time involved in personal research and developing the portfolio for submission. It is for learners to open a discussion with their manager about when they want to take this leave. The study days can be taken on any week-day (or combination of days) as long this is (i) appropriate to the stage of portfolio preparation at the time, and (ii) agreed with the Team Manager who will take into account team and service needs. The level of paid leave described here assumes that the learner works full-time hours. Where the learner works less than 37 hours a week, paid time will be approved in accordance with the employer's local policies.

Resources

Learners are able to access learning and library materials from their employer's existing resources or as described in the Programme Handbook from the University. The employer

understands that the Graduate Certificate is to be completed by newly qualified Social Workers in their first period of registration and will support this timescale. But there is also an expectation that as a professional development programme, Learners take responsibility for their own learning and will also use their own time for personal study and portfolio preparation.

The employer's training department agrees to:

- Arrange for eligible staff to join the programme
- pay course fees directly to the University
- provide additional guidance and support by:
 - a) facilitating access to existing learning materials or library resources
 - b) providing appropriate training opportunities from existing internal training programmes as agreed with the learner and mentor
 - c) providing programme induction and Consolidation Workshops
 - d) providing learners' with guidance and support about programme requirements and portfolio completion
 - e) helping to resolve any programme difficulties encountered by the learner, mentor or service managers

The learner agrees to:

- work actively towards completing the qualification within the agreed timescale of 12 months from the date of registration on the programme
- Identify with manager/mentor appropriate internal training and arrange to attend these courses
- Identify with manager/mentor and Training Manager any special requirements e.g. dyslexia and contact the University's Student Services office directly about additional support that may be required
- attend induction and 4 Consolidation Workshops. These are mandatory components of the programme
- produce work and evidence appropriate to the portfolio and learning outcomes within agreed timescales
- make and keep agreed appointments with mentor/line manager
- ensure they are prepared adequately and obtain all necessary consent for observed practice
- inform mentor/line manager and training department immediately of any problems or changes in circumstances while undertaking the programme, especially where this may affect completion of the programme by the agreed deadline or ability to attend a mandatory workshop.
- liaise with their line manager/mentor to confirm study days and use their own time for self study, research and portfolio preparation
- take personal responsibility for preparing and completing all work necessary to submit their portfolio
- act at all times in accordance with the Code of Practice, the employer's and University's policies, procedures and processes
- ensure they understand the need to complete the programme within the first (three year) period of registration with Social Care Wales.(Qualifying after April 2016)

Line Manager/Mentor agrees to:

- attend an induction meeting to become familiar with the requirements of the programme
- provide or arrange to provide sufficient assessment opportunities in order for the learner to evidence competency and undertake required observations. Where opportunities may not be immediately available within the team, arrange to provide these elsewhere within the Service,
- guide and support the learner for the duration of the programme
- release the learner for programme induction and Consolidation Workshops, and any internal training courses agreed as being appropriate to meeting agreed learning needs.
- agree with the learner, use of up to 3 additional paid leave days over the whole duration of the programme, as a contribution towards time needed for personal study, research or portfolio development
- Hold supervision with the learner, ideally monthly, and ensure this incorporates mentoring support and monitoring of the work undertaken and still outstanding. Maintain a full record of supervision dates and record discussions and agreements.

Completion and submission of portfolio

Learners are expected to complete the Graduate Certificate and will normally submit their portfolio within 12 months of attending induction to the programme. Any Learner anticipating any difficulty in meeting this requirement should immediately discuss the matter with their Training Manager/Co-Ordinator

The portfolio submission process and dates for each programme cohort will be published on Moodle. Once registered on a programme, learners **CANNOT change the due submission date without gaining agreement from the employer and University.**

Pressure of work is not regarded as a reason for non-attendance at any Consolidation Workshop.

I understand and accept the terms and conditions of this learning agreement as stated above.

Signed: [Signature] Print Name: Sarah Thorne Date: 18.2.2020
(Learner)

Signed: [Signature] Print Name: Neel Patel Date: 1/9/2020
(Line Manager/Mentor)

Signed: [Signature] Print Name: R. Roberts Date: 18.2.2020
(Mentor, if different to above)

PLEASE PLACE THE SIGNED COPY OF THIS LEARNING AGREEMENT IN SECTION 9 OF THE PORTFOLIO

