

Care Services Improvement Partnership 

National Institute For
Mental Health in England

**THE SOCIAL WORK CONTRIBUTION TO
MENTAL HEALTH SERVICES
THE FUTURE DIRECTION**

**REPORT OF RESPONSES TO THE
DISCUSSION PAPER**

21st MARCH 2006

INTRODUCTION

Purpose of the Report

1.1 The purpose of this Report is to set out and collate the main themes and comments to emerge from the 103 responses received to the Discussion Paper on “The social work contribution to mental health services the future direction” distributed in November 2005. The Report does not set out to provide a detailed analysis of the responses, nor does it provide recommendations. That is the main purpose of the proposed national conference - see below.

Who is the Report for and what are they expected to do with it?

1.2.1 This Report is intended for those people and organisations who have an interest in the social work contribution to Mental Health (MH) services both now and in the future. Specifically, the Report will provide the context for delegates who will be attending the national conference scheduled to take place on Tuesday 25th April 2006. The aim of that conference will be to consider the feedback from the Discussion Paper and so help inform the development of action plans and identify programmes of work designed to support the social care contribution to mental health services both now and in the future.

1.2.2 It will also be placed on the web sites of all the organisations shown in paragraph 2.3 below for information.

BACKGROUND

What led up to the publication of the Discussion Paper

2.1.1 Since its inception in 2003, the National Institute for Mental Health in England (NIMHE) National Workforce Programme (NWP) has been developing a programme of work that has included Workforce Planning; looking at New Ways of Working (NWW) for Psychiatrists and other members of the MH workforce; introducing New Roles (NR) into the mental health and social care workforce such as Support, Time and Recovery (STR) workers; Education and Training; and Recruitment and Retention.

2.1.2 One strand to this programme was to set up a specific multi-agency Social Care Group primarily with the aim of exchanging views and intelligence across the MH and social care agendas and to ensure work was not being duplicated. At the same time, it also became clear that changes have been happening in the delivery of social care services with, for example, staff being seconded to or employed directly by NHS Trusts as well as the proposed changes in the MH Bill around the role of the Approved Social Worker (ASW). As a result, the Group decided to focus on these and other changes to see what effects they might be having on the social work contribution to MH services particularly around recruitment and retention. It became clear that before attempting to develop a specific programme of work, more information was needed to obtain the views of as wide a range of people and organisations as possible. This resulted in the preparation and distribution of the Discussion Paper in November 2005.

Purpose of the Discussion Paper

2.2 The purpose of the Discussion Paper was to generate a debate with commissioners, employers and social workers in primary, secondary and tertiary MH and social care services on the contribution that social workers can and do make to the support and recovery of people of all ages in mental distress, both now and in the future.

Who the key partners are

2.3 The preparation and distribution of the discussion paper was a collaborative exercise, co-ordinated by the NIMHE NWP [now part of the Care Services Improvement Partnership (CSIP)]. The other key partners included the Association of Directors of Social Services (ADSS); British Association of Social

Workers (BASW); the Department of Health (DH); General Social Care Council (GSCC); Social Care Institute for Excellence (SCIE); Skills for Care (S4C); and the Social Perspectives Network (SPN).

OVERALL MESSAGES (EXECUTIVE SUMMARY)

3.1 The responses were collated centrally, anonymised and analysed using a Computer Assisted Qualitative Data Analysis tool. For each of the 12 questions set out in the Discussion Paper, there was often a difference of views or responses and the Report captures both “sides of the argument” ie there is no attempt to sway readers one way or the other. In summary, the key messages are:-

Q 1 and 2 - roles and competences: Working with users and carers, social workers promote an unique holistic, recovery orientated, values based social care/social inclusion model that is able to challenge the dominant, task orientated medical model and this is reflected in the competences required. This model should continue in the future.

Q 3 - access to qualifying training and learning: The continued diversity of access to qualifying training is welcomed and it had a positive link to recruitment. The three-year social work degree is valued as improving academic rigour and competency to practice and hence supporting a well-trained graduate workforce. The Post Qualifying (PQ) framework provides opportunities to consolidate learning and to develop areas of particular practice. The quality of PQ programmes is high although consideration needs to be given to staff whose qualifications are not recognised within the PQ framework. Further clarity as to the opportunities within the Advanced level would be welcome. Better access to therapeutic skills/training for social workers should be considered. (eg Cognitive Behavioral Therapy (CBT) and Psycho-Social Interventions (PSI).

[This question produced the biggest response in terms of the length of the replies and range of issues raised]

Q 4 - deployment of social workers: The majority of social workers are working in integrated, multi-disciplinary teams with a mixture of secondment to or direct employment by MH Trusts. Professional isolation in small teams is of some concern. Future plans suggest all social workers who are seconded will be employed by Trusts.

Q 5 - meeting workforce development needs: These are often being met by a variety of approaches such as annual appraisal; supervision; PQ training; social worker/ASW Forums; Continuing Professional Development; and Personal Development Plans. But these are not applied everywhere.

Q 6 - recruitment and retention: Apart from the “usual” methods eg advertising, a variety of different methods are used demonstrating some innovative approaches. These include “growing your own”; a £100pm “honorarium” for ASWs; a £2K award for a new social workers as part of a recruitment drive; offering quality placements to students; social workers receiving an honorarium of £300 for achieving PQ1; use of additional increments; and provision of Social Work Forums (discussion groups). However, differentials around pay and terms and conditions between health and social work staff in the same teams do not help with retention nor does the lack of a clear career pathway.

Q 7 - comparative pay and conditions: Some social workers are included in the Agenda for Change process and some are not. Some retain Local Authority pay and conditions of service. Some social workers are on Band 6 pay scale so being comparable with ex G Grade nurses. However, it is also clear that there are some disparities in pay and conditions between NHS and social care staff eg nurses and social care staff working in the same Trust.

Q 8 - career structure: Some localities are introducing a career pathway (eg Social Worker; Senior Social Worker; Principal Social Worker; and Head of Social Work) but more development work needs to take place (eg to consider the introduction of a Social Work Consultant role, linked to the PQ framework). Work is required in relation to developing career opportunities either as, for example, advanced practitioners (clinical leadership), or proactive choices to move into management, education or even a combination of these roles. Work also needs to take place to develop a career pathway for non-professionally affiliated staff who may want to move into the social work training.

Q 9 and 10 - New Ways of Working (NWW): Whilst some were unclear as to the NWW programme others see it as an opportunity to raise the profile of the social work contribution particularly in relation to social inclusion, empowering practice and recovery. NWW has the potential to help shift the emphasis from social work as a passive recipient of integrated mental health services towards active participants in future service developments and delivery.

Q 11 - development of leadership and management: This is being developed by a variety of methods to include action learning sets; Directors of Social Care at Trust Board level; Departments of Social Care; networking; Trust leadership groups; mentoring; and secondments. But the provision of these initiatives is not universal.

Q 12 - developments and implementation of the Mental Health Bill: The knowledge and education base of, and the high respect for, ASWs will be invaluable to help implement the education and training of staff particularly in respect of the new Approved Mental Health Professional (AMHP) role. ASWs will also be able to contribute to the assessment and management of risk as well as the development of the Code of Practice.

Other issues not specifically raised by the 12 Questions set out in the Discussion Paper:

- Concerns were expressed about the new workers e.g. STR workers. Is this a dilution of social work and a devaluing of the support these workers provide?
- Whilst not opposed to moves to identify, value and recognise the particular contributions social workers bring to Community Mental Health teams (CMHTs), there would be concern if this meant their roles were to become too rigidly prescribed as if there were artificial demarcations between social workers and other CMHT staff
- One possible further development for social workers that may arise out of integration with the NHS is greater opportunities for training in therapies like CBT, group work, PSI etc
- There needs to be a single, central body representing and advocating for social workers
- There is a fear within social work staff that with Trusts becoming social care providers, that their professional identity will be lost.

3.2 In no sense of “ranking” or priority order within each of the 12 questions, Appendix 2 fleshes out the main or common responses in more detail.

SUMMARY

4.1 The CSIP/NIMHE NWP and the various partner organisations listed in paragraph 2.3 would like to thank all those who contributed to the Discussion Paper and for their well thought out and cogent responses. This will prove invaluable in helping to take the issues forward in a more collaborative and coherent way.

NEXT STEPS

5.1.1 The next steps will be for:-

- the delegates at the national conference to consider the responses to the Discussion Paper and so help the development of action plans and identify programmes of work; and
- in conjunction with the existing multi-agency group, the CSIP/NIMHE NWP to then develop and publish a radical programme of work as part of the wider NWW initiative, to support the social care contribution to mental health services both now and in the future.

APPENDICES

Appendix 1 List of the 12 questions raised in the discussion paper

Appendix 2 Summary of the responses to each question in the Discussion Paper

Appendix 3A	Summary of the Number of Responses to each of the 12 questions by Organisation/Group
Appendix 3B	Number of Responses by Organisation/Group
Appendix 4	Number of Responses by Staff Group
Appendix 5	Number of Responses by CSIP/NIMHE Development Centres
Appendix 6	Glossary

List of the 12 questions raised in the Discussion Paper

- Q1.** What do you see as the role for social work in mental health services both now and in the future?
- Q2.** What do you see as the key competences required for the social work role? What are the knowledge, skills and values that underpin the application of a range of theoretical perspectives to evidence and values-based interventions?
- Q3.** What thoughts do you have about the existing or potential diversity of routes to access qualifying training and the specific learning and development which is associated with the PQ framework including the ASW role?
- Q4.** How and where social workers are deployed within your service and is this likely to change?
- Q5.** How does your service ascertain and meet the individual and wider workforce development needs of social workers?
- Q6.** How are you encouraging recruitment and retention of social workers?
- Q7.** How are you addressing issues of comparative pay & conditions, including Agenda for Change?
- Q8.** How do you see the career structure for social workers developing in the future?
- Q9.** How do you think NWW might influence the future development of the social work role?
- Q10.** In turn, how do you think social work might influence NWW generally?
- Q11.** How are you ensuring the development of Leadership and Management for Social Care, including succession planning?
- Q12.** How do you anticipate social workers being involved in the developments and implementation of the provisions in the Mental Health Bill?

Summary of the responses to each question in the Discussion Paper

[The abbreviations used in this Appendix are set out in full in the Glossary in Appendix 6]

Question 1: What do you see as the role for social work in mental health services both now and in the future?

Summary of responses

- To develop skills and expertise in the use of the social model in mental illness, and to ensure that the social perspective and environment is included as part of the assessment
- Promoting a value based perspective relating to such things as human dignity and worth, social justice, service to humanity, integrity and competence as well as embracing and expressing the 10 Essential Shared Capabilities
- Questioning and challenging the dominant medical model which pathologises service users + Not bound by treatment labels – we see the whole person
- Continue the social work role in SI in the widest sense
- Promoting the rights of users and working with carers
- Having a track record anti discriminatory and anti oppressive approach and practice
- Bringing a SW and social care perspective to the teams working with patients and carers and to the governance of the hospital
- Having a particular focus on issues relating to victims
- Public safety/risk assessment in the community and SWs, through their training and experience, are well placed to adopt “positive risk taking” strategies
- For the future, an expanded role in therapeutic delivery
- The role of the SW is to provide a holistic perspective on the care and treatment of service users and carers. SWs have a breadth of professional experience working with people who have multiple problems and complex needs
- SWs sometimes offer practice help when other professionals would not
- They have extensive knowledge of complex legislation unrelated to MH
- Many SWs have experience of family interventions, working with families and children and worked with high risk service users on child care and protection issues, taking a lead role in safeguarding children
- The strength of the SW in MH is to bring experience of working and supervising high risk users in high risk settings
- The SW has extensive knowledge on housing, education, leisure and finance, taking an holistic approach to care and not just a medical approach
- ASWs often challenge other professionals, particularly regarding compulsory admission to hospital under the MH Act 1983, as they have knowledge of other community options and support mechanisms which can be used to maintain people in the community
- SWs advocate for the Human Rights and dignity of service users
- The thing the SWs have brought most to the integrated CMHTs has been a willingness to use statutory powers to protect the public and or the individual and to assess people who were not agreeing to being referred but, about whom third parties have significant concerns

- I do not see a defined role for non-ASW trained SWs in MH - as integration/secondment of SWs to Trusts and care co-ordination with crossover of roles, has led to an increase of the medical influence in teams
- It is important, in our view, that the knowledge, skills and values reflect not only in-depth knowledge of issues and models of MH and mental illness, legislation and social policy but also engage with deep critical analysis of social issues and knowledge, high level interpersonal skills including the ability to stand up against strong opinions and to present and sustain cogent, informed arguments based on high quality assessment
- The new group of AMHPs (at least at the outset), will provide another opportunity to present the ‘acceptable face of social work’ which would otherwise remain largely invisible
- SW is the essential counterbalance to medicalising perspectives. It provides staff with a strong value based, person centred and strengths based approach. SW further propagates more inclusive entry criteria, and is more disposed to look at families holistically, to be mindful of child protection concerns, and to be responsive to the needs of sometimes marginalised groups such as people with autism; AS; PD; dual diagnosis; and the needs of carers
- We do not however see MH SW as an entirely separate profession and role within MH services. A social care focus should be all pervasive in MH services, given the otherwise often strong emphasis on medical care and treatment. The particular contribution that social care brings is a focus on recovery, long term support and sustaining people in the community – often long after other disciplines have lost interest, or written service users off as ‘untreatable’ or ‘difficult to work with’. In other words, the ‘social perspective’, which is being championed through this Discussion Paper
- We do see the role of SW in MH continuing to develop both as a separate, specialised discipline, and as an equal profession with others in the MH service
- Support alternatives to admission to hospital and supporting care networks – the notion of least restriction
- Emphasis on individual self determination rather than dependency on ‘expert’ professional
- Empowerment and self determination (choice) rather than creating dependency
- Working with service users and carers in society/social systems, taking a person centred approach and providing social empathy
- Experience of gate-keeping and access to resources
 - The Group saw the Differences from other professionals as;
 - The conscience of MH services
 - Anti-discriminatory as a core value practice
 - Political engagement
 - Independence of role – lack of hierarchy – eg ASW
 - Challenge to medical model – providing an alternative philosophy and approach to diagnosis/medication/treatment
 - SW values encompass the new buzzwords of choice, independence and wellbeing and recovery
- Challenging narrow definitions of “mental health” and redefining in terms of social functioning rather than “diagnosis”
- Promoting independent living and lifestyle choices, choice and quality and respecting diversity
- Promoting a “recovery” ethos - the profession has a role in assisting MH services develop away from a predominantly illness model and more towards a recovery model
- A much valued “statutory expertise” and the experience of a profession accustomed to managing the complex and inherent tensions of “rights versus public safety” and “control versus autonomy” issues. The profession’s legal knowledge, its level of professional autonomy and ability to work with complexities of risk and multi agency involvement contributes to an integrated approach to mental health treatment and care
- Care and brokerage which incorporates the full spectrum of individual need (eg housing, welfare benefits, employment, occupation opportunities, recreational and social

networks in addition to medical and nursing care). The SW profession can help MH services make more linkages and forge partnerships with wider agencies and community organisations necessary to make such holistic care planning a reality for service users

- On the whole, OPMH SWs feel more positive and attributed this to an equal number of social and health professionals required to follow a more social care orientated 'agenda'
- SW holds a different perspective to that of a CPN/OT. We are person orientated while they tend to be task orientated. In practice, I do tasks like housing, benefits, access to groups, day care. All are done with an inner eye on the psyche, values and experience and strengths of that client. Trying to walk in their shoes, to understand their context
- It is the only profession to have core training around social science and social policy issues
- SWs, and in particular, ASW's, are skilled at making complex assessments involving a high degree of risk and encompassing a whole systems approach which takes into account social networks; knowledge of inter and intra agency support systems; family dynamics and social factors. In particular, social work assessments are not bound by a treatment and diagnosis model of ill health, and can therefore include a focus on skills and achievements in relation to well being
- SWs are least satisfied with their role in MH when they experience it as a combination of under-stimulating work on the one hand and an excess of stressful crisis work – mainly ASW – on the other, with little of the more rewarding therapeutic contact with service users in between
- If the profession is to establish itself within the NHS, that SW is able to establish its intellectual credibility through its engagement in research into what is effective in social care, the dissemination of the results of such research, and its incorporation into evidence-based practice. Improved links with universities, and the creation of opportunities within the profession both to engage in relevant research projects, and also to maintain an up-to-date working knowledge of research findings, will be important in this regard
- Erosion of the MH SW role risks diluting this discipline specific, social science contribution to future MH research which the discussion paper highlights as being particularly valuable
- The advocacy role played by SWs as part of their work role may assume greater importance in future. That role would be in ensuring that service users' needs are being met appropriately. This however needs to be differentiated from the need for independent advocacy outside statutory services. Social workers are renowned for their practical "can do" abilities
- It is no accident that social workers have the word "social" in their title
- Our influence within the joint teams (and we do tend to be quite vocal!) has gradually shaped the team culture which in turn shapes all new workers as they join
- SW staff carry key roles in Care Co-ordination under the CPA and naturally, in Care Management
- To reduce stigma and discrimination of service users
- They have direct therapeutic skills and knowledge which comes from a social science background and also understand systems so that they are effective at managing the interface of services for and with their service users enabling them to negotiate complex systems
- The new teams (eg Assertive Outreach) were seen as more integrated with shared skills and responsibilities and it this was seen as a positive way to move forward. If such work is developed along recovery models, then the SW skills of engendering independence and self-management will be enshrined in the demands for preventive services. SWs have a huge opportunity to lead the recovery and social inclusion process and their employment and job roles need to reflect this ability and skill
- SWs in the future also need to get involved with research as they have the training for this but do not usually have it as part of a job description and so are frustrated by this lack of opportunity. The future role of SWs will depend on training and entry requirements and it is imperative that access is made as open , as imaginative and as flexible as possible in order to retain a mature and diverse workforce with the capacity to take on new roles
- The position of SWs in primary care needs very careful consideration. Many issues raised at primary care level have a direct social cause (housing, relationship breakdown etc) so the skills and knowledge of SWs should be represented in the primary team so that it does not become overly medical or treatment focussed

- Within SW training, issues of race and culture are seen as being very important and one of the strengths SWs have is to bring those topics out in the open
- Holding a sociological understanding within a MH setting, provides an important counter balance to a medicalised view of an individual in that it: promotes an inclusive style of working; looks beyond symptom management; takes account of the wider relationship contexts in which individual function; encourages a deeper understanding of the individual thereby develops a broader range of possible interventions; increases the likelihood of successful outcomes
- In the future there is a concern amongst SWs in MH settings that their unique role within health and welfare systems will be subsumed by a more powerful health lobby. This will only be avoided if SW is given a central position within MH services and individual SWs are supported in their role by clear management and professional structures
- The profession is not good at publicity articulating what we do or at ensuring that there is a research base for social care
- In the future: need to carve out new roles in the new services contexts; need to be more clear about articulating the role; creative supportive professional structures and enhancing existing frameworks, such as supervision; go back to the roots of SW and make it work in a service where SW is a marginal player. Need to maintain our difference as a professional group ie the social and holistic viewpoint is complimentary to health models and approach of health professional. We should focus on ensuring that we lead the SI agenda and it should underpin the services we provide. We still have a much wider range of tasks to perform and an holistic stance with links out into the community we need to promote our role as being as valuable and essential
- One core value is that we challenge systems and organisations; we see part of our job as changing systems. It could be family or organisation. Health is a command and control structure. Health culture does not promote challenge, and SW's can be viewed in a negative light. There is an art to putting across a divergent view without being perceived as a bunch of moaners. It is essential not just to challenge but also to offer solutions
- STR workers. OT's, PSI interventions – will this mean that there will be no future need for a qualified SW role? If do away with social work role who will challenge?
- An additional and essential role we feel has not been included in other responses has been that of acting as a link with the knowledge and skills to assist professionals in the interface between MH and children's Services. The generic aspect of SWs training equips them with the knowledge of legislation and with the networking skills to balance the needs of eg a child in need and a parent with mental illness. A parallel point relates to SWs' knowledge and skills in Adult Protection investigations. In both these areas they have a central role and we would foresee that increasing in importance as Children's Services are distanced from Adults
- MH SW in our locality is going through a period of major change. We are developing in quite a different direction to some of the assumptions made in the Discussion Paper. After working for approximately five years in an integrated management structure with our Health colleagues, we have recently returned to a single line management structure (Health staff managed by the Trust and social care staff by the Council) for the majority of MH SWs. This has been a turbulent period and staff are still in the process of adjusting to the change. The views of staff on the future of MH SW based on our local experience, following the separation of the management structures include the following: Some staff feel that care co-ordination previously operated on the basis of 'one job fits all' and that thus some of the potential benefits of multi-disciplinary team working were lost. Some feel that in practice, integration was actually assimilation of social care into a health-dominated structure and way of working, within which it was difficult to maintain a professional identity as a SW. One worker described herself as feeling like a 'chameleon'. The return to single line management is seen as an opportunity to re-gain the social care agenda. Concerns have been expressed that there is a risk of duplication of assessments and returning to the old debates between agencies about who has responsibility for what, with the associated danger of service users and carers 'falling through the gap'. Another area of concern for MH SWs within our new arrangements is the possibility that opportunities for direct therapeutic work with service users may be reduced. Many SWs have taken up opportunities for training on therapeutic techniques such as CBT and PSI. There is a need to be realistic about what SWs can offer in terms of direct therapeutic interventions – within or outside an integrated structure. SWs offer a therapeutic approach in the broadest sense, which will incorporate elements of particular theoretical frameworks, but they are unlikely to be able to offer contracted 'therapy' in its pure form to more than a small minority of service users

Question 2: What do you see as the key competences required for the social work role? What are the knowledge, skills and values that underpin the application of a range of theoretical perspectives to evidence and values-based interventions?

Summary of responses

- The key competences are seen as including the Ten Essential Shared Capabilities
- Competences in relation to assessing the importance of social factors in MH knowledge of the social factors behind the aetiology of mental illness, the ability to balance competing ethical demands within MH, reflexive practice
- A robust value base built on empowerment and anti oppressive practice
- A wide knowledge of the MH issues incorporating the social model of disability
- To identify and challenge inequality
- To protect and promote the rights, dignity and self-determination of service users and carers consistent with their own needs and wishes
- Be sensitive to the individual's need for personal respect, choice and dignity
- To have a sound knowledge of the legislative; policy framework; and other statutes and codes of practice relating to Social Care and Human Rights.
- Ability to plan, negotiate and manage interventions. Good negotiating skills
- Have a critical understanding of a range of models of mental disorder, and in particular the contributions of social factors to presentation of mental disorder.
- Critical understanding of the implications of mental disorder for service users, children, families and carers
- Critical understanding of the implications of the range of relevant treatments and interventions for service users, children, families and carers
- Critical understanding of equality and diversity issues particularly in relation to gender and race. To respect the individual's qualities, abilities and diverse backgrounds
- Ability to obtain, analyse and share appropriate information from individuals and other sources in order to manage decision-making processes
- Ability to communicate effectively, both verbally and in writing, including use of IT, to promote effective decision-making
- Ability to articulate the role in the course of working with other disciplines
- Ability to use networks and influence collaborative working and to work in partnership with different organisations and individuals
- Ability to contribute to planning and implementing Care Plans
- Ability to communicate appropriately, and establish effective relationships, with service users and carers across a range of agencies and structures/multi disciplinary practice
- Ability to exercise the appropriate use of authority and autonomy together with an appropriate use of self-reflection, consultation and supervision
- Ability to work with conflict between the power inherent in a statutory role and the objectives of empowerment advocacy

- Ability to effectively recognise, assess and manage difficult situations of anxiety, risk (including positive risk taking) and conflict, reflecting on their impact on self and others
- Ability to research findings and their use in practice
- Ability to evaluate the outcomes of interventions with service users and others
- Possess the skills, knowledge and ability to bring about effective change when needed and highlight unmet need
- Be accountable for quality of work and take responsibility for improving knowledge, standards and skills
- Knowledge required:-
 - how societies work; how groups work; how individuals work/human development; an understanding of the effects poverty, family and community work
- Skills required:-
 - listening, empathy, and ability to contain client's anger, pain, and confusion. Ability to liaise with relatives, to advocate for client. Ability to advocate for client to other professionals, to present clients case in such a way that sympathy is gained
- Values:-
 - All persons really are created equal and remain equal in value. Even the most demented/deranged person has rights
 - As listed in the SW Registration Pack
- The key competencies outlined in the CCETSW 1994 document on the MH Dimension in SW are still relevant and should be developed within a framework which is consistent with the Ten Essential Shared Capabilities and the NHS KSF
- Verbal and written acuity: assessment of need and risk, critical understanding of statutory requirements, empathy. legal and statutory basis; anti-oppressive practice; children's safeguarding, non judgemental approach, high level of interpersonal skill to promote a social model of disability and for the therapeutic intervention pragmatism, sensitivity, courage
- The SW values of our training are still the key components, which can not be easily taught to other disciplines without similar value based initial training
- Assessment, communication, risk management, equality and diversity, Intervention that assists recovery and empowers individuals and enables them to live in the community with or with out treatment in a way that satisfies them and leaves them and others at minimal risk
- The skills required are that SWs have keep the ability to work with all people of all ages in all situations. The need to have a good knowledge of all services available and the skill to advocate to ensure the service user receives them. They need to retain professional autonomy being able to provide an independent opinion, challenging other professionals when required
- We **mustn't** become institutionalised! SWs should be good at and need to be skilled at holistic assessments, reflective practice (as against reactive practice), the recovery approach/model, legal frameworks (MH law and criminal law), social inclusion (employment, housing and housing benefits etc) leadership role in social care, anti-discriminatory practice, working multi-disciplinary and multi-agency, managing complex situations (i.e. within families and 'other' agencies)
- It is important, in our view, that the knowledge, skills and values reflect not only in-depth knowledge of issues and models of MH and mental illness, legislation and social policy but also engage with deep critical analysis of social issues and knowledge, high level interpersonal skills including the ability to stand up against strong opinions and to present and sustain cogent, informed arguments based on high quality assessment
- Networking, thinking skills, awareness of alternatives to hospital, presentation of reports and positions, knowledge of law.
- Communicating with a wide range of clients, ages, and of differing ethnic backgrounds which is important in the present multi-racial environment. SWs require a knowledge of

social work interventions, the political context, a knowledge of sociology and psychology and an empathetic value base reflecting contemporary society.

- Competences required are largely around assessment (needs, risk, MH Act) and care management. Interpersonal skills are valuable but the necessary knowledge, values, theories etc needed to practice is in my view highly debatable
- Networking and partnership working: service users, other professionals and agencies. Broad knowledge base: human development, social policy, social science, psychology, methods and models for delivering interventions. Values of respect, diversity, social justice and empowerment. Contribute to the bio-psycho-social perspective. Promote service user centered ways of working within the multi disciplinary team: assessment and the provision of services. Here the role of “navigator” is important. The 10 Shared Capabilities are a good framework to build on. SWs have largely been working in this way for many years
- Assessment of patient’s needs, assessment and management of risk, practice in accordance with the principles of Equality and Diversity, a knowledge and understanding of mental disorder and its relationship to offending behaviour, effective inter-agency liaison, the protection of children and vulnerable adults, to support user and carer involvement, assist in the process of recovery, awareness of the rights of victims, inform patients of their legal rights, use of evidenced based practice and knowledge of theoretical perspectives
- Assessments using a strength perspective. Bring a carer perspective into discussions. Organisational development and improvement. A strong commitment to anti-oppressive and anti-discriminatory practice. An ability to challenge discrimination in all forms. Respect, honesty, empowerment and recovery
- Ability to form professional relationships with people to help them achieve their objectives. Knowledge of law and policy guidance [national and local]. Confidence and independence of approach to challenge other professionals and organisations on behalf of the service user. Knowledge of local resources and networks.
- On a general level, SW education is now based upon NOS. These occupational standards identify the areas of skills and competence that newly qualified SW will have developed. The NOS are grouped into 6 clusters and are listed below:-
 - Prepare for and work with individuals and/or families, and/or carers, and/or groups and communities to assess their needs and their circumstances
 - Plan, carry out, review and evaluate social care/work practice with individuals, and/or, families, and/or carers, and/or groups, communities and other professionals
 - Support individuals to represent their needs, views and circumstances
 - Manage risk to individuals, families, carers, groups, communities, self and colleagues
 - Manage and be accountable, with supervision and support, for your own social care/work practice within your organisation
 - Demonstrate professional competence in social work practice
- Assess, plan, intervene and evaluate overarching leading framework of Human Rights and in a way that considers diversity within a statutory framework. To rehabilitate or habilitate and intervene in a manner that empowers service users and carers
- Competences will be a huge list – see Skills for Health competences for MH. However key ones include Assessment, Care planning, Introduction to services, Ability to use MH Act
- Should be underpinned by Recovery model and Values based approach
- Perhaps of almost most importance is the social science training that helps SWs to think laterally which can result in more imaginative care planning and problem solving, and the capacity for good management and leadership
- SWs tend to use Maslow’s hierarchy of need as a model for looking holistically at all the needs of a service user within their family and community. SW training in social policy also includes a political perspective that is essential whilst they are employed by councils who have local accountability. It also helps an understanding of the wider community services which are provided by councils and voluntary organisations
- One of the key values that underpins SW is respect for the individuals, to assist them to regain control over their own life, to help them integrate within the community to try

to assist them in maximising their potential within the confines of their illness

- Policy and political influencing skills and an understanding of the individual in society. The core value base for all SWs includes: A desire to promote social justice and social change; to promote individual wellbeing and self help skills; a belief that individuals are autonomous and function as part of society
- Individual SW's are valued by team members and can be a valued resource within the team, but our collective view as a corporate group leaves us feeling diminished and undervalued. Cast adrift by LA and devalued by the Trust

Question 3: What thoughts do you have about the existing or potential diversity of routes to access qualifying training and the specific learning and development which is associated with the PQ framework including the ASW role?

Summary of responses

- More specific and detailed training for ASWs on Risk Assessment. Development of communication and relationships courses from basic level to therapist/counsellor training
- The current training process seems to be much better than previous versions; a 3 year course provides more time for trainees to learn 'on the job' however, some SWs felt that academic institutions are not always rigorous in their assessment processes and seem to shy away from removing under performing/ incompetent students – emphasis seems to be more on the practice assessor to determine if a student has the appropriate range of skills to be a qualified practitioner
- A good number of routes are open. There is a need to maintain an academic standard. Too many nurses/social workers do not seem able to write a coherent paragraph
- Access to professional training: This should include access for newer roles such as assistant practitioner and STR Workers. Consideration should also be given to joint foundation training with other disciplines. Pre-Qualification training for mature students with no formal education may need to be developed to attract candidates from socially deprived communities: all training would need to be rigorous in ensuring evidence of required competences. GSCC PQ Framework is a good development that needs adequate resources, e.g. backfilling arrangements. ASW's and PQ framework: Two issues need consideration, 1) the situation of ASW's qualifying before 1993 needs to be resolved, particularly in relation to the requirements to undertake PQ 2-5 training, and 2) the possibility of linking the proposed advanced PQ award with ASW training and re-approval
- Opinion varied considerably, primarily regarding PQ1. Con: New SW Degree is not necessarily leading individuals to a career in Social Care – particular note of youth entrants – seen as academic achievement more important than desire to care. Pro: New degree will give greater weight to the scientific value of SW and its contribution to social policy. PQ1 an onerous and complicated task, particularly for practitioners of many years 'Educational Fascism'. However the group recognised the need for robust measures in maintaining high standards in SW
- There is a current emphasis on the development of STR worker training. This has a strong inpatient nursing emphasis and does not address community social support knowledge and skills sufficiently. It is not widely understood how people employed in an unqualified capacity can progress into social work training. It is not straightforward to gain information on financial support for fees and maintenance, particularly for mature students. Post graduate Masters Courses are developing but need careful research. ASW's in the locality gained their approval in a variety of ways. Of those who have gained PQ1-5, few have gained PQ6, largely due to the lack of clear pathway to do this, although they have the experience to support completing the award. It is unclear how people employed in the voluntary sector could move towards a SW qualification or how SWs employed in MH services outside the LA could move towards ASW training and being contracted with the LA. SWs benefit from the NHS culture of on-going training across all professional groups but social care training is not mandatory within the organisation
- PQ expectations have been seen as irksome and insulting by some SWs who have obtained their ASW and possibly practice teachers awards some time ago and are now having to re-prove themselves' as competent practitioners. There has also been many changes in terms of developing a competency based assessment process as opposed to the more reflective, discursive approach in the old CQSW course

- The three year degree in SW is welcomed and is a positive recognition of the value and status of social care. We would not support non degree SW qualification routes, but would welcome a fast track post graduate route. The influx of a younger cohort of SWs envisaged via the new degree is also much needed and welcomed. It is essential that employers continue to support staff to access employment based routes to SW qualification.
- There is support for continuing access to professional training by non-professionally qualified workers who have developed their commitment, knowledge and skills by directly working with service users in MH Services. At a minimum, this access should be equal to access to Nursing, OT or other Health professions. There is no strongly expressed opinion as to the longer-term effect of access to SW Degree course by individuals without prior practice experience. There was a strongly held view that recruitment problems in SW are not about access to training primarily, but about the low status of SW, and therefore the policy emphasis should be on supporting and promoting SW as a valued career. The current PQ Framework is seen as perhaps too much competence based, and not enough as a higher qualification that extends knowledge and is recognised and validated by the Universities. The future PQ Framework will offer the possibility of bridging the gap, and its commitment to interdisciplinary learning is welcomed. However, the commitment needs to be linked to investment in continuing professional development in SW to ensure access to higher-level training is made available across the board. There will continue to be a need to ensure working relationships between the Universities and the workplace are close and dynamic given the changing environment in which we are operating. Lecturer/Practitioner posts would be recommended, but currently there are 2 main obstacles to achieving greater numbers of such posts – a) Most Universities require MA and/or research experience which most SWs have not had the opportunity to achieve. b) Many University posts are paid below salary levels of experienced SWs.
- Particular thought needs to be given to new roles such as STR workers and CSWs and a standard competency based approach preparatory to professional training is required. Sometimes it is unclear whether these staff are social care employees. There is general support for the PQ Award and its requirements, but some concern about how this will be sustained in future and applied to staff who qualified before 1993. The ASW qualification is highly regarded and there is some anxiety about whether future “advanced” training will be as effective.
- SWs need to have the same opportunities and similar financial rewards to colleagues in other professions in the Trusts for professional development and to advance their careers. This should involve the continuation of a Senior Practitioner role and consideration of a Consultant SW Practitioner position. Many Trusts have already developed SW Professional Lead or Advisory Posts and we strongly support this. A lead role for a social care professional (Director of Social Care or equivalent) at Executive Level on Trust Boards is also necessary to maintain and enhance the profile of SW and social care in integrated trusts. Social Care Staff must feel equally and fairly valued in terms of status, financial reward and access to leadership and management training if the potential recruitment and retention crisis is to be avoided
- I strongly support demonstrating the development of competences through evidence from practice. However this profession will be left behind if it does not require high level entry qualifications - graduate entry and for qualification at masters level. It is crucial for routes to qualification to encourage access from minority groups and older people. SWs in this service cannot be ASW's; it is also crucial not to lose the lessons and infrastructure of ASW training, which enhanced the competence, confidence and interdisciplinary credibility of SWs in MH. I would like to see this extended to other areas of work eg forensic SW under Part III of the MH Act. In supporting Senior Forensic SW Practitioners, directly employed by the Trust to plan by which route to gain PQA's and how to avoid the risk of undertaking work that does not count for these, I would greatly welcome simplified, clarified, connected, and less bureaucratic pathways to gaining competency post qualification
- The logical consequence would be for the qualification training of programmes of RMNs and MH SWs to be more integrated than at present. Currently MH SWs obtain the same qualification as children and families and other adult SWs. In practice most courses now expect SW students to increasingly specialise as their courses develop, initially into children and adult options and then between the various adult specialties. In reality though the normal RMN and MH SW routes are so different that integration on the ground is going to be a practical impossibility for some years to come. The entry requirements for RMN training are less demanding than for Dip SW courses, the placement structures are very different and at present RMNs usually spend a period of time in inpatient settings as scale 5 nurses before they move into the community. SWs have longer practice placements, in which they usually have case responsibility for a small number of cases, and they are expected to be able to operate in a CMHT setting

from the point of qualification. Although the 3 year SW degree should give students an opportunity to do a placement within another SW area as well as providing specialist experience in MH. Nursing colleagues have noted that the distinction between training requirements and practice placements is not so straight forward, and in integrated teams there is a discrepancy between remuneration of SWs and nurses with similar qualifications and years of experience. Each approach has advantages and although some merging of the training programmes and policies is inevitable in the future it will be a huge job to completely integrate the training. In the meanwhile, we are better off celebrating the different routes and access opportunities. Another view is that it is crucial to keep MH SWs as a distinct profession and to be trained with other SWs. SWs are the only profession which has a full social science background and a training in systems theory etc. It is important that MH SWs keep links with SW colleagues in other fields as it is important to have joined up thinking where families are concerned. MH problems are directly related to deprivation as are child protection issues and problems with older people, if SWs just become generic MH workers then the threads which hold the whole idea of systems together is lost. There are views that the total separation of adult and children's services is a mistake. If the MH SW role disappears then it will need to be reinvented

- I am not keen on the prospect of much younger graduate SWs coming into the field, as I believe a certain level of life experience, and maturity gained possibly in other careers before qualification is something that is valued by service users/carers
- Should there be a generic care training then specialise into qualification. Need to be clear about the workforce skills need/mix and enable SW and other professions to enter this for instance CBT, family therapy. Education, Health, SS and possibly housing need to have access to appropriate training for the area of work regardless of employing agency
- The recently extended training for a SW Qualification reinforces the fact that the profession requires skilled people of a high calibre to take the social agenda forward. The PQ framework continues to emphasise this and sets a clear pathway for continued professional development
- It is important that whatever route is taken, qualified SWs have consistently high standards. Our colleagues in the NHS, the Courts etc, are all highly trained and we must be equal to this. SWs need to be able to present information well both verbally and in writing. In the past SW has benefited from the diverse routes into SW qualification. It is hoped that there will still be some diversity in the future. The SW degree should provide a basis for a career in SW and should therefore be generic. Specialisations should be achieved through PQ experience and training. The PQ framework is therefore important and needs to be developed further
- There are gaps in training opportunities for non-qualified staff (i.e. STR workers) and the organisation needs to appreciate the skills of individual workers. There needs to be an 'approved SW training' opportunity between the LA and the Trust to enable Trust staff to take advantage of the LA SW training route. We consider it good to have evidence and value based practice. We would like to promote the possibility of the ASW qualification being part of a post graduate accreditation and/or whether it will be equivalent to the proposed 'advanced' qualification from 2008. Will there be SW consultants (equivalent to nursing consultants) and what will be the required training. We have welcomed the rigorous nature of the existing PQ requirements and in this county have used the APEL route to enable pre 1993 ASWs to join the PQ award. We would hope that the new PQ arrangements will take into account the diversity of academic ability and practice skills
- ASW education should remain firmly entrenched within the PQ framework and should remain a requirement for this role. Given the implementation of the new PQ awards framework, we would argue that there should be an emphasis on CPD that is linked to higher academic awards, providing the potential for career development reflecting that in other disciplines. Continued up-dating should be a requirement for continued practice. This would help ensure continued quality, would allow for the development of greater inter-professional respect and, hopefully, encourage the future recruitment and retention of ASWs. The potential for establishing joint posts and increasing the exchange between academy and practice is broadly welcomed. We would also stress that a commitment to further research into the role and impact of ASW practice is made
- It is hoped that links will be made with school pupils to encourage them to consider careers in social care/work. The Trust is in partnership with the local County Council for the provision of PQ training. We welcome the continued emphasis on life long learning and support the sequential learning provided by PQ. There are considerable misgivings about the proposed change to the AMHP role and some uncertainties as to the value of this role and where it could be positioned vis-à-vis the new PQ framework

- We appreciate that there need to be a variety of routes through which people can access qualifying training. Being a SW can be a very tiring job as well as a very rewarding job. People need to have the right mix of skills and understanding to be able to work in what are often very complex situations. We have done a lot of work to clarify and revise the pathways to qualifying training. We have completely revised our foundation training for non-qualified social care staff. Over recent years, we have also invested heavily in supporting the PQSW and PQCCA routes, and to a lesser extent the AASW programme. In terms of the ASW role, we are committed to continue to commission high quality initial ASW training through a multi-local authority consortium approach with the University. Management development and leadership training is also available, linked to a Diploma/Masters course at the University. Through our PQ training and development team, we are working with the three universities to develop training and development programmes which fit the new PQ Framework. We have also recently launched an e-learning CPD programme for ASWs, which complements other existing and planned training and development opportunities
- I feel more diversity is needed in order to recruit and to an extent this is being done eg. courses with the OU. In general, I've always had little interest in PQ awards. They seem bureaucratic and have no real gains to them
- PQ1 and ASW training are excellent. Diversity and equal access to training essential in social care/work
- The new PQ framework needs to incorporate modules on CAMHS and make explicit the links with safeguarding/child protection
- Diversity of routes welcome to encompass the different needs of students. Both qualifying and PQ training rely on good quality practice based assessors/practice teachers. There are insufficient numbers and their training also needs addressing
- Qualifying training and PQ should focus on the knowledge, skills and aptitudes necessary to make a competent practitioner and focus less on the value base. PQ training can be difficult to access in more specialised areas. It can be too narrow ie. ASW or Practice Teacher. Forensic PQ or Recovery PQ may be appropriate
- Universities should co-ordinate their PQ training so that qualifications gained at one university are recognised equally at another (eg. once PQ2-5 is gained this should be recognised anywhere in the country without the requirement of top-up training). Try to have a more inclusive perspective to enable previous knowledge and skills to be accredited and a social care pathway developed. Enabling representation from under-represented groups in education and training (eg. BME groups). Unsure about pathway for the AMHP as current ASW role is built on SW values and ethics. The PQ process presently helps to reflect and review SW skills. Experience indicates that routes have narrowed as the cross-pollination of the SW specialisms has all but disappeared. The attractiveness of the profession to the mature work force is likely to decline with the financial implications of the SW degree for that age group who have formed a large proportion of applicants historically. The PQ framework provides an excellent consolidation of original learning as well as a basis for the ASW role but those who reach the highest levels will need proper recognition both in status and financially
- Traditionally one of the strengths of the SW profession has been seen to be in the maturity and consequent diversity of life experience in the new applicants to the profession. The lowering of the age requirements of the new degree as one national measure taken to address recruitment issues will inevitably alter the entry experience level of new applicants to the profession. The profession will need to monitor and appropriately act upon any implications of such a change in terms of the effect this may have on the quality of new SW applicants. The diverse routes of entry into SW qualification and the flexibility in its delivery have long been valued as a practical demonstration of the professions active commitment to equal opportunity. Training needs to continue to allow diversity of access to courses thus enabling both those with generic life experience, those switching careers and those who choose an academic route earlier in life to become competent SWs. The balance between the academic input in the new three year degree and the rigorous assessment of practice skills in placements is felt by most to be an appropriate one. In a general response to this question the focus will be on the new PQ framework which will be in place from September 2007. The route into this framework is clear as it will be accessed by all SWs on completion of their initial training. The entry point for more experienced SWs is more complex as it will be about identifying which particular strand of the framework they enter ie. specialist, higher specialist or advanced. It is envisaged that all SWs within adult service settings will undertake the adult branch specialist level qualification. The higher specialist level for the MH branch is where the ASW programme is anticipated to sit and it is likely that this award will cover all modules required for successful completion of the PQ award at this

level. This award is envisaged to encompass many of the same themes that are already contained within the existing ASW award. However as the guidance will not be issued by the GSCC until June at the earliest one can only speculate as to the core competences that will be included. The framework will need also to be responsive to the needs of those SWs who are not based within statutory work place settings but wish to undertake the higher specialist award in MH. At the current time there is discussion regarding whether the modules contained within this award will be available to other professionals who do not have a SW background. When considering the implications of the proposed MH Bill and the shift to AMHPs it is clearly arguable that the training will need to be accessible to other professionals. This affords the SW profession the opportunity to develop a package of training for AMHPs that reflects the social model of practice and addresses some of the professions concerns regarding extending this role to health personnel. The advanced level of the PQ framework is the one that is perhaps least well defined at this stage. There needs to be a clear link between achievement of this award and a recognised academic qualification ie Masters Degree. In order to address the questions relating to the PQ framework for MH SWs a regional group has been set up with representatives from all the LAs within the North East region, the Institutes of Higher Education, NEPQ consortium, service user, carers and independent service providers. This group will attempt to develop a clear and cohesive plan for the PQ training of MH SWs within the North East region. On a broader PQ training level within MH work needs to be undertaken to explore possible links between what is identified through the GSCC and what is available through health Trusts and the healthcare system. How for instance will training in therapeutic approaches e.g. PSI/cognitive interventions contribute to the PQ award and the advanced award? It is clearly desirable that such specialist MH courses become integrated into the PQ award. Overall, the new proposed modular PQ structure is felt to be more appropriate and the profession welcomes opening up such modules as appropriate to other disciplines in order to further enhance the social perspective in MH. However, any dilution of the social perspective content as other professions access modules and train jointly would be a concern for the profession. In order to maintain professional identity some degree of profession specific training would, it is felt, need to be maintained. We feel there is considerable scope for development.

- There is a paucity of opportunity in comparison with our health colleagues whose framework, for their professional development, is more clearly defined and resourced
- Diversity of routes is now becoming more prominent in health sector and we should learn from social care model
- PQ 1-5 need more focus on becoming a mental health practitioner. Current model of care inhibits progression through PQ route. Access to post-qualifying training must be maintained within terms and conditions of new contracts. Must be clear links between these awards and career progression. Social care training must be funded and supported as part of any in-house training programme. Ensure that there is access to professional supervision/appraisal
- SWs work in what could be called a “grey area”, where there are often no “right” ways of doing things. They have often been poor at “selling themselves” and recognising their own achievements. Competency-based approaches to training, based on the key areas and founded in evidence-based practice, equips SWs with the necessary skills to fulfil these functions. There is no doubt that the move to develop training alongside different professional groups is to be welcomed, as this can only lead to a much greater understanding of respective roles. We would stress though that this should be done from the perspective of recognising, valuing and promoting the differences between the professional groups as well as the commonalities. It is clear that wider routes to qualifying training need to be developed. The implication however – as identified in the Consultation Paper – is that there will also need to be a wider range of valuable practice placements. The reality in busy front line services is that this is not always easy to achieve and often depends on individual willingness to provide placements rather than structural responses. An “incentive” or reward scheme would not go amiss. Any developments in training need to take into account the desirability of the involvement of SW services in primary care MH settings – given their focus on MH promotion and broader public health issues. Access to professional training should include newer roles such as STR workers and assistant practitioners. There is scope to develop – as a part of this – joint foundation training with other disciplines, whilst ensuring that the core values of social care, described above, continue to be taught. We believe that there is a wealth of skill and ability to be tapped from people with restricted formal education and training may need to be developed to specifically attract candidates from socially deprived communities. The GSCC’s PQ Framework is welcomed and is seen as a good development. However some issues have yet to be resolved, including the potential link of the advanced PQ award with ASW training and re-approval
- We endorse the suggestions in the paper. In particular we note that qualifying training provides a good basis for inter-professional work which is essential in MH settings.

The key to good practice is often a sound foundation of practice experience. MH settings can offer challenging experiences for students but placement supervisors require time to be freed up if they are to undertake their roles effectively. What is true of practice placements for qualifying training is even more true of post qualification education where staff need clinical as well as managerial supervision. Supervisors need to be skilled to help staff develop reflective practice. This enables them to continue working creatively in distressing situations. Urgent attention needs to be given to ensure that the flow of high quality staff is not impaired by a dearth of suitable experienced and qualified assessors and supervisors. We believe that the ASW role has been of great benefit to the MH system. Indeed the MHAC regularly commends ASW practice in its biennial reports. Organisational changes should not be used to decrease the time spent in specialist training for the role or to diminish the social context

- Access to training has recently been lowered to 21 year olds and this needs to be further encouraged, ensuring that people have early entry into the profession to build a secure and defined role in the realm of social care. We do need to do more to publicise this as a career choice for young people and introductory ‘taster’ courses could be offered to sixth formers to introduce the concept of a career in SW and simultaneously raise the profile of the role, to the younger generation who otherwise might not have had the opportunity to perceive or develop an understanding of social care. Combined qualifying training modules eg with nursing, can also help here. Pathways within existing MH services could also be further developed for unqualified staff eg in support worker or STR roles who have developed some understanding of the SW role. The NVQ training pathway for such staff could link up with CPD pathways, to offer NVQ4 training courses to provide an ‘escalator’ framework into the SW qualifying framework. The new PQ framework through the GSCC accrediting universities has been well received. With the PQ pathway, however, professional bodies need to remain influential in shaping, developing and evaluating these courses in relation to the needs of the services and the upholding of SW values and their application to the duties and responsibilities in practice. We are doing this through the appointment of two social care practice development managers who will also link with training providers. This is particularly pertinent to the ASW/AMHP course as the dynamic between theory, legislation and practice is extremely robust and thus qualified practitioners’ knowledge skills provide a highly valuable resource in developing future courses
- A key issue locally is having capacity to free SWs up to offer placements. Innovative ways of doing this need to be explored as it is often left to the goodwill and commitment of the practice teacher rather than them being given the workload relief needed. We feel that it is very important that practice assessors for student placements in health are social work trained
- PQ 1 is a useful consolidation period and we think that it provides a good framework to take people from induction and to ensure that they develop the necessary skills and knowledge. We do not feel however that by itself PQ 1 fully equips SWs to then go on the ASW course. We feel that the person needs to have around two years post qualifying experience in MH or related areas before starting the course and the timings of PQ1 and PQ2-5 do not always fit with this. Generally the ASW training is highly rated and the practitioners it produces are respected and valued by others. As with SW placements above, the ability to provide workload relief for practice assessors is always an issue. In addition we do not have funds to provide cover for people going on the course and this creates real pressures on teams. It is particularly difficult where the person may be the only SW in the team. In workforce planning, greater account needs to be taken of essential training and the resources needed to support it. This should be built into staffing levels
- Include in training advanced communication skills and team working skills. Opportunities to develop specialist intervention skills. Social care research
- The new degree will mean a younger workforce and employers and HEIs need to take account of this in developing PQ routes. People will have less work and life experience and may not have the same maturity as earlier cohorts of qualified staff. However, new, younger SWs should bring enthusiasm and should be more research and evidence-oriented having all come through the new degree or postgraduate equivalent. MH Trusts need to be required to maintain SW qualifying placements in order to ‘grow our own’ recruits. MH Trusts need also to continue collaborating with local government in respect of apprenticeships, traineeships and secondments to enable people to train as SWs within services. Such schemes obviously need to be developed alongside all the other training opportunities that are emerging at different levels in MH e.g. associate practitioners, foundation degrees in social care etc. The principle of encouraging (ex-) service users and also carers to train in SW should be embraced by MH Trusts. The PQ framework for SW is changing at the moment and was felt to be confusing in both current and proposed forms. The need for clarity about the future

of PQ and also about how people can bring past training into the new framework is needed urgently

- I am dismayed that the new probation officer qualification is not recognised for SW and that it is not possible to then go on to the PQs and ASW. Forensic Services need a diverse workforce to bring different specialised needs to its service, one of which is criminal justice work and probation experience
- One of the key issues to be worked out here is how AMHP training (based on current ASW training) would fit into the professional framework of other professions such as community MH nursing and OTs. Added to this it would be helpful to have guidance on whether AMHP training is optional or mandatory for all professions. With the structures for Adults Social Services and Children's Services now bifurcating, the future training structures will need to respond to those changes and not result in having AMHPs for Children and AMHPs for Adults as this would reduce the critical mass of AMHPs and create challenges for workforce planning
- Whatever the formal routes to training, we need to ensure that we are recruiting and training people that reflect the communities we work within. LAs and NHS Trusts have a significant role to play in facilitating and enabling local people from diverse communities to enter social care and ultimately SW. Training schemes for school leavers as well as graduates, along with payment for undertaking training, secondments and a full range of modern employment benefits are required. The profile of social care within schools and colleges needs to be raised. Volunteering, community groups and activities should be accessed as potential sources of future SWs, as well making use of faith organisations
- We have found the recently introduced PQ framework messy and confusing. We are glad that our ASW training has been rigorous, but feel that the requirement for everyone, including individuals such as senior practitioners, to undertake PQ1 is belittling of our years of experience. We are unsure as yet what the role of the GSCC is
- SW training is far less generic with candidates having to identify preferred 'specialisms' before engaging in training. Therefore, there is a responsibility to ensure that the core values of SW, as it refers to all client groups, still forms a foundation to the core education programme. PQ programmes should acknowledge that there are 'specialisms' within 'specialisms' and therefore specific skills arising from particular areas of expertise eg. Forensic SW, cannot always be given adequate recognition in a common umbrella programme. The same can be said about ASW work which although is under the umbrella of MH is a very specialist role in its own right. PQ education should promote the expansion of evidence based practice through research in order to raise the academic profile of the profession
- The joint degree for SW and nursing also causes some concern in producing workers who have had a limited chance to practise in both areas of work (a 3 year degree for the joint award, when each separate discipline has itself a 3 year degree course)
- We can see the "diversity of routes to access training" in action, and consider it to be helpful, healthy, and in some cases, the most fruitful way of recruiting staff. Many people are attracted to support worker roles to gain experience in MH, many of whom have had a very wide variety of other experience
- The other important factor is availability of good supervision not only for overall professional development, but particularly for preparation for PQ1. In many MH teams (and there is a growing diversity of them) team leaders may well be from a different discipline, and access to senior SW staff may be very limited. The fact that SW are now spread through many small teams is contributing to a fragmentation of the service. It is becoming more important that SW based in these teams have a strong sense of their own professional identity and a level of internal resourcefulness, to cope with extra stress (and are self-motivated and able to seek out appropriate support). In our experience newly qualified staff, with little previous MH experience, often really struggle. Some leave after an unhappy time for themselves and their teams. By contrast, within MH, there a large number of highly experienced and skilled practitioners many of whom have come into MH after working in SW but in a variety of other fields/ settings. They appreciate the challenges and rewards of greater autonomy within a rapidly developing multi-disciplinary service. It is of concern that the current PQ arrangements will militate against easy transfer between client groups. Our local ASW training programme is highly thought of, and valued as excellent training and preparation for the ASW role. It would be our hope that the quality of that training is preserved (along with the rigour of the selection process) so that the proposed AMHPs are as skilled and competent as most current ASWs. We think that many other professionals would struggle with the role or would not want the responsibility, but many would be excellent

- Links between practice and academia should be strengthened. All SW students should undertake a placement in a statutory agency during training, but diversity of experience, for example in the voluntary sector, was also thought important. Supervising students is valued but some found it an unacceptable burden without caseload relief
- We strongly supports the recruitment of SW from a wide range of backgrounds and cultures. It is essential that this practice is promoted and encouraged, especially as in many areas such as London or Manchester, people from different ethnic backgrounds make up the majority, not the minority of the local populations and this trend is likely to rise. It is also important that people from the local area, who may also have used services, are encouraged and supported to gain the necessary skills and qualifications to become SWs, since they bring valuable experience. We welcome a strong inter-professional focus of the PQ framework. The majority of people we work with have complex needs. People's complex needs can have a breadth (range of need across a number of different areas) and /or depth (severity of need). Therefore it is essential that staff are skilled in working in multi-disciplinary teams and have the confidence to work across boundaries. It is not usually possible for a single agency to meet the range of these needs. However, SWs and other professionals need to know how their role fits in with that of others and have the skills to work with and draw on the expertise of different agencies. We endorse the value of SWs and other professionals studying alongside one another. It is important for different professionals to work and train together, breaking down some of the professional and organisational barriers. Although structures cause people with complex needs to slip through the net, different professional cultures pose significant challenges
- A major challenge is to support the professional identity and creativity of MH SW. It may be difficult for SWs to articulate their specialist SW role and identity in the multidisciplinary teams particularly when they do not have a SWmanager. The PQ pathways will offer a way forward to develop professional identity and practice. Access for established staff through the use of APL and AP(E)L needs to be clarified. The costs of the different levels of awards need to be clarified and workforce plans made to encourage staff to access the training. The use of e learning and distance learning will support the access to programmes. There should also be access to modules for other health professionals. Modules will be using work -based assessments and portfolios to emphasise practice learning and research. For SWs who have already accrued PQ awards and professional experience the PQ should offer opportunities to achieve an advanced award. PQ arrangements will also be an important avenue for supporting CPD. The first Specialist PQ award should include the MH multi professional Ten Essential Shared Capabilities. Specialist MH SWs are likely to study the Practice Assessor module and will then have the choice of specialist modules. Here SWs should develop specialist skills in Risk Assessment Social Model, Family Work, Group Work, specialist social casework and generic skills in the Recovery approach, CBT and counselling if offered within a PQ programme. The Higher Specialist MH award will contain the ASW or new AMHP qualification which it is likely that most specialist MH SWs will study. The other higher and advanced awards are Management and Leadership, Practice Teaching and Research. It is important that the PQ awards create flexibility for students to complete the AMPH and also continue along the pathways of Research, Management and Leadership and Practice Education so that MH SW is strengthened in these directions. The Higher Specialist MH and Advanced award could offer the more advanced Masters level modules in the Social Model including advocacy and interagency skills, SW Methods and multidisciplinary MH skills, inter professional work. Access to this award follows completion of the specialist level or the use of APCL by experienced staff or through GSCC flexibilities. The Advanced Award in specialist MH work may be completed by studying further the masters level modules described for the Higher Specialist award. Students may have the option of completing a dissertation or research module at this level and/ or pursuing interests in practice areas such as Global Developments MH SW that may be offered by different PQ programmes
- A long view is needed from attracting students ('growing your own') through PQ training, to favourable terms and conditions and retention in general
- The diversity of access to SW training is beneficial. SW has been able to attract mature people who have chosen the profession as a second career, and with the integration of health and social care services unqualified MH staff from a health background are now being recruited to do a SW degree. A diversity of routes will also facilitate a broad spectrum of applicants for training including those from minority groups
- It is a matter of some urgency that the current MH Act training and the future training for AMHP is integrated into the PQ framework for SW. Of necessity, this training will not be exclusive to the SW profession. Our Trust runs a well regarded in-house ASW training and clarity is required as to whether in future this will be able to

continue, with the proviso that the programmes will be academically credit rated

- Good standards of placement, the NOS and the QAA benchmark statement for SW ensures standards are maintained. The PQ framework and registrations provides an evidence base of further training and competence before progressing to complete ASW or Practice Teaching
- There are currently a number of routes to the Degree in SW course. We have recently established the Associate Practitioner course with the University. Although this course has not yet been mapped to the SW Degree Course, it is envisaged by the WDC (Workforce Strategy Group) to do this. The Associate Practitioner course will then provide a useful way into the SW qualifying course. The STR posts are often seen as a preparation for people to apply for the SW degree course and such people can apply to their LA for secondment
- Practice Teachers need to be established in the service and incentives for SWs to become practice teachers should be identified
- We are concerned that the previously diverse ways of training to be a SW, which encouraged part time study and a more mature entrant to the profession, are being replaced by degree courses which attract much younger entrants without the valuable life experience older entrants bring to the job. This is not to deny the contribution which younger SWs can and do make to the profession. We are of the opinion that the new joint nursing/SW degree course needs overhauling as it is not integrated in it's approach and graduates emerge feeling qualified in neither profession and without jobs to go to which enable them to retain a dual registration
- Lack of clarity about recognition of previous training, experience and qualifications. Concern that those who have been qualified for a long time will be de-valued because they did not undertake competency-based training
- A number of respondents expressed confusion concerning PQ framework. The fact that the PQ framework forces SWs to specialise in working with one particular client group as soon as they qualify was seen as regrettable. The overwhelming response to this question was one of confusion and lack of knowledge of the PQ framework, how it impacts and how to access it
- In order to ensure that the future workforce of more unqualified workers have access to qualification in adversity of professions, the current funding arrangements will need to re-examined. At the present time, the easiest and best supported route to a qualification is MH Nursing – students are supported through university and posts do not have to be backfilled. Training of unqualified staff for a SW qualification is fraught with difficulties, both for the organisation and the individual. Within the present funding arrangements for professional qualification, unqualified workers are more likely to become nurses than anything else. And this position is supported by the SHAs who set priorities for training that does not support SW (or OT) training. Training moneys provided by LAs for SW professional training courses compare very badly with the investment from Health in nurse training and continued professional development. However, the LA does support ASW training adequately financially and there is a robust ASW consortium and ongoing refresher training. There is concern around access to professional supervision in order to enable individuals to access and be prepared for PQ training and consolidating this into practice
- The existing routes to access qualifying training are limited. We would like to see a significant extension of the trainee route, valuing and encouraging experienced, unqualified workers to go forward for training and then hopefully return to the workforce. Finance needs to be available to allow for the needs of mature students. We have some concerns about the potential age profile once the new SW degree graduates come into the workforce. We wonder whether there needs to be a lower age limit (25?) to allow for a variety of life experience prior to qualified work
- Basic SW training: Some basic training is seen as being of poor quality with an over emphasis on competences rather than standards .Whilst a three year degree is welcome, it is an expensive training and thus can exclude older people with other responsibilities. It is especially hard for older women and as SW historically has a mature and diverse workforce this could be in danger of unplanned changes. It is imperative therefore that there is attention paid to widening the access to training by grants, bursaries, child care availability, in service training, open university, part time courses, secondment and a variety of innovative schemes. The current routes are potentially too excluding

- Post training: The PQ training is welcomed as a very positive development, especially as it gives a level of specialist expertise in MH not possible in more generic basic SW training. Time to achieve this level of training needs now to be acknowledged in workloads and remuneration
- The ASW training will be reviewed as the MH Bill is implemented but it is assumed that current ASW training will not be diluted as the need to understand and work with legislation and codes of practice will be no less
- Specific training in CBT/PSI is not always available to SWs. This seems rather strange as this mirrors the way they already work and is seen as key to developing modern services . Access to specialist training in some therapies (systemic, psycho social, family, drama and counselling) is very variable. Whilst it is acknowledged that these would increase the skill level of a team they are seen as training and service luxuries
- The move to different qualification routes such as work placed learning and part time qualification courses, will further open up professional training opportunities for a broader range of individuals. A challenge will be to ensure that these new forms of training are rigorous and of a satisfactory standard to equip the student for professional life
- The new PQ framework has a strong interdisciplinary focus which is welcomed and will facilitate learning and understanding between professional groups. The stepped approach to professional learning and development within the PQ framework is positive and enables individuals to identify and consider their learning in a planned way. However, an over emphasis on achieving competences needs to be counterbalanced with an understanding that the SW role is more than the sum of a range of competences and that effective professional practice draws on an interplay between an empathetic appreciation of individuals in difficulty, an understanding of the impact of social forces and sound communication and assessment skills
- SW in our locality are required to undertake professional PQ training and submit evidence of meeting competence in year 1 and year II that ties in with PQ1. Successful completion of PQ1 enables eligibility to apply for ASW training. Competency based approaches to training, although open to criticism, provides a supervised evidence base to professionally monitor and ensure development of professional SWs in line with GSCC's recommended standards. Some SWs feel that there needs to be a consolidation of the SW role however there needs to be a recognition of the specialism in which they chose to practice and a recognition of personal qualification and individual life experience. There needs to be more incentive for practice teachers and the department needs to support practice teaching at a strategic level ie reduction in workload and maybe financial/holiday incentive. ASW's feel that there needs to be formal refresher training opportunities made available at a more advanced level than is currently provided, ie updates on caseload etc. We are committed to professional SW development through its established MH practitioner forums, ASW, MH SW Forum, Newly qualified MH SW forum, Newly qualified SWs up to 2 years PQ receive more intensive focused support to enable them to meet professional standards outlined in GSCC. There is a focus on professional identity and role and on developing the confidence of social workers to challenge the medically led models of care by asserting their SW value base. Some SWs feel that PQ1 is repetitious and that they feel it undermines individual competency
- As noted in other responses, the new PQ Framework due to come into force in September 2007 provides a good vision of how PQ training should be provided. The model provides many feature which we welcome – building on the graduate entry in line with other professions; providing a range of programmes at different academic levels from degree level to Masters; facility for learning alongside other health professionals from related fields. However, there does need to be employers support to enable this to be effective. Currently there are no real drivers for employers to support candidates to access the Higher Specialist and Advanced Awards. There is also a need to look at PQ training in future in terms of more therapeutic skills for SWs. Many of the skills required for effective PSI are those which MH SWs have traditionally learned. However, the profession has focussed more training on analysis and reflection and assessment and care management skills than therapy. There is a need for programmes giving qualifications in CBT and PSI to be commissioned within the PQ framework to enable SWs to gain the academic and professional qualifications which nursing colleagues are increasingly gaining. ASWs who trained at whatever stage of implementation of PQ, need to have their award recognised. Further there needs to be better acceptance of parity of qualifications within career structures. For example the linking of MH Advanced Award in the PQ framework with the DH requirements for Specialist Practitioner role

- The change from the DipSW to the SW Degree is viewed mostly positively as it offers the opportunity for a greater breadth of practice experience within the framework of training. There is still a great deal of uncertainty among SWs about the requirements of the new PQ framework and some feel frustrated that they have just got to grips with the old system, only to have it changed. Having said this, many of our MH SW have welcomed and used the opportunity to complete their full PQ Award. Some MH SWs have begun to access programmes of PQ training aimed at multi-professional audiences. Whilst improving the opportunities for development of effective inter-disciplinary working, this also brings with it particular challenges. The differences in culture and theoretical orientation are apparent, particularly where SWs are in a minority on a programme predominantly attended and taught by health professionals and there is the potential for SWs to feel professionally isolated within these situations
- Speaking from a health background but as an Integrated Service Manager, the consensus amongst the service was that some SWs who work within our service do not necessarily want to follow the traditional roles of PQ training, eg ASW. They would much prefer to look at developing their knowledge and skills into psychosocial education, PSI, cognitive behaviour psychotherapy and also family interventions. Particularly in a field such as early interventions, this may be more appropriate in some circumstances than the traditional PQ training framework. Joint training is a way forward and as a service we do internal training together where possible – with STR workers and admin staff too

Question 4: How and where social workers are deployed within your service and is this likely to change?

Summary of responses

- Within CMHTs. With the exception of those who work in LD services and OPMH services, the majority of MH SWs in the county are seconded to work in the Trust. All remain as employees of the County Council. All these staff are supported by a strong professional leadership infrastructure within the Trust
- The County Council employs and appoints all the ASWs and all are on the payroll of the County Council. We do not use locum ASWs from employment agencies
- Succession planning for the MH SW workforce is likely to emerge as a significant issue in the coming decade. There have been a number of opportunities to expand the MH social care workforce in recent years, on the back of specialist MH services modernisation. In particular, we have been successful in achieving real SW presence within the county's assertive outreach services, crisis resolution and home support services, and in the development of early intervention in psychosis services. We have been much less successful in engaging with MH commissioners around the opportunities presented around a revamped primary care based MH service
- With the increasing specialisation of SW practice, compounded by organisational change, there is a very real difficulty that working as a SW within the MH services will not be viewed as a natural opening for career development. This need not be a difficulty if SW in other specialist areas such as Adults' Services is seen as encompassing the core activity of promoting health (including MH) and wellbeing. Ironically, this is what the 1994 CCETSW statement, referred to in the Consultation Document, suggests is a minimum for all qualified SWs!
- Our SWs are already within the NHS Trusts and we work in multi-disciplinary teams but all teams need to have an awareness of the social model of care, knowledge of law, psychosocial intervention, child protection and adults at risk
- SWs are deployed throughout AMH services but are not currently represented in day care, inpatient services or the assertive outreach team. Out of hours MH service provision is currently restricted to the CRT, AOT and the inpatient services. The expectation is that service changes will occur and a new referral and assessment service will be established which will provide a one point of access to prospective MH service users. The majority of social care practitioners (in AMH services) are currently not prepared to work out of hours or accept any changes to their terms and conditions. Changes are welcomed in service provision and the extension of services in to the out of hours arena but most social care practitioners feel this needs to be 'properly resourced' with new staff recruited
- In our secure service, each patient has a multi-disciplinary team and a SW is part of each team. Each patient, their network and carers therefore have a SW and with each we

work to the National Standards. In some Clinical Directorates, we have space and training to take on individual and group based therapeutic work. This service is imminently moving from a Departmental to a single line structure. SW teams will locate in multi disciplinary Clinical Directorate bases with their SW manager and admin support. Teams and managers will receive professional oversight from the Head of Service but direct line management and budget holding will be from the Clinical Directorate

- SWs are deployed in all Adult CMHTs, Specialist District Wide Teams, OP Service, and General Hospital Teams which cover all Adult service users, CAMHS Service, Supported Accommodation and Day Services. SWs operate at Team Manager, Senior Manager and Director level. The only discussion about change has been in relation to particular posts where there have been difficulties in recruiting SWs. The proportion of professionally qualified SWs to non-professionally qualified workers may change in the future as the services required by users change and develop. In line with the move to Social Inclusive models of care, we would wish to argue increasing numbers of professional and non-professional staff in MH have social care qualifications
- SWs are employed as care managers and care co-ordinators under the provisions of the CPA. SWs are sited in multi disciplinary teams and can be managed by a range of professionally qualified staff. It is envisaged that social care/work will remain a key component of service delivery in the future although organisationally we need to flexibly respond to forthcoming changes eg. Foundation Trust status, Payment by Results, etc
- SWs are currently directly employed in the Trust's secure services in the Hospital. In addition, SW and social care services are seconded from LA to AMH and drugs and alcohol community services. Social care AMH provider services are also seconded to the Trust. Future plans are to directly employ all currently seconded SW and social care staff but that ASW duties will be seconded back to the relevant LAs. No decisions have been taken about future deployment of SWs from other disciplines to the Trust, ie LD or OPMH services
- Our "Advance" programme is likely to change environment. Reconfiguration to functionally focused teams will allow more SW involvement in primary care MH services and therapeutic interventions in line with their choices and skills base
- The Borough's CMHTs were formed in 1998 with the LA SWs joining NHS Psychiatrists, Psychologists, CPNs and OTs to create joint teams. Initially there was a Borough Social Care Team Leader and an NHS Team Leader in each team, but in 2000 an integrated management structure was introduced. From the outset, we adopted a single care co-ordinator model, ie each case had one care co-ordinator, usually a SW or CPN, who would deal with the whole case. The policy was that the care co-ordinator could seek advice from other colleagues if dealing with issues they were not familiar with but had insufficient resources to allocate a CPN and a SW to each service user, in any case it would be impossible to try to differentiate social care tasks from health tasks. In the past when such differentiations were attempted the SW role tended to get minimised to welfare rights (although health staff were often very surprised to find out how little time was spent on welfare reports on Dip SW courses) and accommodation. In general this "whole case" approach has worked well, particularly in supportive teams where care co-ordinators can get advice and help from colleagues in areas they are unsure about. It has meant there has been considerable role blurring between the SWs and CPNs and it has meant considerable changes in custom or practice for the pre-1997 staff. In particular, health staff have had to deal with duty and social care issues such as direct payments, carers' assessments, appropriate adult interviews and no resource cases etc. For the SWs it has meant becoming the CPA care co-ordinator far more often than was the case in the past, with the result that the SWs and CPNs now hold equal numbers of care co-ordination responsibilities. At the allocation point there is some consideration given to who the core co-ordinator should be, but considerations such as gender, race, specialist interests and skills and, of course, space are of at least as much importance as professional background and qualifications. Though the majority of posts are now advertised on a generic basis and are open to people of any professional background, efforts are made to create a balance of CPNs and SWs in each team. If there are too many of one discipline in a particular team, there is the option of advertising specifically for a SW or CPN. Of course, there are some tasks, which can only be carried out by SWs or CPNs. In particular, SWs cannot administer medication, meaning that if a case is core co-ordinated by a SW and needs injectable medication, other arrangements have to be made usually via a Depot Clinic. CPNs and other NHS staff are also currently precluded from being ASWs. Given the integrated management structure, workers can find themselves supervised by staff from a different discipline. When that happens, staff can also request clinical supervision from someone from their discipline but in practice relatively few staff members have done so. Most staff apparently take the view that the quality of their supervision is more important than the

discipline of the person providing it

- SWs are employed in various area of the Trust, not all are employed by LA
- SWs are deployed in traditional CMHTs and the newer teams introduced through the NSF funding stream. There are less SWs pro rata in the newer teams. There appears to be some inequity of funding for SW posts and a lot depends on individual managers and their perception of SW. For example, when there is a vacancy on the team, the Manager may decide which profession will be advertised (rather than need of the service). Some Managers (more from Health than a Social Care background) consider SWs 'too expensive' as their role as ASW is perceived as taking them away from the team and this can/is seen as 'wasted team time'. There needs to be a greater understanding of the ASW/SW role and its contribution generally to a team. Our county has an ageing workforce of SWs who will retire within the next 5-8 years and consideration must be taken towards succession planning
- In complex care co-ordination roles ASWs remain as employees of the LA attached to the Trust. Some SW posts are employed directly by the Trust. This is unlikely to change in the foreseeable future although we are unsure how the proposed change to the AMHP will affect this in the future. Wherever deployed, SWs have concerns that their time now seems to be 70% office based and 30% face-to-face client work. Paperwork and administration generally is felt to be a significant burden
- Currently MH SWs are employed within the secondary and tertiary care parts of integrated MH services. There is a commitment within the profession to ensure that a social perspective input is developed in all aspects of service delivery. SWs therefore need to be employed across all the new specialised services. In such teams however issues of professional isolation and tensions around discrepancies in pay and conditions between health care social care professionals undertaking similar tasks tend to become even more acute and would need to be addressed if long term integration in these services is to succeed. There is also a need to assist in the development of a social perspective in in-patient settings where an illness model of treatment and care understandably tends to predominate. If an illness model is over influential, then this will slow down the incorporation of a social inclusion and recovery based approach and possibly hinder the continuity in the philosophy of care between the hospital and community. Options including deployment of SW staff into in patient wards may be worthy of further consideration in order to ensure that all staff embrace this new and challenging agenda. There is, in addition, a lack of SW involvement in other key areas of service delivery e.g. primary care and acute day services work. The introduction of the new role of Gateway Workers in primary care and CDWs (in relation to their role in BME service provision) are also areas where SWs could be deployed. The direct deployment of SW staff into such teams and functions however is only one way of promoting the social perspective in MH service delivery. Social care input into training and development, specialist consultancy/supervision and into strategic management and policy making are other possible developments
- Whilst it's clear that MH SWs are moving towards greater integrated NHS MH providers, it is not clear that Health Trusts are enthusiastic about taking over the responsibility for these staff
- The issue of R&R has been one that we have lobbied the Government and the employers on for a number of years. We welcomed the development of the 3-year degree qualification for SW and the subsequent PQ framework along with registration as being a much needed step to achieving professional status and standing for our members. It is too early yet to see whether this will bring the improvements to the profession that are so needed to attract and retain significant numbers of staff but the early signs are that training courses are beginning to see at long last an increase in students applying for SW degree courses. Hand in hand with the improved professional status has been the outcomes of various job evaluation exercises whether in Local Government or through A4C in Health. In Local Government, the indications are that when social care staff are evaluated the outcomes reflect the degree of responsibility they carry which, combined with their qualifications leads to improved pay. This is particularly true for SWs
- As the process by which MH NHS Trusts increasingly take over the responsibility for all community MH services accelerates, it will be important both that SWs are adequately represented across the whole range of MH services, and that wherever their location they receive effective professional support
- In small teams however, the issue of professional isolation and tensions around discrepancies between pay and conditions tend to become even more acute and would need to be addressed if long term integration in these services is to succeed

- The direct deployment of SW staff into teams and functions is only one way of promoting the social perspective in MH service delivery. Social care input into training and development, specialist consultancy/supervision and into strategic management and policy making are other possible developments
- As would be expected, across the Region, MH SW staff are deployed in a wide range of settings, from High and Medium Secure Services to the full range of community and secondary care services. The ways in which this is done in specific localities is however more patchy and depends on local commissioning decisions
- The workload implications and issues for the deployment of the full range of MH staff, have yet to be evaluated
- With the exception of a few specialist teams, SWs are deployed in all teams and in most settings with the exception of inpatient care. Posts have been specifically set aside to ensure that this happens (as is the case for OT). In teams where the R&R of staff has left them without SW the difference this makes has been noted with some practical problems arising because of lack of knowledge in certain areas but also in terms of the culture of the teams and ensuring all aspects of holistic care are present
- Care is needed in where posts are advertised and in the language used in them and in job descriptions. Use of words like clinical and clinician can exclude SWs. It is important to recognise that SWs are normally in the minority and a significant number of them are the only SW in a team. This can lead to isolation and pressure particularly where the worker strives to offer a distinct perspective. In these situations professional supervision, the opportunity to meet with other SWs and recognition of the issues and active support from line managers is important
- Registered SWs are deployed within the full range of NSF community teams, OP's teams, CAMHS, Addiction services and in-patient forensic services. The majority are ASWs. None are directly employed by the Trust, but this may change over the coming years
- In the 5 years since the partnership agreement with the Trust, the number of MH SWs has risen from 49 to 83. SWs are employed in CMHTs and in new service areas including Early Intervention Services; Crisis and Home Treatment team; Assertive Outreach; forensic services; and substance misuse. In the main, new monies to establish new ways of delivering services in the NHS have been used to fund these posts and usually at a higher ratio than outlined in the PIGs. Recruitment of newly qualified staff is encouraged in most of these service areas. MH SWs and care managers are moving into the Trust to join OP's CMHTs later in 2006
- SWs are deployed primarily within community teams within MH Trusts, whether under joint management, formally seconded to health, TUPE transferred or directly recruited into health
- Some clarity is required as to the legal position of ASWs who must currently be "Officers of the Local Authority" under S.145(1) of the MH Act. Concerns have also been voiced that a TUPE transfer represents a financial risk in that the A4C arrangements may lead to a wage drift. This is because the salary range of A4C bandings is broader than existing SW grades
- The majority of SWs are located in CMHTs based in either Social Services accommodation or in Trust premises. All are still employed by the County Council. We are in the process of establishing CMHTs for OP but the same will apply for SW staff in those teams. A small number of staff are located within Primary Care MH Teams, Forensic Teams, Liaison Psychiatry and Substance Misuse Teams

Question 5: How does your service ascertain and meet the individual and wider workforce development needs of social workers?

Summary of responses

- Currently through the PQ SW Route
- We have created a lead professional structure within the Trust whereby we have a Head of SW, and locality social care leads who ensure that SWs receive professional supervision as well as line management supervision. All SWs have an annual appraisal and a PDP which focuses on their professional development as well as their performance in their job. We have created an integrated training service within the Trust with a strong leadership on social care issues. A programme of training is available

to staff and we support unqualified staff to enter professional training. Experienced SWs and senior SWs can access management training provided by the Trust

- SWs ascertain their own needs. In-house training, but not a lot of this is SW specific. My employer supports PQ1 training
- It has been agreed with LAs that all seconded staff will use the Trust's PDP process to identify individual needs. In addition annual TNA are submitted to LAs and it is their responsibility under the secondment and partnership agreements to resource learning and development needs. The Associate Director of Social Care, chairs a Social Care Workforce Development Group and its membership consists of key social care managers across the Trust. Under its auspices, task groups have been set up which are responsible for running quarterly social care seminars, (open to all Trust staff and service users and carers); annual social care conferences; quarterly social care newsletters; developing social care research opportunities; developing annual TNA and agreeing SW and social care competences
- Through professional supervision in conjunction with regular appraisals involving line managers
- Since integration, the group felt the quality of line managed supervision was poor. It was felt that supervision was not structured and unclear to both parties. More valued was peer supervision. Professional development under KSF outlines was seen in a positive light but expectations were still unclear
- Through induction, supervision, appraisal and personal development for which policies and training have been provided, it feels as if social care has been forgotten in the service redesign
- SWs are encouraged to complete a professional development action plan at the point of their annual appraisal; this appraisal is undertaken with the SW's line manager and the SW professional lead can also be included in this process. The appraisal should review the past 12 months and set goals and objectives for the next 12 months; these should then be reviewed on a regular basis in supervision. Professional SW supervision is available when SWs have a health professional as their line manager. There is also a monthly SW forum which focuses on topical subjects and encourages ongoing debate and discussion about key professional issues
- There are individual review and development processes in place for all SWs in whatever setting they are working. By this process, training and development needs are identified, and these inform workforce and training plans. SWs have access to Professional Supervision as well as workload management. The SW Forum is a quarterly meeting, which gives all SWs the opportunity to meet together. SWs in MH services are given PQ training opportunities. PQ1 initially moving on to attaining the ASW Award. Pay scales for SWs in LA Adult Services now link PQ attainment work progression and offer all SWs PQ Opportunities. The need for SWs to develop Supervisory and Practice Teaching Skills as part of their CPD has been identified as a key issue. The integration of MH services has highlighted the difference between current SW and nursing professional development where all nurses are expected to take on mentoring and supervisory roles as they gain experience, and as a consequence are better placed to take on first line management positions. SWs, on the other hand, until recently have opted in or out of a Practice Teaching role, and have not been expected to take on supervisory responsibility unless they decide to go into a management position. A SW post combining Expert Practitioner with teaching and supervisory responsibility for students, SWs and support staff has been developed and is being introduced across the community teams. SW career pathway should mirror other MH professionals with the opportunities to be rewarded for research, teaching and practice as well as management skills
- ASW programme and refresher and update training of a high standard. Individual development needs are met through supervision and appraisal. Most Trust training can be accessed by SWs free of charge
- By SWs annually setting PDP through the Trust appraisal process with their supervisor who is the SW manager. These will now relate to progress under the A4C KSF and the requirements of GSCC re-registration. In fact we have no dedicated trainer for our team of 24 SW professionals so we arrange it ourselves on a small budget. We are able to take advantage of some training offered within clinical directorates and from the LA through our developed links
- Appraisals are the main source for identifying needs. Dependent on line management and resources access to development is given, though within MH this is mainly limited to ASW training. There is limited scope for other development or career progression
- Currently hit and miss. Will be included in the Trust Workforce Planning but this has been difficult in that there are no profiles for ASW or SW in line with A4C and getting

all staff on to new profiles is a priority (star rating) SW who are not employed by the Trust but simply assigned get missed. SW employed by the Trust are called generic MH workers and are gradually losing their professional identity. We hope that GSCC registration will address the need for SW to be true to the values of SW and evidence this in portfolios

- The PDP process is key to ensuring that the workforce is appropriately trained, developed and professionally supported. Within the Trust, the PDP process is led by the team managers, working alongside the social care professional leads in localities. The outcomes from these PDP are fed into the commissioning of training and development programmes. The County Council employs a Practice Development Manager who is responsible for all aspects of the ASW continuing professional development programme. We also have a joint agencies training and development officer who takes the lead around joint work including in particular training and development on the CPA, and on Safeguarding Adults. The local Safeguarding Children's Board has also published good practice guidance for MH SW staff concerning the interface with child protection work; that guidance has been the subject of recent training for social and healthcare staff. The Trust has a social care professional infrastructure which ensures that the wider developmental needs of the social care workforce are not overlooked. Some of that reflection and development is currently being taken forward with a 'virtual' pan-county group of the national SPN. This 'virtual' group comprise interested managers and practitioners from across many agencies.
- Staff have standard refresher and update training. We also put on ad hoc training. The Council are developing CPD portfolios to encourage adherence to GSCC regulations. Some SWs, seconded as they are into integrated teams, feel that the social care perspective is marginalised and ignored, that information does not get through to them, and that they are not enabled to meet their duties with regard to social care legislation
- With difficulty. Theoretically via supervision and appraisal but SWs/ASWs do not always have access to SW/ASW qualified managers. There is difficulty accessing funding for training and it is not a level playing field with health
- Annual IPDR annual ASW appraisals/reviews. Interagency collaboration. We offer regular formal supervision to all staff including regular dates for supervision set in advance, notes taken, supervision forms signed and kept in personal file, reviews, shared agendas. ASW/SW Standards Group – sets local standards from a professional stand point
- The Trust seeks to ascertain and meet the individual needs of SWs in a variety of ways. For example, the Trust has recently undertaken a skills audit and is developing a data base of training needs and requirements. All staff receive an annual appraisal and four weekly supervision where individual needs are discussed. The Trust has supported a number of initiatives in recent years to address the stated needs of SWs. For example, the appointment of a Professional Social Care Advisor whose role is to support and develop social care in the Trust; the development and launch of a social care strategy to reflect the needs of social care workers; the development of robust ASW re-accreditation; the continued support of the ASW forum; the forthcoming development of a social care meeting for all staff
- LAs have well established Staff Development Units whose role it is to identify and address the training needs of the MH social care workforce. In addition, professionally integrated "training teams" exist across the Trust in order to address development needs for MH staff. Members of these "training teams" typically include service leads for inpatient and community staff, psychology, nursing, SW and OT, plus staff development officers and managers of MH services. In addition, one locality has an integrated training officer funded from social care responsible for commissioning, organising and delivering training to meet individual need both from a health and social care perspective. It is worth noting that there are variations to how training is planned between the three LAs. This integrated approach to the development of a co-ordinated training strategy enables the representation of views from all the professional groups within MH services. However there is also a recognition of the individual needs of the SW profession, i.e. the need for ASW training. The training plans encompass both specific training needs for working within MH settings but also includes training on general themes and issues such as adult protection, child protection and case management. In terms of ensuring high PQ practice standards of ASWs training events are commissioned regionally from the Consortium linked to the University. Such training events in addition to local workshops, facilitated peer supervision and bi monthly ASW forums all contribute to ensure that ASWs demonstrate a sufficient level of practice, knowledge and skills to enable them to meet the three yearly re-approval requirements

- By strength of numbers, we are a lone voice within the Trust and the service does not meet the individual and workforce developments needs. The ASW Training does bring together the SWs which is an important meeting place. We are able to accept some responsibilities for promoting social care within the host organisation, but in terms of capacity planning it is difficult to discern any direct influence in the workforce planning process
- Across the Region there is a wide variety of approaches to this question. A common approach is to link individual training and development directly to the organisation's business and to national and local service delivery targets. The necessity for effective workforce planning and integrated training plans for the whole of the mental health workforce was recognised, although the development of this varied across localities
- At an operational level, annual performance management reviews evaluate the SWs performance and identify future training needs in relation to the PQ MH pathway and service/organisational plans. We have appointed two social care practice development managers who are responsible for the development of effective links with all seconded practitioners and their development needs in the Trust. Training needs are identified via the Trust social care practice development managers and fed into the appropriate channels for programme development and delivery. There also a thriving development group structure in the Trust, dating back to 2002 that has been used as a model for other partnership Trusts. This includes a two tier approach with monthly local SW development groups in each Trust area and a twice yearly Trust-wide SW Development Forum which focuses on new social care policy and practice developments, training and research
- There are social care leads within each of the borough directorates and service directorates, who link into the Trust's training and development programmes, as well as the host LA programmes
- This is primarily done through Annual Development Reviews which link to supervision. These are collated by staff development and used to plan training. Staff development sections also work with operational managers to identify areas which the organisation needs to meet its outcomes but this is an area which needs strengthening. The Trust has similar mechanisms which are well established and it is important that the needs of SWs receive equal prominence. There needs to be a greater focus on the needs of the organisation and wider stakeholders as traditionally training and development has been done within professional silos
- We have created a lead professional structure within the Trust whereby we have a head of SW, and locality social care leads who ensure that SWs receive professional supervision as well as line management supervision. All SWs have an annual appraisal and a PDP which focuses on their professional development as well as their performance in their job. We have created an integrated training service within the Trust with a strong leadership on social care issues. A programme of training is available to staff and we support unqualified staff to enter professional training. Experienced SWs and senior SWs can access management training provided by the Trust
- At the individual level, we receive supervision, training, and hold monthly ASW meetings with our Principal Officer. At the county-wide level, we have attended workshops on the ASW role. However, because most of us as MH SWs now work for or are seconded to the NHS Trust, we sometimes fail to receive information about what is going on in other areas of SW eg the children and families team, and we can at times feel we are losing touch with wider SW issues and developments
- In most parts of the region, training and development initiatives are shared/split across local government and the Trust. In particular, social services still coordinate (increasingly in conjunction with HEIs) ASW training, PQ awards and other social care focused training updates while Trusts provide training in a wide range of issues that are central to the work of the multidisciplinary workforce, some of which are driven by social care delivery priorities. The importance of inter-professional learning and focus on integrated MH capabilities frameworks (eg the Ten Essential Shared Capabilities) was noted in the consultation. It is important to develop models of training and development that enable staff of all disciplines in MH Trusts to be thoroughly updated on social care issues. There is a danger that SWs and their health background colleagues within MH Trusts may become divorced from social care learning in relevant aspects of eg children's services, physical disability, OP's services etc. if a joined up approach to health and social care training within areas is not achieved
- It was pointed out that as well as the HA and social services departments having responsibility, SWs also have personal responsibility. It was noted that GSCC registration places an obligation to provide training and development opportunities to enable social care workers to strengthen and develop their skills and knowledge. It was felt that

SWs need to be much more pro active in enforcing this through their employers. SWs need to come together through forums such as the ASW forum and the social care forum. The need for regular legal updates is important. A single integrated appraisal system and freedom of access to both health care and social services training is needed, with clear pathways to identify training needs through supervision and appraisal. There was debate about whether this should be done through team managers or senior practitioners or both. SWs want access to advanced practitioners courses

- There is a need for greater SW representation at senior manager and Director level. A number of Trusts are achieving this by appointing staff from a social care background into these positions
- There was evidence of lack of knowledge of opportunities that are available. Separate staff review and development systems for health and social care staff not seen as helpful. Establishment of SW Advisory Group seen as positive. Establishment of a Social Care Lead post, currently in planning process, seen as crucial. System of professional support for ASWs seen as currently disjointed and needs to be backed by a system of professional support and advice
- Almost three years ago, the new post of ASW Development Officer was created, in recognition of the particular needs of ASWs, particularly those who are employed in isolated settings and/or who do not have an ASW-trained line manager. Part of the ASW Development Officer's role is to consider the individual development needs of ASWs and offer opportunities to meet these. For example, we now have an annual 'ASW Development Day' to update each other on resources and service developments, and to consider local practice issues. We are fortunate to have thriving ASW Training Consortia, both for the ASW Programme and Refresher Training. Both of these are provided through the local University, in partnership with the twelve LAs in the region. Thanks to the good working relationships which have been built up over many years, there is a real sense of ownership by all partners within the consortia and we are proud of the high quality of training provided

Question 6: How are you encouraging Recruitment and Retention (R&R) of social workers?

Summary of responses

- No specific strategies appear to exist
- The effective operation of the County Council's HR Unit is central to the successful recruitment of SWs. Retention is achieved by having good policies and procedures, comprehensive training and development packages, strong leadership and professional support. We have a full complement of ASWs
- Difficult to respond to question in view of current frozen posts and the organisations need to create financial balance
- I encourage recruitment of SWs through my stories of clients and what I was able to achieve. I encourage retention through support of colleagues, listening, sympathy, etc
- Having an Executive Director of Social Care and key senior personnel appointed within the Trust from social care backgrounds helps encourage R&R. In addition, there is a need nationally to address the practical difficulties that organisations have to overcome in relation to full integration of health and social care services. For example, the provision of clear guidance on delegation of LA responsibilities to NHS Trusts and a responsible senior strategic MH role within the LA to ensure Trusts continue to fulfil these responsibilities is needed; differences in complaints systems; different terms and conditions between health and social care staff need to be resolved and adequately funded learning; and development pathways need to be introduced to ensure a skilled workforce that feels valued. To encourage career development in relation to SW and social care, NWW roles need to be accessible to social care staff, eg. STR workers, gateway workers, assistant practitioners and advanced practitioners. It would also be useful to consider the development of a SW consultant role
- By being responsive to indicators from unqualified staff that they are interested in training. Listening carefully to their circumstances and supporting with finding pathways through. As the support worker role can be more linked to OT or nursing for supervision, there are challenges in ensuring that the SW role and route is recognised. Coordination of requests for placements whatever their nature from initial observation to landlords/families interested in providing supported accommodation; to SW students

(preferably on 3rd placement) and trainee ASW's. There is an established liaison with the LA Social Services Training Department. Of the 6 people employed in SW posts in the locality, 2 are Practice Teachers, 4 are ASW Practice Assessors, 1 is a mentor. The Social Care Specialist is a teacher, assessor and mentor and participates in the advertising and interviewing for SW posts and supervises and jointly appraises SWs with their line manager. With A4C, it is likely that newly qualified SWs with little MH experience or who have not needed to take significant decisions in their previous work would not be considered for Band 6 SW posts. They would be more likely to be accepted for Band 5 generic posts, which carries consequential challenges for establishing and maintaining professional identity and competences which transfer to other care groups. Consideration needs to be given to mentoring during the early stages and secondments to provide breadth of work experience. SWs are particularly affected by the changes in MH services and need particular support when the organisation is culturally different and not governed/driven by the same core skills and values

- At present, there are 12 SW posts in the AMH services and no current vacancies. However, there have been issues raised regarding retention of SW staff and attempts have been made to ameliorate this situation through the provision of professional SW supervision, monthly SW forums and the general raising of the SW profile in the wider MH arena. AMH has had a higher turnover of social care staff than OPMH services. However, it was also noted that some social care professionals have been in AMH for a considerable length of time and turnover of staff is not as high as in some other adult social care teams
- Provision of Training Development opportunities linked to pay. Provision of professional supervision. Provision of SW Forum providing professional support and identity. Use of Bursaries. Use of traineeships and sponsorship for non-professionally qualified workers already working in MH services. Provision of student placements. Developing contact with Universities. Developing expertise in research, teaching etc
- Establishment of senior practitioner roles in CMHTs to address R&R issues. Honoraria for Practice Supervisors also acknowledges key skills and workloads
- We and our colleagues at the Hospital are a small group of SW professionals directly employed by NHS Trusts. As such, we are affected by A4C. Both practitioners and managers are appealing their banding, which was judged by a panel having no experience of SW. Banding for practitioners is particularly low. If this is upheld an effect will be to make us less competitive in recruitment. This has never been a popular specialism because of the client group and the institutional setting. Salary levels for comparable MH SW posts in LAs have been overtaking ours. Being located at the top of Band 6 takes away financial inducement for career progression through KSF. Effects of this on retention are unpredictable though likely to be negative. What does attract recruits, for instance Probation Officers with experience of delivering Accredited Programmes but no current requirement to do so; is the opportunity to train in and deliver sophisticated therapeutic interventions with hard to treat groups. Some Clinical Directorates wish to expand this opportunity. Our practice of working with some autonomy within National Standards provides an attractive balance for some experienced practitioners. Also a high secure hospital can be seen by some as an exciting and challenging workplace where cutting-edge legal and therapeutic developments are found. This can be appealing to the career track of more recently qualified mental health workers. Traditionally the award of the Higher Environmental Allowance has been a significant factor in recruitment but this will be subject to review under A4C. We have started to attract SWs on secondment from the County and seek to expand mutual secondments with them and the local Probation Service. We seek to develop the number of student placements by use of our Practice Teachers
- Have raised the starting salary. Created the role of Senior SW, and Head of SW. Raised the pay of ASW by 4 increments
- This varies across the Trust, however in one borough at least, the R&R of SWs has been much less of an issue than in Children and Families and other Adult teams. The emphasis in CMHTs on personal change, the balance between self determination and protection issues and the development of trusting relationships with service users (in contrast to some of the more mechanistic, care management arrangements elsewhere) means MH is likely to remain an attractive setting in which SWs can practice their skills for many years to come. We should not be complacent about this but we shouldn't be overly pessimistic or unduly dramatic about the current market place for MH SWs
- Are encouraging newly qualified and a trainee scheme
- Recruitment: Through persistent advertising and trying to attract applicants by focusing on the positives in our area. Also by trying to promote and offer opportunities to unqualified staff interested in professional training. Retention: by ensuring that SWs receive effective and good supervision which encourages them to continue to develop

professionally

- We reviewed the remuneration package to SWs three years ago, to include accelerated progression through attainment of PQ1 and ASW, plus an ASW allowance. New senior SW posts have been created to provide more opportunities for progression. We provide a professional supervision structure and opportunities for training and development. The Council promotes a 'Life Work Balance' so staff can take advantage of flexible working hours etc. There is some access to key worker housing. Recruitment is ongoing and challenging. Links are being made to the local colleges when we have vacancies, also to offer practice placements as this often results in people applying for a job. We hope to 'grow our own' through helping unqualified staff access professional qualification
- Promoting 'social work' at every opportunity within the work place. We have an Annual Social Work/Social Care Conference where we reinforce SW across the various MH work settings. Encouraging student placements and having closer links with our local University and SW course staff. (A SW lecturer takes part in our annual social work/social care conference). In supervision, an individual's professional development plan is discussed and reviewed. Staff are encouraged to attend a variety of training opportunities to enhance their skills and knowledge. Regular training programmes and dedicated MH training officer – training outcomes are monitored by Annual Report. Currently career pathways consist of SW; senior SW; and principal SW. At present, the next step would be in management, but the introduction of a 'Social Work Consultant Practitioner' would enable an individual to hold a senior position whilst retaining their expertise in practise. We think there should be training pathways for principal SWs who want to go into management positions so that they can be properly and professionally trained for the job. We currently pay our full time practising ASWs two extra increments as an enhancement per annum (paid monthly), all SWs receive an honorarium of £300 for achieving PQ1
- ASW's receive two additional increments in addition to their salary. Pay is in parity with our colleagues in the local County Council from whom a substantial number of social care staff were TUPE'd. There are a number of support networks in place or being developed. Recruitment is often problematical due to geography and history. There is a need for leadership and ownership at board level to ensure that social care staff are encouraged to join, and remain with, the Trust
- This is a particular problem as pay is poor and other things such as private health plans are non-existent. Substantially more money can be obtained through agency work, and retention could be improved if pay were increased. This money could be easily found as we are currently needlessly supporting a massive agency industry
- We pay our ASWs well!
- I was recently awarded £2,000 as part of a recruitment and retention drive, which was welcome!
- By marketing attractive training courses that enable SWs to reach beyond their care management prescriptive role and develop skills in direct work with troubled children and young people. These are proving very popular with SWs but are not being actively promoted by SW employers naturally fearing staff exodus from statutory child care activity
- Through Service Governance, Service Review and Service Planning. By promoting the SW role and the existence of the National Standards. By creating a service ethos of support, supervision, training and developments, and recognising individual interests. R&R retention has not been problematic in High Secure Forensic Social Work but this may change if future pay scales are more convergent. Recruitment of BME SWs has been an objective but not achieved yet. In other SW Teams there is an over reliance on agency workers which is not cost effective
- ASWs and SWs need to feel adequately supported and supervised and that the SW role is valued at Board level. Through having SW students. Having good formal and informal support networks. By acknowledging experience and expertise through enhanced remuneration and attendance to the needs of staff through a robust SW leadership/management structure. Ensuring a robust system of team and professional supervision. To look at developing a pathway for career progression in the future. Nationally and locally numbers of SWs appear to be reducing. SWs in specialist teams are not being offered ASW training and this might be a hindrance to career progression within MH services as well as a loss of expertise to their specific area of work. SWs are positive about the introduction of the new degree course in terms of professionalism. Job evaluation seen as positive

- Problems around having a professional body without teeth; no standardised pay/conditions; the commitment to more ASW training – may prevent people from applying; 6 months training – no extra pay; no specific SW training; and health lead/driven
- In secondment to predominately health care environments, ASWs can feel detached from professional peers and undervalued. Perceptions of loss of status and peer support can be enhanced by the lack of parity and conditions with health care professionals. One of the main differences in approach between health and social services is the national conditions of service structure for health care staff compared to locally agreed Social Services terms and conditions. Differentials around salary pay and service conditions have been exacerbated by A4C and represent a threat to the R&R of staff. One relatively recent development in order to begin to address R&R issues has been the employment of SW Advisors/ Leads for MH. Part of their role has been to assist the strengthening of professional identity. Specific work being undertaken varies across the different LA areas but has included areas such as strengthening professional supervision; exploring the social care evidence base and the professional SW identity; establishing SW/ASW forums, inputting a social perspective into Trust management groups; leading on social care related project and policy developments; linking to national social care bodies and developing professional registration systems. On an organisational level systems of appraisal and a commitment to Investors for People have also been initiated to assist staff retention. It is accepted that further work needs to be undertaken in order to strengthen the professional identity and status of the SW profession. Integrated management has historically been perceived as a positive contribution to such perspectives. The SW lead posts are an integral part of this integrated management approach but they are not present at a senior level of the organisation. The Trust however is in consultation with such SW professionals regarding how representation can best be achieved taking into account the diversity of LA cultures and differing issues within the three localities
- We have a strong pro-active student programme and we support SW training. We do a lot of multi-disciplinary training promoting the social care within the locality. We are involved in building an evidence based social structure through Service Governance
- R&R is an issue nationally. This has many reasons; one pertinent issue that springs to mind is inconsistency across LAs around terms and conditions of contract. Within our locality, each LA has different terms and conditions in relation to the ASW role. In the County, this has led to long running industrial action, much ill feeling and loss of good will. Perhaps assimilation to A4C may help prevent this phenomenon
- It was strongly felt that the appointment of a social care lead within Trusts at Board level was also essential to this, demonstrating the commitment of the overall MH service to social care and allowing for promotion of specific social care issues. In addition, it was felt that there is a need nationally to address the practical difficulties that organisations in overcoming obstacles to full integration of health and social care services - clear guidance on delegation of LA responsibilities to NHS Trusts, a responsible senior strategic MH role within the LA, differences in complaints systems, different terms and conditions between health and social care staff
- Organisations need to demonstrate from the top down that they sufficiently understand and support the SW role. This includes valuing challenge and a critical approach. We need to do more to offer student SWs placements in MH teams. The SW assistant role has been a useful way to develop the profession and support people into training. These roles have often been squeezed out by the need to maximise the number of ASWs. It is important that SW is promoted as a possible career for all workers in MH and in some ways integration provides us with the chance to recruit from nursing assistants, healthcare support workers and others who traditionally would have gone into nursing
- We have emphasised the Trust's commitment to integrated management with a good mix of people with both health and social care backgrounds at different levels in the organisation, and also the strong research and development culture and commitment to post qualifying SW development and training
- Offering quality placements to SW trainees. Addressing cohorts of trainees at their induction to promote the opportunities available to SWs in the service
- We see movement of SW staff from one borough to another – with all the costs to the LA – while still working within the Trust. We have begun discussions with social care leads and LAs around some kind of joint recruitment, but have 3 star social services that would not want to recruit jointly with 2 or 1 star authorities

- Other possible areas for development include enabling career breaks for staff. There also needs to be some consideration for older SWs whose qualifications don't fit with current or future requirements eg the potential revised PQ framework to have pay and condition protection
- The diversity of pay scales and terms and conditions for SWs is having a significant impact on R&R nationally. The appeal of locum work through SW agencies or self-employment also appears to be contributing to the problem. In Forensic SW there is also inconsistent access to environmental leads which further adds to the discrepancies in salaries between forensic units resulting in more competitive recruitment to the services. The recruitment 'problem' results in less experienced staff being recruited to posts which has an impact on the management of these members of staff in terms of professional supervision and training needs etc. Within forensic work, posts traditionally filled by SWs or SW qualified probation officers are now being filled by probation officers who have undertaken the new probation qualification. This will ultimately have an impact on the number of ASWs employed within these specialist services as these MH practitioners cannot undertake ASW training within the context of the current legislation. Offering student placements within secondary and tertiary settings is becoming increasingly difficult due to the lack of available workspace and time. This ultimately impacts on Practice Teaching opportunities for the existing SWs but also fails to provide students with learning opportunities, particularly in specialist areas
- While R&R are not the specific responsibility of SPN, we believe that this is one of the most urgent issues for the future. There are both generic and specialist recruitment issues. Despite the short-lived initiative launched by the DH which reversed the downward trend in recruitment to SW, this has not been sustained. Nationally social care salary levels have fallen behind comparable occupational groups. The impact of A4C in nursing is further widening differentials. A full scale review is required across social care roles. In the MH context the problem is rendered more acute by the planning blight mentioned above. Salary levels – if not addressed nationally- need to be addressed by employing bodies including MH Trusts to ensure that SW becomes a more attractive career option. Additionally universities offering degrees in SW need actively to encourage understanding of factors contributing to emotional and mental wellbeing early in the degree and provide placements that develop this
- While the R&R situation varies across the country we believe that there a number of national issues which need to be addressed as follows: Secondment arrangements. There are variations across England and Wales in the nature of the secondment arrangements – and in some cases the direct employment of SW staff to MH services. While we recognise the need for diversity in the light of local circumstances, we believe that actual arrangements should be based on a clear understanding and agreement on arrangements through partnership agreements which are reviewed on a regular basis rather than on what is felt by all concerned to be the 'safest' option. Just as we should not undermine the strong sense of commitment felt to local government by SWs, particularly in view of their statutory accountabilities, we believe that it is counter-productive to 'institutionalise' inequity through indefinite secondment arrangements. There is a need for a national review of best practice in order to identify and implement best practice in this area. Career Development. SW in MH services will often expect to make their careers in these services. They will need the same opportunities as colleagues in other disciplines to advance their careers, including leadership development alongside other disciplines, gradings for managerial posts that are in line with other disciplines, etc. We would also like to the role of 'Consultant SW Practitioner' being developed to recognise the complex nature of specialised SW as well as to provide opportunities for career development for those experienced MH SWs who do not wish to develop management roles. Other 'pressure points'. There is no doubt that we have to address the 'pressure points' which cause SWs to leave MH SW. Key for us is a proactive stance to service conditions issues, and in particular parity issues with other professionals, strongly developed systems of professional supervision combined with active encouragement – a resourcing of PQ routes, as well as systems which detect and deal with 'burn-out' at an early stage
- Overall, the picture from Eastern region was that R&R are currently problematic and it is not clear that any area has a very well developed or successful R&R strategy for SW. The Counties bordering London have particular problems recruiting SW staff because of pay differentials with outer London Boroughs. SW pay is still locally determined within LA areas so competition between areas has given rise to different incentives being offered in neighbouring areas in respect of pay, increments, allowances etc. These have included incentives such as 'golden hellos', increments/allowances for ASW duties, unsocial hours payments and retention bonuses. Ensuring continuity and/or parity of benefits in respect of pensions, annual leave entitlement, sick leave entitlement, car leasing, housing help etc. are also very important to encourage people to come from local government into the NHS. Some Counties and Trusts collaborate to provide fully funded secondments and/or traineeships to enable

unqualified staff to enter SW. These are very important and may be beneficially expanded. MH Trusts also need to provide SW training placements for people on a variety of training routes in order to attract qualifying staff to stay in the sector. Only in one County in Eastern region does the MH Trust directly employ SWs, although TUPE transfer and subsequent direct NHS recruitment of SWs is planned in at least two other County areas. For directly employed staff, the lack of a national profile under A4C has delayed opportunity to integrate SWs into the new system of reward for comparable work. It will be very important to ensure that, if possible, when the A4C national profile is produced for MH SW, it takes account of LA terms and conditions for SWs if SWs are to be attracted to work in the NHS. Overall, SW R&R was seen to be currently badly affected by insufficient candidates, a workforce disproportionately approaching retirement, advertising that did not highlight the 'social work' nature of posts where these were open to a variety of professions, poor NHS office accommodation, poor or mixed reputation of NHS as an employer compared to local government

- The pool of qualified staff appears to be shrinking, even for well paid SW employment. The separation between SWs and probation officers has not helped. Newly qualified probation officers can no longer apply for PQ roles, such as ASWs or practice teacher though this may change under the new MH Bill. There is also too little training for management in SW, although I understand this will change in the future. The leap to management is difficult and there needs to be an intermediate step. Although forensic work is well paid, staff leave as it is difficult to give staff the intermediate stage necessary
- Generally the borough Directorates grow their own ASWs. Commitment to the service is enhanced by working in integrated settings which means they are constantly in a multidisciplinary environment learning about other professions and the multifaceted approach to service delivery. This enhances practice especially in service areas where there is a high commitment to development and learning. With the pressure in the community teams particularly some staff do feel that the issues relating to social care staff are marginalized and through addressing these through the leadership of the heads of social care, ensuring there is professional supervision and PDP are in place, has aided R&R
- We need to start looking at SW consultants, senior practitioners etc and to consider both academic and practice routes
- A4C facilitates NHS employers to address R&R in a coherent way. Through A4C, NHS Employers have developed a job evaluation scheme which can evaluate the full range of roles in health organisations including social care staff. Initial national job profiles have been developed for common professional roles including the SW role. These job profiles are linked to A4C pay scales. This job evaluation scheme has proved capable of accommodating the nature of social care jobs. These do not yet cover ASWs as they currently cannot be employed by the NHS. There needs to be greater consideration and specification of the issues regarding the recruitment of ASWs in MH Foundation Trusts
- We are working closely with the County Council and a local SW agency to recruit SWs from abroad, within the DH Code of Practice
- The working relationship between the Acute and Community Manager and the Head of Social Care is a significant one. They work closely on many matters, and invariably with the goal of managing to minimise differences between health and social care staff that might be seen to disadvantage either group. SWs have the advantage of being able to use Council and Trust training. Being in an integrated setting means that they are constantly in a supportive multi-disciplinary environment, learning about other professions and the multi-faceted approach to service delivery. This enhances practice, especially in relation to clinical areas with a greater appreciation of mental state examination and wider therapeutic interventions
- Flexible working arrangements and a key worker housing scheme are available. Each year there are a specified number of secondments available to non-qualified staff from health or social care backgrounds (support workers, STR workers, day care staff) to undertake the Degree in SW and there are clear routes via NVQ to progress towards this training. The Trust has Practice Plus status for IWL The Trust training programme for social care is well developed and well respected and this can act as an incentive to recruitment. There is a clear professional and supervisory structure for SW staff
- If students have a good experience, on placement, then our attractiveness as an organisation/service is enhanced as a good place to work

- There is agreement that improved career pathways are needed. The ‘community matron’, the ‘nurse consultant’, and the GPWSI are all examples of other disciplines progressing this issue. Experience is that student placements are well worth investing in as many do choose to stay
- We would welcome a more national approach to a career in SW. Currently each LA has developed its own responses to eg integration, staff retention etc. Consequently, we have a situation where we are fighting for scarce staff by an increments war. Lack of career structure and clarity over pay and conditions does affect R&R. We need to ensure that social care staff are represented equally in the upper echelons of the management structure. This gives an important message to staff and ensures social care and social work issues are given their due importance. There is a difference between social care and SW
- We attend local recruitment fairs. Exit interviews completed on any social care staff leaving the department. We encourage students and offer a range of statutory placement (many students return to work here). We offer professional forums and management coupled with regular supervision. We offer 2+ increments for ASW’s and 2+ increments for SW. Social Care Staff have asked about loyalty payments and feel that the Council should follow the direction of A4C
- Recent “Single Status” Job evaluations have been carried out by the County Council . This has resulted in SWs and ASWs being upgraded in terms of salary
- We are fortunate at present that we have had no major problems with R&R of staff within MH teams. Approximately three years ago, a package of measures to enhance the pay and conditions for all SW staff in the Council was agreed, which included extending the SW pay scale by two spinal column points (to SCP38) for all SWs. There are also lump sum and annual payments for all staff who achieve Part 1 and/or Part 2 of the PQSW Award. Additional payments are made to SWs who act as Practice Teachers or Link Workers to student SW on placement. ASWs formerly received an additional allowance, but within the new arrangements this was replaced by ASWs going straight to the top of the SW scale on appointment and receiving the PQ payments, whether or not they have completed the full Award

Question 7: How are you addressing issues of comparative pay & conditions, including Agenda for Change?

Summary of responses

- Has not happened for social care
- We need to better address discrepancies in pay and conditions particularly as a result of the A4C exercise, but also because each local social services authority has tended to set its own pay and conditions often without due regard to the arrangements in its neighbour LAs. The ASW role has, however, alongside all the substantive main grade SW posts, been through the Job Evaluation process – a not dissimilar process to A4C
- Currently it is not possible to address any issues of parity which may arise in relation to A4C for seconded staff and there is a risk that morale will be affected in integrated services if one group of workers compares unfavourably to another as a result of the separate and uncoordinated service conditions systems in existence
- As a locum, I could earn more per hour working with another agency or for another council, but I will not exploit the system at the expense of services to clients
- Integration for SW is already well under way. A4C now implemented for social care staff. However, SW’s feel they are still unequally paid after initial band positions. Feel they are having to play catch-up to their nursing colleagues
- Under A4C, SWs have been placed on Band 6, so being identified as comparable to ex-G grade nurses. This has been encouraging for SWs and particularly ASWs who had watched their pay slip behind nurse colleagues undertaking work of similar levels of responsibility and complexity. The job description and KSF Outline were achieved within the context of widespread consultation of SWs, their managers and their professional leads. In agreeing to transfer from Social Service to the NHS, the SWs have accepted the same terms and conditions as their health colleagues, most notably, those associated with flexible and 24/7 working and the supervision of junior staff
- This issue has been focused on in the recent service review. There is an expectation that AMH SWs will consider working out of hours as part of new service developments.

This has highlighted the discrepancy in pay conditions given that health care professionals receive enhancements/ additional remuneration if they work out of hours whilst their social care equivalents do not. Nursing and social care pay scales are roughly comparable here. Health care professionals receive a few more days in annual leave that has generated some concern. It is hoped these discrepancies will be addressed and resolved

- SWs remain employed by the LA. Terms and Conditions are comparatively similar to their main colleagues who are nurses. No work has yet been done on evaluation of social posts under the A4C framework. A4C has thrown up some issues for non-professionally qualified social care staff whose pay scales were reduced following A4C evaluations. These are being reviewed
- It is vital that the role and skills of SWs in multi disciplinary teams is recognised in the A4C terms and conditions frameworks and that such posts are on the same points as other CMHT care co-ordinators, such as CPNs and OTs. Indeed there is probably a very strong case for arguing that those staff who take on the additional statutory responsibilities to act as ASWs or applicants under the new Act should have that reflected in their salaries
- With difficulty, the LA has recently gone through the Job Evaluation Process. This will be even more difficult if the new AMHPs are offered inducements higher than ASW to undertake the role
- SWs are still seconded to the Trust so they retain LA Pay and Conditions. Other social care staff were transferred to the Trust under TUPE conditions and can choose whether to accept A4C pay and conditions or remain with their LA Terms of Service
- As we continue to employ SWs through the LA, we have not had to address A4C issues for these staff. For other staff including support workers, their grading under A4C has meant a substantial drop in pay, although existing staff can choose to remain on their existing salary and LA terms and conditions. In the longer term, the down grading of salary for people in support worker roles will affect R&R and the quality of people that will come into the work. As this group of staff is likely to contain the people who may wish to professionally qualify in the future, this is a problem
- Pay and conditions are identical to the local County Council. There are, however, other regional competitors who are able to offer substantially better pay and conditions. The full outcome of A4C has not yet been decided, although staff who were TUPE'd from the local County Council will have the right to opt out of A4C and remain with LA terms and conditions of service. ASW's receive two additional increments in addition to their salary which gives them parity with Band 6 nursing colleagues
- Our workforce is seconded to the local Trust at present and as such is not part of A4C. However, the County Council is putting its staff through a comparative exercise (Pay and Benefits Project) and our staff are part of this. We are acutely aware that there is disparity of salaries and conditions between SWs and Nurses and would want this addressed as a matter of urgency if we are to be TUPE'd across to the Trust and see A4C as the vehicle to do this. We also pay practice teachers and ASW practice assessors one off payments for supervising staff
- Progressing through the process of A4C via completion of Job Analysis Questionnaires and awaiting decision of job evaluation panel. There is no national profile
- ASW remuneration in the Trust currently compares favourably with health colleagues of similar status and as employees of the LA they have not been part of A4C. Comparative pay is likely to become an issue under the MH legislation around the AMHP role
- Differences in salary and conditions represent a major threat to R&R and morale of MH SWs. These differences exist in comparison to health care colleagues and have been exacerbated by A4C, leading to some nurse colleagues in the same team, undertaking similar functions (with the exception of the added ASW responsibilities for MH SWs) being recompensed above the level of ASWs and with up to 6 days more annual leave. This results in a feeling of being under valued, through central Government initiatives, in the profession. In addition other social services adult care staff in one locality have also been granted similar salary levels with ASWs (dependent upon completion of the current PQ award) and such discrepancies have led to a number of MH SWs seeking health contracts as "care co-ordinators" within the Trust. These crucial issues are currently being discussed within the relevant LAs and Trade Unions. In addition, one locality group of ASWs has raised the possibility of being employed by the Trust. Such a move is a reflection of the degree of health and social care integration within that locality as well as seeking access to A4C and the better terms and conditions

currently being offered by the health service. The SW leads, as representatives of the Association of Directors of Social Services for MH, are currently monitoring this situation. In terms of A4C, a number of LAs are using this a model for appraisal for its mental health social care staff (but unlinked to pay progression). Work is also being undertaken to cross reference the KSF to the GSCC registration requirements and to its Code of Ethics. The SW leads are monitoring these developments in order to consider the most appropriate system for registration and CPD and professional re registration for MH SWs. Despite these efforts the profession remains concerned in relation to the central issues around salaries and service conditions. There is the possibility of a R&R crisis in the ASW service as staff increasingly move out of the ASW role into Trust posts or mainstream Adult Care Social Services (offering better or identical terms of conditions without the personal and legal responsibilities of the ASW role). With the NHS preoccupied with structural change in response to “Patient Led NHS” and LAs preoccupied with the imminent White Paper on Adult Care such issues are not seen to be high profile on the agenda of either service. Unless urgent action is taken to address such issues, the profession fears that an ASW recruitment crisis will ensue leading to a deterioration in employer-staff relations

- The Job Evaluation Exercise initiated in 2004 by the LA has been suspended until 2008 whereas the A4C in health is expected to be delivered by October 2006 and neither process is linked to the other. This is all we need to say about the drivers behind the harmonising of pay and conditions
- Within our area, a harmonisation process took place for the SWs. This led to a ‘two band’ scale grade. One starts at SP39 and can only go to SP40. ASW allowance is payable on top of this. There is also an HEA. Management grades are yet to be assessed. A4C affects the administrative staff and many of our multi-disciplinary colleagues
- Assuming that the new AMHP will be approved through the authority of the LA, and there is every indication that this will be the case, questions will be raised about the parity of pay and conditions for the reasons stated above. These issues will need to be addressed through the new MH Bill
- This needs to be nationally led to ensure that SWs do not experience any pay, professional, pension or other disadvantage if they move organisations. There needs to be a national policy to rectify the current disincentives for SWs to move into NHS posts
- On a practical level – A4C may well increase salary bill for NHS and in the current climate of financial balance may impact on posts
- A4C, apparently entered into with no involvement from the LGA/ADSS, has the potential to seriously threaten the comparability issues we have been trying to align since integration in 2001. Work on integrated job descriptions based on NOS has proceeded in some areas, and management job descriptions have been aligned for several years. AFC threatens results to date, if only on affordability grounds. Any widening of pay gaps will be a disincentive for SW at a time when the opportunity is significant. Practically we have a joint HR appointment in place in the integrated service to work on the detail of pay and conditions alignment
- It was acknowledged that the disparity for the social care workforce was becoming a issue of enormous proportions which will absolutely have to be tackled. Even though this national problem it is being managed in a temporary piece meal way by some local conditions of service. A final discussion at the seminars reached a 100% agreement that this issue must be tackled by national agreements, nationally negotiated. There also needs to be a recognition of unsocial hours and the level of specialist skills and knowledge expected of ASWs and following the PQ award, neither of which are universally being remunerated. Some local differences of up to £3000 for the same job are reported between adjacent providers and this is as much a problem between LAs as one between health and social services. This is resulting in difficulty in recruitment and retention and in general the discussions have not yet even been started. In the forthcoming merger of our two Trusts and different LAs, it will mean there will be three different pay scales and conditions of work to be brought together
- The Council is currently undertaking an evaluation of all posts

Question 8: How do you see the career structure for social workers developing in the future?

Summary of responses

- More specific attention to development of advanced practitioner posts (as in nurse consultants) more development of joint appointee roles-ie half time practitioner/trainer
- There are senior practitioner posts available to all professionals and SWs are always encouraged to consider these positions. However, in a recent internal recruitment process, all applicants were health professionals and subsequent appointments duly reflected this. At present, there is only one social care professional in a SP position. Further work needs to be done to address this issue through individual staff development and wider service development validating the social care perspective, particularly in AMH
- There also needs to be a management career pathway in place in integrated services which is accessible to social work/care professionals
- This group were very unclear about a career structure for SWs. There didn't appear to be a pathway for them to follow
- SWs are appointed on the basis of agreeing to train as ASWs which currently results in a two SW increment enhancement for ASWs. The A4C SW role is identified as a "senior" practitioner. Job matching has been achieved for SWs but has been more difficult for SW assistants and social care specialists (the social care and ASW professional lead roles). Promotion within a health and social care Trust is currently to a "health and social care team leader" line management role or "social care specialist" professional lead role. With management restructuring, service redesign and Foundation Trusts, it is difficult to predict how the career structure for SWs in MH will develop. It is also difficult to predict if the skills gained in integrated health and social care MH Trust will allow career routes in non-integrated social services departments
- We do not envisage changing the existing progression structures for qualified staff. We need however to put more effort in to promoting the contribution that SW makes to modern MH services in order that practitioners, not currently based in MH services, can make the transition to this area of work
- Increasing opportunities for progression as Expert Practitioners. Opportunity to participate in and influence SW and Interdisciplinary Training and Education. Perhaps joint posts between academic institutions and the field. Developing Leadership and Management to ensure there is a mix of health and social care professionals in management posts. More positive initiatives to ensure workforce reflects the diversity in the community served
- I wish it could be more akin to the career structure of medicine whereby one can progress to be an expert practitioner and still see clients, ie. the more complicated ones. You do not have to move into management when you progress
- I can not currently see any specific SW scope, unless further amalgamation of roles continues and access to a variety of development is given through Trust structures of career development, as I do not see that SW PQs are particularly valued on an equal level in MH career progression
- SW progression through main grade to senior SW and then limited choice into Professional Lead or Management
- No identified lead on ASW and other SW roles. Need to consider a Head of Social Work post with a remit to raise the profile, co-ordinate and structure the social work role for now and the future
- Currently SWs can apply to become senior SWs, and following that they can either choose to enter 'general management' within the NHS – for example CMHT manager, or pursue the professional route such as social care lead
- As senior SWs with the ASW allowance, staff can achieve salaries broadly comparable to those of CMHT managers now
- There needs to be a structured career pathway for vocational staff, i.e. STR workers, CSWs etc to progress within the vocational field and into SW training
- There is a need for a SW consultant post which has been highlighted in the social care strategy
- I don't think there is a structured career path at the moment, but this will have to be clarified because of the R&R issues
- A professional career structure with specialist branches will enable SWs to move employers and job locations away from the old LA employers into the voluntary and independent/charitable sectors or as independent practitioners
- The leadership role to champion SW and social care perspectives within MH Trusts. Practice teacher / assessor role should be seen as a job in it's own right with appropriate remuneration

- Career structure could develop with differentiation between Level 3 SWs and Senior SWs. Also development of Clinical Practitioner role may assist. The advanced and assistant advanced practitioner will hopefully embrace SW as part of the overall framework
- Basic, senior, principal, Head for the Trust
- It would be helpful to have specialist SW in MH. eg CAHMS, drug and alcohol
- SWs need a clear career path to management positions which would be aided by the provision of a good programme of management training. ASWs with PQs should be officially recognised as senior practitioners
- It is important to have clear pathways for progression using the PQ framework as it expands in 2007
- Acknowledgement that it is positive we have a professional Head of Social Work
- At present MH SWs who wish to progress beyond current salary grades are required to move into team management, policy development or educational posts with no direct client contact as a consequence. However recent introduction of SW leads in MH services are a welcome development for the profession. Such posts tend to be responsible for the professional development issues of ASWs and MH Social Care staff and tasked to link the social care perspective and professional issues into the Trust management
- It is interesting that the new PQ framework has a strand devoted specifically to Management and Leadership which may lead to consideration of the development of two separate career structures, one focussing upon management and the other leading to a specialist practitioner role
- Could use the model of the Career Framework as in the health sector – this could be easily fitted together
- The recent introduction of SW leads in MH are a welcome addition for the profession. Such posts tend to be responsible for the professional development issue of ASWs and MH social care and tasked to link social perspective and professional issues into the strategic management of the Trust. Whilst the precise job descriptions of the individual posts vary some will also have a consultancy role in relation to high risk cases (e.g. adult or public protection) where there are possible legal ramifications
- Locally the creation of Senior Social Care Practitioner roles has provided a good route for people to develop who may not have wanted to go into team management. This role is currently centred on providing professional and practice supervision and also in ASW work as these are priorities for the organisation. It would be positive if funding and capacity allowed people to develop other areas of specialist skills and knowledge and to progress to senior practitioner level in these. Examples of this might be child protection expertise, social inclusion and community development etc
- SW training provides a good base for developing other specific skills – advocacy, counselling, psychotherapy, therapeutic and community group work etc. We believe that SW is also an effective preparation for managerial/supervisory roles and see the role of clinical supervisor as one to which SWs are well suited
- We recognised that the original SW structure lacked long term career development opportunities and we introduced changes during 2005 to significantly improve this and to further develop our focus on initiatives related to carers and employment. We have created three consultant SW practitioner posts and now have three levels of SW practitioner – main grade, senior practitioner and consultant. We will use the new posts in part to help generate and maintain the professional identity of registered SW who are working outside of a LA setting and who have begun to recognise the importance of taking responsibility for their own profession and its development, with our support and with sound professional advice and supervision systems in place
- The outcome of the consultation on management arrangements at inception of the Partnership Trust required one of the 5 Board Executive seats to be a Director of Social Care with a SW qualification
- The Trust also appointed a Head of Social Care (now Associate Director) reporting to the Director, providing effective day-to-day leadership and management/ professional advice to colleagues as well as managing the continued development of ASW practice across the whole area. Substantial changes to structures at the County Council also required higher than anticipated input / liaison by both director and head of social care to maintain effective levels of integrated working. As part of our further development of this approach, we have appointed the two social care practice development managers to work more closely with social care staff on training and professional development

issues and social inclusion

- Some SW staff are developing skills in clinical interventions more associated with health colleagues e.g. nurses and psychologists. This is seen as leading in the future to some SWs moving into advanced practitioner/clinician posts open to staff of a variety of professions. The development of specific advanced SW roles varies across the region with some MH Trusts already further developing senior practitioner and consultant SW posts. The development of such advanced SW roles was advocated by the regional consultation participants. The roles and purpose of such posts would include ensuring social care and SI priorities and outcomes are promoted within Trust practice, ensuring the professional needs of SW staff are attended to and providing a career structure for SWs within MH Trusts. The new proposed AMHP role will need to be made specifically attractive to SWs if it is to be a multi-professional opportunity for career advancement
- More guidance, including the Code of Practice, is needed on the role of the AMHP. It is difficult to be precise about the changes that this might bring about. However, the value of independence, and of having a holistic and broad view of MH are critical to preserving the very good work of ASWs finely honed over many years. These skills need to be migrated into the APMH role as far as the Act permits
- As MH services continue to deliver integrated services, there is a serious risk that the SW career ladder will stop at the Senior Practitioner level. However, the absence of SW representation at higher management levels has a significant impact on the development and shaping of future services. The social care element of MH services must be maintained within a SW context. It is crucial that Directors of Social Care are recruited from a SW background in order to adequately and effectively be able to promote the fundamental principles of the profession and translate this directly to the contribution SW makes to MH services
- Opportunities to bridge the gaps between academic institutions and service providers are currently offered through CASE Studentships and Knowledge Transfer Partnerships that are taken up by SWs. These schemes could be more widely developed and current incentives expanded to strengthen the link between professional practice and service development. There may also be new possibilities for developing SW practitioner research arising out of the implementation of the new Best Research for Best Health strategy. In terms of developing research capacity LAs could be encouraged to build a research component into some of their Senior SW posts and above. The introduction of the new PQ framework, in particular the higher and specialist awards, presents a real opportunity for SW research in MH to relate directly to career progression and promotion. However we note that prestigious awards for recognising and furthering a research contribution to the health field more generally such as the Career Scientist Award are not accessible to SWs and this needs to be redressed within the development of a career structure for the profession as a whole. Opportunities for some SWs to develop research skills to PhD level are urgently needed to ensure parity of the evidence base with other professions
- It was strongly felt that all career development had to be linked to A4C, bearing in mind that SW conditions of employment and remuneration have not been through this process and it represents considerable practical challenges for LA systems
- The loss of practice opportunities following a decision to enter management was seen as a career problem and may be why some practitioners are keen to develop a leadership role but unwilling to undertake managerial progression
- Specialist roles for SWs are being developed, including part time practice teachers linked to a lecturing role and SW consultants without a management responsibility
- It is noted that while central policy places emphasis on the need to move towards a model of intervention that promotes SI, and seeks to develop ways of working that draw on social interventions such as assertive outreach and crisis resolution teams, there is a tendency to diminish the formal professional role of SWs in contributing to the development of these type of services. This is a contradictory and confusing stance on the part of central government which is echoed in operational experience
- There is a perception that statutory services will be lost to the voluntary sector in the next 10 – 15 years and that more posts are becoming specialist and ring-fenced, suggesting that the role of SW is being eradicated. This is particularly the view of established SWs who have been practising for several years and perceive their role as becoming more diluted. SW needs to be proactive in defining its profession ie. solution focused therapy, task-centred approaches, crisis intervention etc, and retain them explicitly as SW models of intervention. Currently, Senior Practitioner roles are being developed following consultation with social care staff who have identified a need for

the opportunity of further career development separate to the role of ASW as management

Question 9: How do you think NWW might influence the future development of the social work role?

Summary of responses

- The literature in itself is only rhetoric. SW being valued will be shown in more concrete ways
- I suspect NWW in MH can positively influence development of the SW role to the extent that SWs influence NWW as it is applied to their profession. The strategic aim of SW organisations should be about promoting NWW for SW to focus, for instance on the future aspirations listed in 13.4 from Appendix 3 of the Psychiatrists Final Report. NWW can influence achievement of this by promoting new approaches to training and staffing
- Please keep SW as an essential. A lot of our work is relational. Clients and carers want one caring professional to relate to. I once asked a client “What have I done that has been most helpful to you?” He replied, “What has been most helpful to me is your humanity.”
- With its emphasis on the need to embrace a SI and recovery approach, NWW implicitly highlights the need to ensure that SW and social care services are pivotal to NWW. This needs to be made explicit in terms of outlining how new working roles will include the SW and social care agenda
- By recognising the importance of the knowledge, value and skills that SW brings MH services. By bringing to greater attention roles such as AMHP and “Person Centred navigators” which build on SW training
- NWW proposals are not widely known about or understood so it was difficult to comment at this stage
- NWW provides a golden opportunity to claim a new visibility for SW and social care practice. Those of us who have been around for long enough recognize that we need to reclaim our expertise and push it within modern MH services. For instance it would be helpful to see SW and social care having the same kind of national profile as our colleagues in psychology have managed to capture for themselves, comparatively recently, in policy and service modernisation terms
- It is envisaged that the NWW will be helpful in examining the career structure of SW, R&R, the organisational and service value of SW, particularly within the context of Payment by Results, and Foundation Trust status developments
- Social Care has a lot to offer the new professional roles, but there is a concern that this is being fragmented and watered down. The Social Care perspective needs an authoritative base. We ALL cannot do it ALL
- Hopefully by highlighting the invaluable role that SWs have to play in the field of MH particularly with reference to their unique experience through provision of the ASW function
- Some concern expressed about over specialising eg. in MH and this will diminish the wider perspective and community awareness that SW (and SW values) brings to MH. We do not see the concept of a generic MH as a positive development and there is some concern that NWW 'may' lead to this
- In enabling clinical staff to understand that SW has promoted person centred planning, diversity and carer and user involvement for many years and has a wealth of experience and knowledge which is available to share with NHS colleagues
- Discussions on the changing role of the SW profession clearly needs to be in the context of all professional and team roles due to service delivery issues
- In terms of social care specifically, NWW may involve re-examining the skill mix between professional SWs and unqualified workers, a review of when SWs are actually available to offer services, eg. outside of normal office hours, and crucially review current tasks undertaken in relation to all other specialist workers in MH. Such a discussion is particularly important in view of the recent appointment of new types of posts, e.g. Graduate Workers, STR Workers and CDWs - all aimed at facilitating the

modernisation agenda in MH. Such discussions should present a window of opportunity for the SW profession and enable a re-examination as to whether their skills are being utilised to their full potential

- The role of SWs and of social care staff is integral to role redesign and the CWP. In particular the STR worker role will need to be carefully reviewed alongside other staff roles as experience is gained across MH Trusts. Qualified SW staff need to be appropriately trained and have their confidence developed to take on new roles and responsibilities emerging from the NWW initiative
- The role of SWs, particularly those employed as ASWs appears to have become more complex over recent years. The impact of the Human Rights Act has been pervasive and certainly broadly welcome to SWs, but has helped to generate enormous amounts of case law which ASWs need to keep themselves apprised of and to incorporate into their practice. There is an increased emphasis on sophisticated risk assessment and management, and the greater prevalence of dual diagnosis amongst the user population has complicated these tasks further. SWs have also needed to develop new skills and expertise to deal effectively with more recent diagnostic categories, such as those for example of DPSPD or AS. The latter is perhaps not new, but its increased prevalence/diagnosis, and the greater onus on MH to cater for people with AS, certainly is. People with AS remain few in numbers, but their needs can be extremely complex and placements tend to be few and far spread. It is an area where MH SW is having to develop a new expertise. SWs also have a key role in advancing the government's choice agenda, and it is clear that there remains much work to be done in this area eg enhancing the low rate of direct payments in MH. Additionally, with the creation of SCIE etc there is clearly much greater emphasis on the need for SW to be underpinned by a clear evidence base. Evidence-based practice is certainly very much part of the culture of the NHS and it seems clear that if SW is to have credibility as a profession within large MH Trusts, it will need to be able to articulate the empirical basis for its activity much more confidently and clearly than has perhaps been the case in the past. Again, this is a fresh challenge for the profession
- NWW will influence the future development of the SW role via the redistribution of duties and role across the MH workforce. Social work is recognised for its holistic model of intervention, that enjoys evidence from national research, which cite the positive effects relationships, SI, equity and empowerment have on peoples lives their well-being and community. Simultaneously, the enhanced recognition of this SW role will further define the identity and profile of SW within the MH services and influence other professionals to drive the social care agenda forward and de-stigmatise mental illness
- In respect of NWW, the consultation participants suggested that SW should influence NWW as much as/more than the other way around! However, consultation participants did not yet fully appreciate the potential impact of NWW on SW. There was a perception that NWW may draw SWs into undertaking tasks outside of the core business and values of SW (eg becoming more drawn into medically-orientated tasks) which may weaken the social perspective within multidisciplinary teams. Even if SWs take on broader responsibilities within NWW, consultation participants were keen that SWs can continue to bring a questioning, egalitarian, anti-discriminatory social perspective to multidisciplinary practice
- We are very unclear what the role of NWW might be - this document is the first time we have heard of it. We hope that NWW is able to protect the SW role and its psycho-social, holistic ethos
- In an integrated setting, there is a dilemma about working effectively with colleagues while not blurring boundaries causing SWs to undermine their identity and core values. The role of the ASW has helped maintain professional identity in MH settings. Attached to this is a growing recognition that core skills are needed by all MH professionals to do the job, hence the 2004 guidelines on core competencies issued by the DH. SI is a challenge. SWs are well placed to spearhead this initiative, but will themselves have to modernise their approach. Concentration on the recovery model is relevant here as it pre-supposes a change in the worker-client relationship, at least over time as a client 'recovers'. SWs will need to make sure that they keep abreast of developments in this area, including a greater emphasis on paid employment and aligning clients to mainstream non-MH services. Changes in Incapacity Benefit will be important. The evolution of 'impact assessments', beginning with the Race Relations (Amendment) Act should bring about a more proactive stance to diversity and human rights issues across all interest groups

- I have concerns that it will impose a medical model and medical authority on SW and suppress the development of SW in MH
- With the research that has been commissioned by the DH into the NWW the SW contribution will be subject to some level of scrutiny in the case study sites. One way in which the NWW might influence the development of the SW role is by exploring the SW profession's contribution in its widest sense including practitioner's involvement in research and service evaluation/development. All SW students currently undertaking qualifying study at Masters level in England have to complete an empirically based dissertation as part of their qualification thus providing them with research skills early on in their career. In the majority of cases these pieces of work are directly linked with the service or organisational development agenda, thereby providing evidence of the transfer of theory into practice
- The NWW was received with much interest as it was seen to have the potential to raise the profile of social care although it implies the need to change job descriptions flexibly to meet changing circumstances which could have considerable employment implications in terms of negotiations with LAs. The NWW would support the development of a SW consultant role and the potential for a specialist assessment for some people who might previously have been seen only by a psychiatrist, thus leading to less duplication of assessment for the service user as well as clearer shared roles and the use of single assessment tools. This would also potentially lead to changes in the balance of power by encouraging service user empowerment. The NWW is also welcomed as a vehicle for change in inpatient services as the ability of others to prescribe may widen the current medical model and encourage SWs into leadership and therapeutic roles on wards, as well as being a key part of a move towards a more preventive model. NWW is also welcomed as demonstrating opportunities for SWs to provide consultancy and supervision to a multi skilled team. Whilst this is currently possible, it will become a more accepted way of using specialist SW skills
- Whilst agreeing entirely with the summary given at Annex 1 to the Discussion Paper, we are not convinced that this is saying anything new. SWs in MH will need to face the challenges within the Green Paper, 'Independence, Well-being & Choice' and now the new health and social care White Paper 'Our Health, Our Care, Our Say'. As we have already mentioned, MH SW here is developing in a rather different direction to that outlined in the Discussion Paper and our current challenges are the re-definition of the social care agenda in the light of current developments and striving to establish an effective interface between health and social care in our local MH services. For those SWs who remain in an integrated structure, it is felt that NWW present significant challenges in terms of maintaining the SW professional identity, where SWs may be in a minority of one or two within a multi-professional team

Question 10: In turn, how do you think social work might influence NWW generally?

Summary of responses

- Hopefully the discourses that take place within SW may begin to integrate with those dominant medical discourses and provide the medical model with a broader perspective; something that appears to be happening to a small degree already. This in turn may create an appreciation of the role of the SW
- SW can influence this by bringing the specific strengths and skills of the discipline to the new roles and by ensuring that these roles are included in social care career pathways
- Promote their knowledge, skills and values in order to achieve social inclusive service development. Participate in all the key developments in their localities, regions and at national level including having the opportunity to sit on strategic planning committees
- By clear communication about the unique contribution that SWs make particularly with reference to their close partnership working with voluntary agencies and emergency services as well as their advocacy role for the most vulnerable people in our society
- SWs need to be more involved in teaching and training other staff to promote SW values and a social care perspective
- The main contribution SW can make is to ensure that a holistic, user centred, joint assessment approach becomes the norm – as opposed to the dominance and acceptance of

the medical model

- Through organisations like BASW
- SW can influence NWW in general by a continuing emphasis on values based practice, recovery, service user and carer involvement and social inclusion and their central role in delivering MH services based on holistic and multi-factorial models of understanding and responding to mental distress. SW skills and experience in working across boundaries, networking and building partnerships with and between individuals, groups, communities and organisations are also an important contribution that can influence the development of effective working in multi disciplinary and multi agency teams
- SWs should be encouraged to develop their ‘voice’ within multidisciplinary teams, to bring social perspectives to bear more effectively and to be willing to manage case work and risks from a distinctly social perspective
- There is a risk the SW contribution could be watered down to such an extent that it can become marginalised e.g. MH Review Tribunal reports being written by other members of multi-disciplinary teams. There is already evidence of a marginalisation of expertise within community MH services because of the low numerical representation of SWs. Insufficient emphasis on the SW perspective can result in dangerous situations arising eg child protection
- NWW needs to consider all aspects of social care as part of the programme to develop effective and appropriate interventions. As such there needs to be a clear understanding of the relevance of social care issues in service design and delivery. Only once this is done, can appropriate roles and tasks for all professionals be developed. SW work at all levels needs to inform this process. Policy leads and academics should be lobbying to ensure that all new guidance includes consideration of social care within developments. Local managers, service commissioners and front line practitioners should be ensuring the same focus on social care when services and posts are being redesigned to meet national, modern requirements for service delivery
- We hope that SW will champion NWW as these emphasise areas which link well with SW values. We are, for example, well placed to promote the Ten Essential Shared Capabilities. We hope that SWs will therefore champion values based approaches, social inclusion and recovery and continue to encourage better understanding of safeguarding adults and children
- SW has the potential to have a significant impact on the application of NWW in promoting flexible and creative way of working across the MH workforce. Similarly, the emphasis on community development and network management in SW is a valuable model for other MH professionals to draw on. This type of inter-disciplinary learning is in keeping with NWW and the emphasis on finding creative solutions to challenges within existing systems. The process of SW integration into MH services is, in itself, an early model of this flexible and creative approach to NWW in that the social care workforce were required to surrender familiar and long established professional systems and move to unfamiliar professional territory in MH Trusts that required a very different ways of working

Question 11: How are you ensuring the development of Leadership and Management for Social Care, including succession planning?

Summary of responses

- Managers locally, including myself, are involved in the two Action Learning Sets being facilitated by Professor Peter Gilbert on behalf of NIMHE and the SCIE. Social care managers are also able to access management development training through a formal Diploma/Masters in Strategic Management course at the University. Leadership master-classes are run by the Trust, involving outside speakers, and are open to all managers to attend
- The Trust has appointed key personnel from social care backgrounds to senior positions and, where appropriate, is promoting seconded social care/social work staff to senior positions. The Executive Director of Social Care post at Board level is important in maintaining and enhancing the profile of social care. The Associate Director of Social Care is important in ensuring social care workforce development needs are addressed, that a social perspective is promoted in the Trust and that social work/social care is

valued

- Meeting some of the needs for succession planning by developing a network of support and learning
- The Social Care Lead and Social Care Specialist roles have promoted the social care agenda and developed expertise in social care. In the Foundation Trust, there is a shift from Director of Social Care to Director of Nursing, Social Care and Allied Professionals. CPD allows SW with an interest in professional leadership and management to identify training to support their development
- The Department of Social Care is committed to leadership training for its' MH social care managers
- There are Managers with SW qualifications at all management levels in the organisation from Director down. There is a Professional lead in SW at Assistant Director level. The Professional SW Forum aims to support and build a stronger professional identity which encourages self-confidence and an ability to take the lead. The individual development of staff through professional supervision. Developing learning and practice opportunities including Expert Practitioner posts
- Through involvement in discussion groups and forums involved with this development. This is not a high priority for a MH Trust so pressure is required from social care to get this process moving and then to provide an important contribution to its' development. Succession planning is discussed with senior colleagues in LA Adult Services. It is important these approve of and participate in recruitment to senior social care posts in the Trust. Managers are encouraged to attend the Trust leadership programme and through mentorship and secondment learn about leading and managing in a large NHS organisation. They are also encouraged in having autonomy to develop a social care approach to the workings of their Clinical Directorates and Directorate Manager Groups – particularly in relation to diversity issues anti oppressive practice and the involvement of users and carers
- By encouraging SWs to take up training opportunities for Management and Leadership offered within the Trust
- Following extensive lobbying and pressure from Social Care staff to the Chief Executive of the Trust, we established a specific 'social work leadership post' as well as a 'Director of Social Care' at Board Level, who reports to both the Chief Executive of the Trust and the Director of Social Services
- There is currently a deficit in the development of succession planning in social care in the Trust. Staff are able to access leadership and management courses but there needs to be leadership from Board level to ensure continuity and coherence
- This is not happening in my current workplace. My new role as Head of SW and social care is intended to champion this profession and try to address these issues
- By making team management attractive to SWs. Formally recognising that team members often feel very supported by SW managers who are used to established systems of professional supervision. We currently have documentation being discussed at Board level for agreement and action on team managements training. Through the development of a SW strategy for the Trust which provides opportunities for leadership and management training for its' SW workforce and support for those who have an interest in assuming greater responsibilities
- In terms of specialist MH courses, NIMHE have introduced a series of regionally delivered and highly specialist leadership programmes commissioned specifically to assist LAs and Trusts develop current MH agendas. One of the social care leads is currently on the social inclusion module within this programme. Such high quality training needs to continue and remain open to both social and health care staff
- A recent welcome development has been the setting up of bi-monthly meetings of the three SW Leads with the Director of AMH Services. The explicit purpose of such consultations is to enable the social care voice within the Trust to be heard and to provide an opportunity to raise specific issues
- The gradual loss of social care leadership in strategic integrated management is a concern to many in the profession. SW posts within integrated health and social care management, due to restructuring and personnel change, have diminished both in number and in seniority in relation to their position within the managerial hierarchy. Social care managers within integrated health and social care management positions are 'culture carries of social care' for the organisation. Without SW leadership being at and being seen to be at the highest level or organisations, there is concern that the culture of challenge and championing of rights may be lost, genericised or water down. A

recent welcome development has been the setting up of bimonthly meetings of the three SW leads in the Trust with the Director of AMH Services. The explicit purpose of such consultations is to enable the social care voice within the Trust to be heard and to provide an opportunity to raise specific issues. Research into successful integration continually emphasises the importance of social care having a voice throughout all levels of the organisation and especially at the more senior levels. It is noted locally that there is no Board level leadership for SW. There is, the profession feels, the need to revisit management structure in light of its commitment to integration. Constant restructuring and the move to merged Trusts may also lose the very community approach in which SW flourishes. 'Super Trusts' are at risk of becoming more and more remote and losing the locality community focus. In terms of social care leadership, unless safeguards are put in place to avoid such dangers becoming a reality leadership within such Trusts may not be a place where social workers want to be. On a wider national level social care organisations such as the ADSS, SCIE, SPN etc are being seen to be increasingly active as leaders in the social care world

- If we are right in our assertion that social care is central to the delivery of modern and effective MH services, and that this derives from both the value base and practice issues, then they are well placed to act as change agents in the drive towards SI and recovery. As such, it was felt that there was clearly merit in investing in leadership development for social care in MH
- The Trust and its constituent 5 LAs, have commissioned a piece of work from the Institute of Public Care at Oxford Brookes University to review salient issues in social care, including that of leadership. Specifically, it will address the "ways in which the Trust can ensure that governance, professional and managerial representation and professional development of social care staff can be supported, so that the Trust can increase the effectiveness of its full range of health and social care services for people with MH support needs". This project will involve exploring current arrangements, interviewing relevant staff and other stakeholders, and analysing best practice in other comparable MH Trusts. The resulting report, to be presented to the Trust and LAs in the Spring of 2006, will then inform longer-term decisions about the development of leadership and management of social care
- The Trust is developing a comprehensive leadership development programme for all managers and professional leads which will be open to all staff including those with social care backgrounds. Work is underway via our Associate Director, Workforce Development, to assess individual needs using an independent HR consultant. We are also hopeful that the recently introduced regional social care leads meetings will also begin to identify additional development opportunities. The national learning sets for MH have also been very helpful in providing an opportunity for leadership development for Directors and Associate/Assistant Director/Head of Social Care levels. This model could be usefully further developed for other staff
- The forensic social care world is quite small and includes small numbers of SWs and probation officers. At the moment, we have the assistant manager role which develops leadership skills. This role also plans for succession or ensures appropriate training and development for a post holder
- There are approaches within nursing and health which we can learn from. The RCN leadership course and initiatives to encourage all staff to have leadership skills are good models. In the past, social care leadership agendas have focussed on managers and higher level staff. SWs, like all others, would benefit from learning leadership skills and this would help MDT working. It is useful for integrated services to collect information on access to courses and promotion by profession, to understand what is happening and make sure that opportunities are open to all. A further area which we can learn from health colleagues, is their success in developing practitioner/academic posts and in using and doing research and audit. Again, capacity is an issue but we need to overcome this as others seem to have done. This is an area where there has been investment in SW work through Research in Practice (for childcare) and SCIE. Practical and developmental support are needed to facilitate this further on the ground. This will enhance the opportunities of SWs to move into other roles. It therefore needs encouraging in SW training. While we are clear that SW provides a good grounding for management, it is the reality that the majority of staff in teams will be health workers. Support to understand what nurses and others need from managers will be needed to enable SWs to progress into management
- Extension of Senior Practitioners across service areas. Promotion of management as a valued resource especially within the health service. Promotion of management training. Promotion of leadership training within the service and with education providers. Consideration of the value of Consultant SW posts. Lead Professional role for SW

embedded in the Care Trust structure. Executive Director of Social Care post within the Trust

- There are some key personnel from social care backgrounds in senior positions, particularly in one of the three boroughs. No Social Care post at Board level, but Associate Director of Social Care appointed 2005 with a professional lead role to ensure social care workforce development needs are addressed and that a social perspective is promoted in the Trust. Associate Director of Social Care is on the CSCI national leadership programme. Overall this needs more attention and some clear commitments within workforce planning, but current secondment arrangements lend some uncertainty to this
- Locally there is no specific work currently being done on this, although as indicated, individual developmental paths are identified as part of an annual review process. The wider work on development of effective leaders and on succession planning, will need to sit within the context of an effective workforce strategy
- The GSCC has outlined courses on this subject and it is imperative that social care staff are allowed access to such courses when available. This MH service will allow SWs seconded into the Trust to access their purchased courses with the local university on subjects such as the Certificate in Management Studies, Diploma in Management Studies and Masters in Social Science. Similarly, SWs have access to such courses sponsored by their employing authority. Very often, the opportunity for secondment into management posts arise within this service and SWs are at liberty to apply for these as anyone else. SWs frequently deputise for their managers regardless of the professional background of the manager. With the formation of the Foundation Trust, there will be a SW staff governor. Any SW within the Trust environment will be eligible to stand as this governor. Senior posts have been established within the Trust structure such as the Consultants, Assistant Director for Social Care and the Director of Partnerships. All provide good examples of leadership and management opportunities. The two former posts are not only focused on social care staff but have the lead within the Trust on rolling out socially inclusive practice. The Assistant Director for Social Care is also the Trust lead for the CPA as it affects all staff across the Trust. As other leadership and management training needs are identified, through appraisal and supervision of staff; these will be fed into the local Workforce Development Group
- Social care is incorporated in Leadership planning for the Trust and SWs are involved in the planning. The PQ Award in Leadership and Management was seen as a positive development, but few were aware of it. Some respondents saw lack of inpatient experience as an impediment to accessing leadership and management positions within an integrated Trust. Proposed Social Care Lead role seen as positive development
- There is a clear professional structure within the Trust for social care. The Head of SW posts and Social Care Leads offer a focal point for leadership for social care staff. A new but important local initiative has been the Management Programme. The Trust is an accredited centre able to deliver the Certificate, Diploma and Executive Diploma Levels of Chartered Management Institute qualifications. This results in a very good level of Management CPD. Applicants are interviewed and are then able to take up a place at the relevant level. Further supporting CPD within the management context are the Supervision and Appraisal Training Programmes and the non-accredited Management Programme which will begin in January 2005. SW staff who are in or have expressed an interest in managerial careers are encouraged to undertake this training
- We are currently piloting a leadership development centre. A comprehensive management development programme has been established. By January 2007 operational services have in place a workforce development plan that covers retention, development and succession planning issues
- SWs are less likely to receive training and shadowing opportunities for the next level of responsibility unlike many of their health colleagues. This again affects recruitment, retention, career progression, opportunity to use and further the values of social care and general satisfaction with the job
- Leadership issues are considered within a local SW Forum where questions of professional identity, roles and responsibilities are discussed and actions planned. Also within this Forum, ideas are formulate on how the profession might represent itself within the Directorate. In line with this, the Directorate social care workforce are engaged in developing the work plan for the Forum and determining issues of importance that need addressed at a Directorate wide level. Links are being developed into professional SW leads in the LAs in order to promote greater role clarity and professional understanding between SW professionals
- Access to management and leadership training on a par with health colleagues

Question 12: How do you anticipate social workers being involved in the developments and implementation of the provisions in the Mental Health Bill?

Summary of responses

- Through greater consultation and advice on the formulation of a social assessment as a counterbalance to the medical assessments (as in the 1983 Act)
- Workshops will be held to consider the MH Bill implications and the ASW will be pivotal in achieving a successful transition to the AMHP role. Some ASWs have expressed ambivalence about some of the fundamental changes in the legislative processes and these need to be explored further once the Bill begins its journey through Parliament
- ASWs will be invaluable in terms of their knowledge and skills and their commitment to assessing complex, high risk situations within the framework of the “least restrictive alternative” for service users. In the context of new legislation which extends compulsory treatment to community settings, it is imperative that this value base and these skills are not lost
- ASW knowledge base would be invaluable to implement training and policies and procedures on the new Bill and new ways of working. ASWs may also become Tribunal Panel members
- SWs are opposed to some of the main elements of the Bill and some specific parts. They will have difficulty accepting participation if the Bill goes through with only minor changes
- SWs should be involved in the training of AMHPs. The GSCC should remain in its current position in relation to training and standards. SWs have key skills in the management of risk in the community which will be needed
- We are pleased that the current thinking is for LAs to take the lead on the training for the new AMHP and we would want this to continue
- ASWs will continue to challenge what they see as 'unacceptable' parts of the current Bill and will want to uphold their 'independent' opinion amongst their medical colleagues. It is envisaged that SWs will take a larger role as members of expert panels and Tribunals. As potential AMHPs within an integrated Trust, we must make sure that Trust Boards are aware of the roles and functions
- The new Act extends the role of the ASW to other suitably trained MH professionals. This is a desirable move provided that any CPNs or other health based staff who are to undertake the application role in the future have training similar to the current 65 day training ASWs have. In practice with London Boroughs, the application role is likely to be dominated by SWs for many years to come. There is another view that the loss of the ASW role is a mistake. As noted in the discussion paper, ASWs have done a good job of seeing things from a different perspective. SWs do stand up to the consultants something which the less experienced nurses are often not equipped to do
- The current ASWs should be central to the Trust plans to implement the new Bill, with due reward! This could herald a NWW and managing the most serious part of a possible admission process with people who are most at risk, SWs have a long history of working in this area with imagination, confidence and integrity. We have the opportunity to take our colleagues with us to provide a truly empathetic but assertive process which could offer better outcomes for patients
- ASWs should contribute to the creation of the Code of Practice that will accompany the new legislation. ASWs as a profession take the existing Code of Practice very seriously and have to demonstrate that they incorporate it into their work
- SWs will play an invaluable role in informing and supporting other disciplines in this new development as they will be the profession with the experience and knowledge of working within a legislative framework. They are likely to be the key players in delivery of this revised service
- There will inevitably need to be a period of transition between the current and future MH Acts during which a social perspective will be central to the training and

development of all staff who work in MH services. Whilst it is likely that ASWs will form the bulk of the new group of AMHPs (at least at the outset), the role is another opportunity to present the 'acceptable face of social work' which would otherwise remain largely invisible. We already have workshops planned during the 2006-07 financial year to look at some of the details of what the new Act may bring for the SW profession, and the wider opportunities it will present for social care in general

- I don't see them having much influence, but I would imagine BASW, and other bodies will
- There are many new and exciting roles that SW can embrace under the new legislation. AMHP, Expert Tribunal Member, Tribunal Member, Clinical Supervisor as well as continuing to provide a competent SW service to the multi-disciplinary approach to MH and well being
- According to government expectations ASWs, as experts in this field, are expected to have a salient role in the preparation of other professionals for the AMHP role for which they will need appropriate time and reward. Given the current stress levels within the ASW workforce and the concerns they hold regarding the AMHP role, this expectation is likely to need some attention
- The SW profession is already involved in all discussions around the proposed MH Bill. The ADSS is an official member of the MH Alliance and which is active in voicing concerns and constructive criticism of the Bill. Individual SWs and professional social care leads have also participated in national consultation exercises in relation to the Bill. In addition regular discussion and dissemination of ideas is occurring through professional SW forums and within local staff groups
- SWs will have the opportunity to ensure that service users are well represented and that their social milieu is understood in relation to their MH problem. In addition, as the role of the carer for someone assessed under the new Bill will change, SW skills in working with carers is well placed to continue this specialist support and social understanding

Other parts of the Discussion Paper

Summary of responses

- In respect of the whole discussion document there is a need for all LAs to appoint a Head of SW to raise the profile and co-ordinate the SW profession for the future
- Have concerns about the new workers e.g. STR workers. Is this again a dilution of SW and a devaluing of the support these workers provide?
- In conclusion, whilst not opposed to moves to identify, value and recognise the particular contributions SWs bring to CMHTs, it would be concerning if this meant their roles were to become too rigidly prescribed as if there were artificial demarcations between SWs and other CMHT staff
- I think that transfer of SW staff to the NHS would further undermine not only SW values, but the independence and autonomy of SWs. I am not sure how this would improve SW retention, as other than care management, which is becoming integrated, and the ASW function, there appears to be little understanding of the roles of SWs and little value held for the skills they have within the NHS
- One possible further development for SWs that may arise out of integration with the NHS is greater opportunities for training in therapies like CBT, Group Work, PSI, etc
- We also discussed what structures/ processes need to be in place to nurture / support SWs in MH services and these were the responses:- Social Care Forums for both SWs and ASW's; clarity of roles and responsibilities; time to attend social care forums/peer supervision; and maintain professional supervision
- I am developing a new degree programme leading to a joint qualification in nursing and SW for MH practitioners. We have used the Ten Essential Shared Capabilities as the basis for the programme and we find that they map across very well to the NOS for SW. I would commend these as an excellent framework of values, knowledge and skills for SWs working in MH. From our consultation with service users and carers, they value the input of SWs who are positive and optimistic in their approach, person centred and creative in helping them identify goals for inclusion, acceptance and participating in work, education and social activities. Being prepared to challenge stigma, racism and discrimination is also vital. From my knowledge – not extensive – of the new curricula being developed for the new degree – MH is squeezed out. And yet

MH is often an issue in all areas of SW – parents of children in need/at risk often have MH problems as do people with learning disabilities. I see MH as core and critical for SW education

- There's a bold statement in the discussion paper (paragraph 3.1) re SWs being the only professionals with social science training. Think the psychologists and anyone else following a non-medical model of training might be a trifle upset by that!
- I hold the professional lead for SW in the Trust MH services; I am at senior practitioner level and there are no other qualified SWs between myself and the head of service (who is also a qualified SW). I am encouraged that this is going to be discussed at a national level – for me the key issue is finding common ground between SW practice and the dominant health ideologies. There needs to be a shift away from the language of 'compliance' and 'home based treatments' to a more person centred approach to MH needs – this requires a fundamental shift in approach to MH practice and service provision which is difficult at this time of risk aversion and emphasis on utilitarian principles
- The changes and challenges for SWs range from exciting to potentially terrifying. It is essential that experienced SWs are encouraged to support and guide workers at fieldwork level to have confidence in the specific role, values and responsibilities that are SW based
- There is a strong argument for future SW and CPNs to hold a dual qualification but given the very different cultures of health and social services' philosophy such an integrated qualification would have to be of a particular high standard and even handed when addressing the wider value systems that are essential to holistic client and patient care. The illnesses of people do not change; it is the ways that they are managed and treated that are different.
SWs have always had to strive extensively to elevate the protracted social economic deficits in society. There is no quick fix for this and as a result the expectations and attitudes of society are still confused/ambivalent about the efficiency and efficacy of SW
- It may be that these changes present an ideal opportunity to give the SW occupation a full 'make over' that will enhance their competence and status in this instance within the MH setting. The ASW role has, to a significant extent accomplished this. Thus by specifically defining the role, there is little ambiguity and through time even the most truculent of GPs, police and psychiatrists have got the message that for the duration of a MH Act assessment there is no doubt about the role of the ASW and the legal framework that gives them the authority to act
- It is the generic nature of SW that presents the biggest challenge ie. what are their tasks, where do their duties begin and end?
The Discussion Paper refers to reports of SWs being risk takers. It is my experience that this is true, but in a MH setting SWs are generally more comfortable with risks – they are less dependent upon the confines of a medical hierarchy. However, in this service, much progress with integrated working has been successfully achieved with very little differences between the core, ground floor disciplines namely CPNs and SWs. This is something that we would fight to preserve as it has provided a comprehensive service and holistic approach to client/patient care. The disciplines have developed trust and mutual respect which has resulted in a healthy lack of defensiveness in seeking knowledge to promote best practice
- With the NWW, the SW, along with other disciplines will have more overall responsibilities and it is in this area that care will need to be taken to ensure that SWs are supported to oversee caseloads without the obvious intervention of a designated consultant. Any qualified SW managing a full caseload should have access to regular supervision from a designated expert practitioner – not a manager
- With such major changes in SW employment/paymasters, it is essential that their interests are kept on the agenda. The SW values and aspirations of proper status need to be made clear and marketable to an ever increasing expectant public and allied occupations. It should be a proud profession not an apology. However, the expectations and tasks are often so unrealistic that success can be elusive ie. sorting benefits, procuring accommodation and any other tasks which do seem to fall to a SW to sort and add to the frustration and demoralisation of this very demanding job
- I am writing on behalf of a small team of Forensic SWs based at the Regional Secure Psychiatric Unit. We provide SW input for the patients detained here whilst working as

part of a multi-disciplinary team. We are concerned about the future of SW in general as well as in MH services. It seems to us that in recent years the status of the profession has been eroded; the proposed change from ASW to AMHP could be seen as further evidence of this erosion. Whilst we welcome any discussion of the role SW will play in future service development etc we are concerned that the Discussion Paper seems to regard MH SW as a profession apart from SW; implying that we are not closely allied to our colleagues working with children or OP for example. However, we share an ethics base, a code of conduct and often poor pay and conditions. We as a team are concerned about the status and development of the profession of SW. Over recent years we believe that the profession has declined in status and has been to some degree 'demonised' by high profile cases, usually regarding the care of children. We think that it is unwise to consider the future role of SW in MH services without examining the changes within the profession of SW. We do not think that it is wise to separate specialisms/disciplines within the profession as this will further weaken the status of SWs. This does not mean that SWs should not have specialisms etc but that this is tied into moves to develop the whole profession

- One of the largest problems we think faces SW is the lack of time for further study and research after qualifying. Apart from PQ and task-specific training, it is difficult for SWs to afford to take a sabbatical or to access postgraduate courses. Therefore as a profession, we have not developed a body of research skills. This is hindering the proliferation of an evidence-base upon which to base our practice. Hopefully, the degree will improve academic capabilities within the profession and more practitioners will then become interested in studying towards a higher degree.
- Having an improved academic and research basis for the profession would go some way towards 'recognizing and valuing SW practice, knowledge and skills'. Increasing the number of lecturer-practitioners teaching the degree course would also help link the theoretical with the practical – something many practitioners find hard to do and even harder to research/write about
- Employers need to give SWs the time and space to continue their Professional Development. The required training component of GSCC Registration indicates recognition of the need for this. If CPD programmes could be linked to obtaining further qualifications (similar to the Open University's 'credits' system) then this would encourage many practitioners to partake of the learning opportunities offered. As the Discussion Paper suggests, there does then need to be a structure in place which remunerates practitioners for the extra skills/knowledge they have accrued; something the PQ framework appears to address (although there is no compulsion for employers to alter their pay scales in regards to this)
- Above all we feel that there does need to be a single, central body representing and advocating for SWs. Through this mechanism pay and conditions could be improved, the various frameworks (NOS, PQ etc) could be overseen and implemented through this one body. At present neither the GSCC nor BASW succeeds in this role. Without a central governing body, the profession of SW will continue to be seen as 'nebulous' and 'woolly' by the professions we work with - I have encountered both terms used to describe SW practice in recent times
- We need to organize ourselves into a more professional, better organized profession so that we can clearly set out an agenda for what we can provide for our clients/service users. We do not feel that the skills etc we have to offer are fully recognized because of this lack of cohesion and organization
- There are a number of issues facing SW. eg its' inability to describe what it does and how it does it. As a consequence the Discussion Paper did not produce any evidence for the efficacy of SW
- Unison is the major Trade Union for MH SWs in the four Countries of the United Kingdom. As such, we have a great deal to say on issues that affect our members in the field and have been widely involved in the current developments not just in MH SW but in all aspects of social care and SW. We would have been very interested to not only respond to the Discussion Paper but also to have been part of the group that discussed it in the first instance and perhaps this can be taken account of in any future work that the group undertakes. Having said that it has proved fairly difficult to respond to the areas identified for discussion as they are clearly aimed at the employers or service providers rather than the workforce
- The Forensic SW Group would welcome opportunities to participate in further discussions in order to ensure that the contribution of social work within all aspects of service

delivery across the MH spectrum is robustly profiled

- Although the focus of this paper is on the contribution of SW to MH services, it may have been useful to explore the role and expertise of SWs in working with people who have co-existing conditions alongside MH needs. This may include additional substance misuse issues, a PD or a forensic history, as well as social care needs. This likely to be the experience of many professionals and is certainly the experience of our staff
- We would like to bring to your attention some of the initiatives we are currently working on with regard to the SW and MH agenda. These include a working group being set up to examine strategies for further development of MH practice learning at both qualifying and PQ levels. Integrated and inter-professional frameworks for MH and SW education and training at pre-qualifying, qualifying and PQ qualifying levels. This includes the development of an ASW programme within PQ framework and inter-professional MH frameworks to meet both professional accreditation/ academic and inter-professional agendas. Service user and carer involvement strategy across the Faculty of Health that has been led by SW and MH developments including the appointment of two MH service users as associate lecturers. Close working with MH practitioners leading to the development of a series of seminars within the University to support those in practice and to promote the profile of MH SW within the University. The first of these was well attended and a second is planned. Expressed interest in the training of CDWs for BME groups drawing on MH training and education, including SW and the experience of Public Health programmes within the school with an emphasis on community development
- There is a fear within SW and ASW staff that the Trust becoming a provider of Social Care Services that their professional identity will be lost
- Traditional areas of practice for SWs are becoming, through changes in legislation, open to the wider professional groups in MH – ASW role; Care Management. What will be different about SW?
- There is concern that the commissioning processes need to be more robust in relation to Social Care Outcomes that the Trust is asked to meet, record and therefore plan for
- A great deal of work is taking place to improve the integrated organisation through HR, through Governance, through developing policy and practice within the Section 31 Agreement coming through for implementation in April. A significant part of this work is about strengthening Social Care practices and traditions
- In response to concerns expressed about training, the Trust and Social and Community Services are about to appoint to a senior Project Manager to look into the way forward to integrate training resources with particular reference to the Trust increasingly becoming a Social Care provider and needing to recruit and retain Social Care staff

Summary of the Number of Responses to each of the 12 questions by Organisation/Group

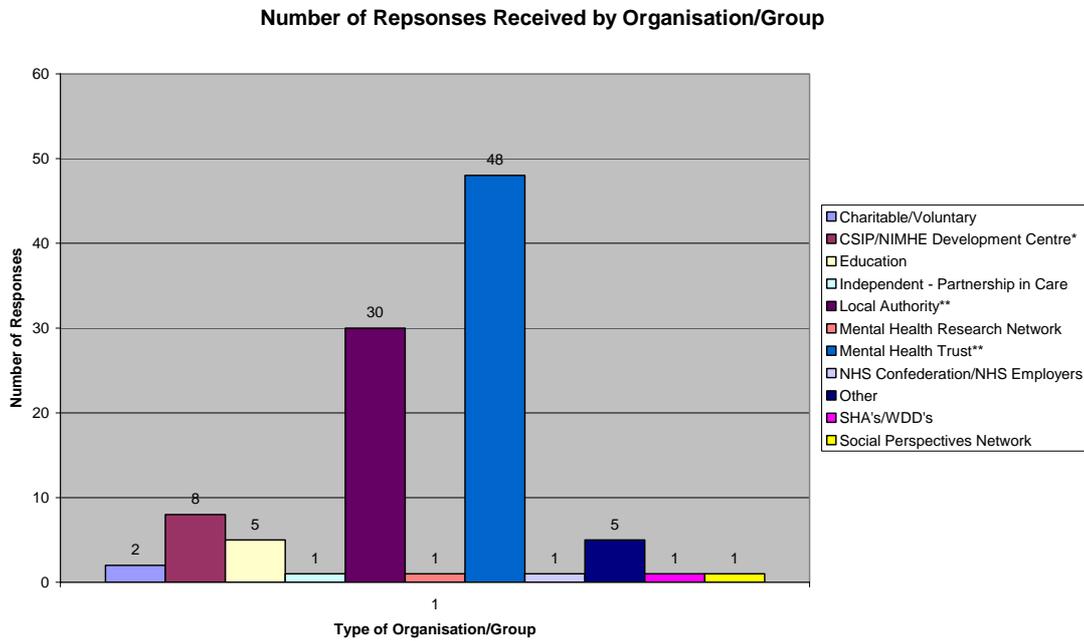
Organisation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Total
Charitable and Voluntary	1	2	2	0	0	0	0	0	2	0	0	2	9
CSIP/NIMHE DC *	8	8	8	6	5	7	5	6	7	6	6	6	78
Education	4	5	4	0	2	0	1	2	3	4	2	3	30
Government Department	0	0	0	0	0	0	0	0	0	0	0	0	0
Housing	0	0	0	0	0	0	0	0	0	0	0	0	0
Independent **	1	1	1	1	1	1	1	1	0	1	1	1	11
Local Authorities ***	30	30	29	30	28	28	23	28	23	25	24	27	325
MH Research Network	1	0	0	0	0	1	0	1	1	0	0	1	5
MH Trusts	48	47	46	48	45	45	44	47	44	39	40	45	538
NHS Confederation/ NHS Employers	1	1	0	1	1	1	1	1	1	0	0	1	9
Other	5	5	4	4	4	3	3	4	4	4	3	5	48
PCTs	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
SHAs/WDDs	1	1	1	0	1	0	0	1	1	1	0	1	8
SPN	1	1	1	0	0	1	1	1	1	1	1	1	10
Total	101	101	96	90	87	87	79	92	87	81	77	93	1071

* = Collective responses

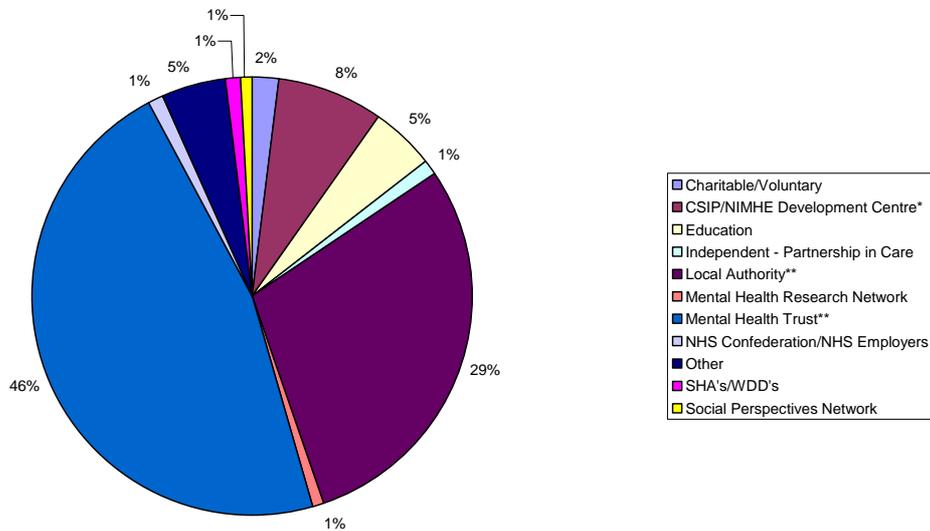
** = Partnership in Care

*** = Including ASws and SWs

Number of Responses by Organisation/Group



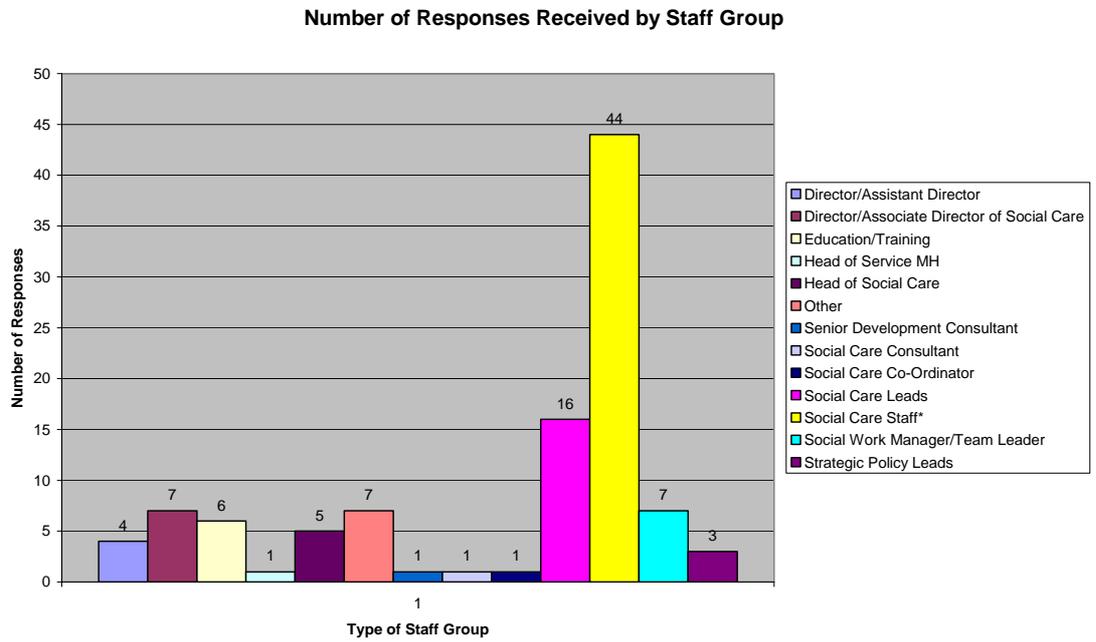
% Number of Responses Received by Organisation/Group



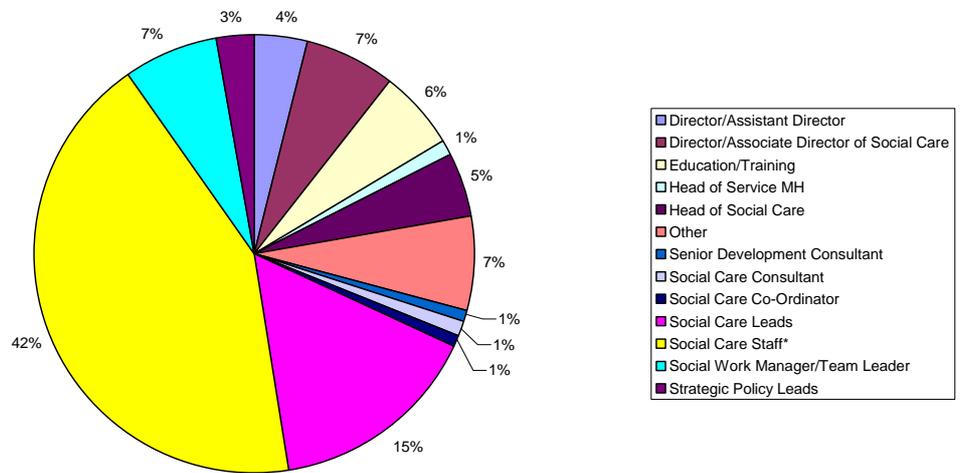
* = Collective response

** = Including Social Workers/ASWs

Number of Responses by Staff Group

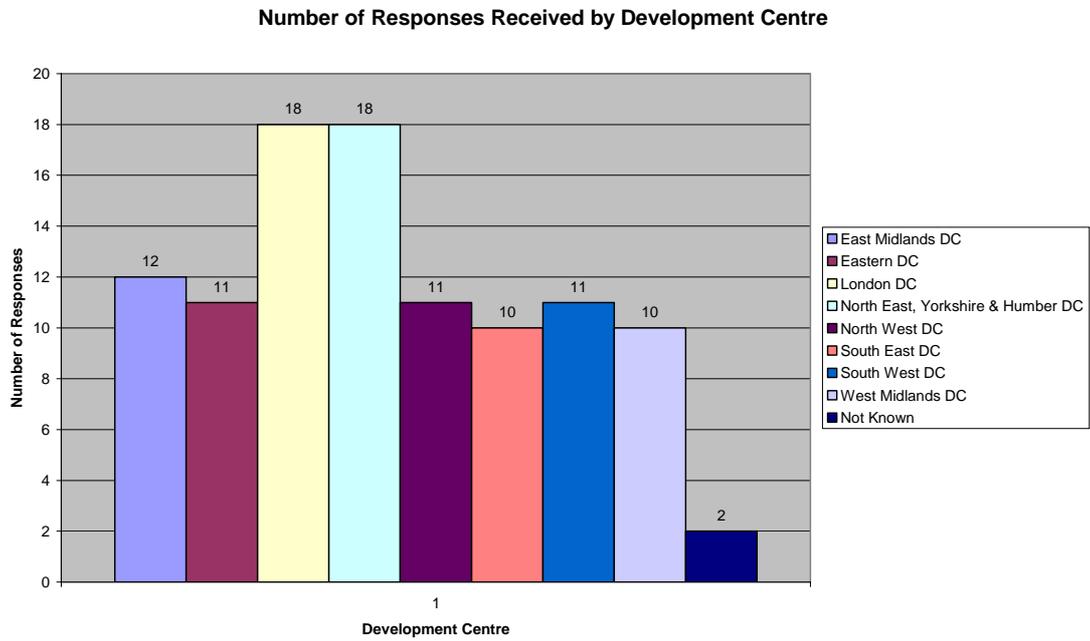


% Number of Responses Received by Staff Group

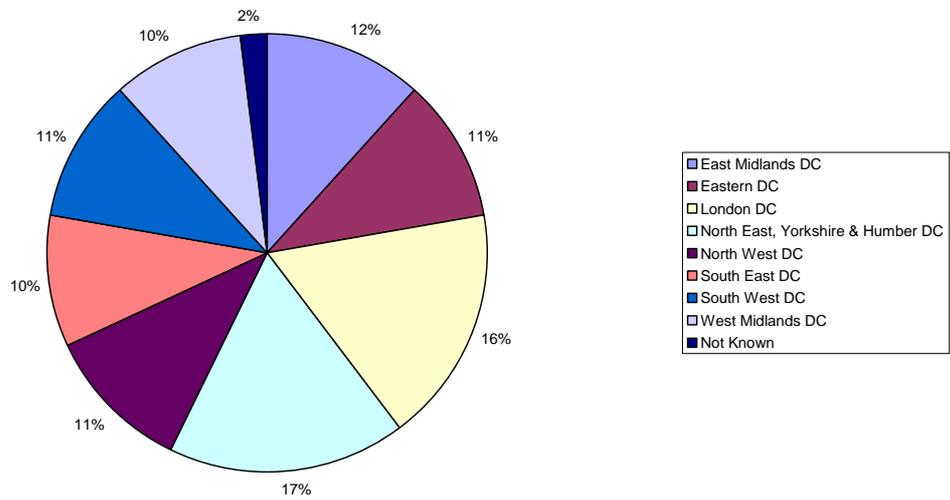


* = Including ASWs

Number of Responses by CSIP/NIMHE Development Centres



% Number of Responses Received by Development Centre



GLOSSARY

AASW	Advanced Award in Social Work
A4C	Agenda For Change
ADSS	Association of Directors of Social Services
AMH	Adult Mental Health
AMHP	Approved Mental Health Professional
AOT	Assertive Outreach Team
APEL	Approval of Prior Experiential Learning
APL	Approval of Prior Learning
AS	Asperger's Syndrome
ASW	Approved Social Worker
BASW	British Association of Social Workers
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCETSW	Central Council for Education and Training in Social Work
CDWs	Community Development Workers
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CRT	Crisis Resolution Team
CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
CSW	Community Support Worker
CWP	Changing Workforce Programme
DH	Department of Health
DipSW	Diploma in Social Work
DPSPD	Dangerous People with Severe Personality Disorder
ESC	(Ten) Essential Shared Capabilities
GPWSI	General Practitioner With a Specialist Interest
GSCC	General Social Care Council
HA	Health Authority
HEA	Higher Environmental Allowance
HEI	Higher Education Institute/Institution
HR	Human Resources
IPDR	Individual Personal Development Review
IT	Information Technology
IWL	Improving Working Lives
KSF	(NHS) Knowledge and Skills Framework
LA	Local Authority
LD	Learning Disability
LGA	Local Government Association
MH	Mental Health
MHAC	Mental Health Act Commission
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NOS	National Occupational Standards
NR	New Roles
NSF	National Service Framework
NVQ	National Vocational Qualifications
NWP	National Workforce Programme (of NIMHE)
NWW	New Ways of Working
OP	Older People

OPMH	Older People's Mental Health
OT	Occupational Therapist
OU	Open University
PD	Personality Disorder
PDP	Personal Development Plan
PIG	Policy Implementation Guide
PQ	Post-Qualifying
PQCCA	Post Qualification Child Care Award
PQSW	Post Qualification award in Social Work
PSI	Psycho-Social Interventions
QAA	Quality Assurance Agency
R&R	Recruitment and Retention
RMN	Registered Mental Nurse
SCIE	Social Care Institute for Excellence
S4C	Skills for Care
SHA	Strategic Health Authority
SI	Social Inclusion
SP	Senior Practitioner
SPN	Social Perspectives Network
SS	Social Services
STR	Support, Time and Recovery
SW	Social Work(er)
TNA	Training Needs Analysis
TUPE	Transfer of Undertakings and Protection of Employment
WDC	Workforce Development Confederation
WDD	Workforce Development Directorate