Developing the Mental Health Social Care Workforce

Mental Health and Wellbeing Policy and Oversight Group

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Association of Mental Health Providers

Introduction

The increasing pressures on the mental health social care workforce and difficulties in some parts of the sector offering social care related packages of support because of workforce issues are well-known. Although the Community Mental Health Framework is a significant opportunity, it also presents challenges for the sector which require careful planning informed by up-to-date intelligence.

There needs to be better strategic action on workforce across social care and at the interface between health and social care, and this paper aims to initiate a discussion about how this can best take place.

Key topics are:

- The opportunities and implications of the Community Mental Health Framework for workforce development of the social care workforce.
- The contribution of mental health social care workforce to mental health and community support.
- How well placed is the social care sector to respond to new policy demands for more integrated place-based workforce plans.
- The case for integrated workforce planning and the enablers to this for social care at national, regional and place levels.

This paper aims to:

- Explore some of the opportunities and implications of the Community Mental Health Framework for workforce development of the social care workforce.
- Consider the complexity of the mental health social care workforce and the contribution it makes to mental health and community support.
- Consider how well placed the social care sector is to respond to new policy demands for more integrated place-based workforce plans.
- Discuss the case for integrated workforce planning in the context of new policy demands for place-based care and consider the barriers and enablers to this for social care at national, regional and place levels.

In doing so, the paper seeks to:

- Improve understanding of the social care workforce and to equip ICSs and their partners to develop sustainable integrated mental health commissioning plans.
- Outline what forms of system leadership and integrated workforce planning would best facilitate the level of innovation needed to harness the engagement of social care.
- Highlight attention to the challenges of ensuring the direct voice of user led, smaller community organisation and those representing marginalised

and racialised communities in transformation plans.
- Identify some of the pressing workforce issues and risks that are closely linked to wider debates about the imperative for a robust social care funding settlement.
- Put the case for how a clearer statement on priority areas for investment in the mental health social care workforce, in the statutory and VCSE sectors can be determined which will bring about a step change in the capacity and capability of social care to contribute fully to the reform of mental health services.
- Share some good practice in shared development of the health and social care workforce.
- Recommend key steps that national key bodies can take in their endeavour to establish and deliver system wide workforce plans.

Executive Summary

The NHS Long-Term Plan includes £4.5 billion new funding for expanded community multidisciplinary services, aligned with new primary care networks and working alongside social care, housing and the voluntary sector.

The Community Mental Health Framework (CMHF) aspires to a model of personalised wrap-around care which requires a radical contribution from the social care sector, especially in community support enhancing prevention and wellbeing interventions.

Perhaps the most pivotal ingredient for the new model of care is enhanced access to the highly skilled, non-clinical, skills associated with social care which identify a person's holistic needs and form a bridge to services to overcome the social determinants of mental ill health. This is a positive opportunity for social care to share its talents but has significant implications for the supply, training, and growth of the social care workforce, and requires its deployment and organisation in new ways.

There is strong impassioned sector leadership for social care which is a significant resource to guide integrated development. The contribution of social care to mental health has not had the attention it deserves within wider social care sector development and is a poorly understood workforce.

All parts of the sector have expanded in growth and complexity but are experiencing significant recruitment and retention issues due to lack of investment, growth in demand and the impact of Covid-19 on community health. There are significant risks that approaches undertaken could have unintended and destabilising effects on the sector if not undertaken in a coordinated and informed way.

Whilst there is significant commitment and promising emergent structures for stronger cross sector collaboration on workforce, the enormity of the workforce challenges require much stronger strategic action (at national, regional and place levels) to enable integrated workforce planning, informed by a clearer vision for mental health within social care. Learning from health and social care partnerships suggests that approaches to workforce development need to be based around recognition of different sector strengths and build on existing sector

leadership to achieve parity of esteem.

Councils have well developed skills in commissioning social care and have been a key driver of improvement in mental health social work and social care and there are many promising approaches to place-based workforce development and planning which could be better harnessed and co-ordinated.

Some of the barriers to progressing this include:

- Government funding arrangements are different across health and care sectors and cause them to travel in different directions with different performance targets and outcomes.
- Historic poor levels of funding of the social care sector have profoundly impacted on investment in learning and workforce functions and the availability of workforce expertise.
- Current funding arrangements for the CMHF potentially destabilise social care leadership rather than creating the conditions for a partnership of equals to enable parity of esteem with clinical approaches.
- Workforce intelligence is fractured and absent for some parts of the workforce.
- The specification and projections for the workforce needed for the CMHF to assist national and local planning has not been well-detailed, especially for social work and social care.

Recommendations

a. The Department of Health should commission a programme of inquiry to develop an integrated mental health social care workforce plan.
b. Develop a mental health social care workforce strategy which outlines the role of national and regional groups in progressing a workforce fit for integrated care. This should aim to align workforce initiatives across professional and unregulated groups.
c. Review current workforce funding streams for mental health and consider how these can be organised to deliver seamless, place-based workforce supply and support.
d. Undertake a survey on workforce data availability and workforce challenges with the mental health social care sector. This should target smaller voluntary sector and community support organisations and invite views on how they are represented in discussions about workforce.
e. Establish clearer reporting on the national and regional picture of the mental health social care workforce with analysis of cross-sector workforce dynamics to improve understanding of how local and national labour markets interact, how different parts of the sector interact and what these interactions mean for workforce planning locally and regionally.
f. Strengthen the influence and role of the Principle Social Worker network and professional social care leadership in workforce developments at ICS levels.
g. Building on the Skills for Care and Health Education England national work underway, establish test sites for integrated workforce methodologies with ICS partners e.g. scenario-based planning - provision of case studies and examples of integrated workforce development in action.
h. Further develop the narrative of the

distinctive workforce contribution of social care to mental health and agree a coordinated way to gather good practice and scale up innovation.

i. Building on the Health Education England's New Roles initiative, undertake dedicated work on the development of a CPD and skills framework for mental health social care which enhances the skills for trauma-informed, social and community interventions.

j. Take forward the recommendations of the Mental health Act Review and the national Approved Mental Health Professionals (AMHP) workforce plan for the effective recruitment and retention of the AMHP role and supportive developments such as a pre-AMHP course.

k. Consideration of steps to improve implementation of shared skills frameworks, test methodologies for system upskilling and establish test sites for learning.

l. Outline the business case for priorities for investment in mental health social care and voluntary sector workforce.

m. Build agility in social care commissioning and community engagement in ICS and social care commissioning bodies to undertake direct engagement with the social care sector using effective communication and workforce tools.

Background

The NHS Five Year Forward View for Mental Health, the NHS Long-Term Plan, the Care Act 2014, and the current government work on developing new models of social care provision, all envisage holistic mental health care that is place-based, personalised, and community-focused. The NHS Long-Term Plan includes £4.5 billion new funding for expanded community multidisciplinary services, aligned with new primary care networks and working alongside social care, housing and the voluntary sector. The development of the social care workforce is integral to achieving these aspirations, which requires integrated workforce planning within the NHS (and with other partners) to secure the right skills and workforce growth across local systems.

The mechanisms for doing this are not yet well developed nor sufficiently informed by an understanding of the contribution of social care and the voluntary sector and what enables its involvement and support and there are longstanding funding and organisational barriers to negotiate. New ways of working require new forms of workforce planning and redesign, investment in training, and learning and significant governmental support to remove obstacles and see the required changes through.

Jordan *informed his mother that he was gay, which caused considerable discord within the family home, where he was asked to leave. This led him to being homeless before being placed in a young person's supported accommodation where he currently resides. Jordan has a history of drug use and binge drinking and disclosed that he was raped and has been sexually assaulted on several other occasions. Jordan currently has no confirmed diagnosis.*

Jordan was referred to ***Sanctuary by Sea*** *(a* ***Choice Support*** *out of hours crisis service) with limited life skills and no coping mechanisms in place. As a result of this, the service was asked to work*

intensively with Jordan for a fixed period to support him and strengthen his resilience. At the time, he was referred, Jordan was spending time in hospital following bouts of self-harming and suicide attempts. Local services have reported that Jordan would not give the hospital staff permission to check drug levels during hospital stays and as a result was often discharged with no immediate follow up plan, thus resulting in a cycle of repeat attempted overdoses and hospital visits. On countless occasions he was picked up by the police and taken to hospital again either in a police car or ambulance. He was often seen by the Mental Health Liaison Team and released with no real fixed structured preventative plan in place.

A small team have provided Jordan with person-centred care. He has been provided with two Sanctuary workers' telephone numbers for him to have a specific point of contact in times of crisis. Jordan has taken full advantage of this, and it has enabled the service to respond directly to him when he has needed support. He has also been given full use of the Sanctuary Café in the evenings which has resulted in him being 'known' by other members of the Sanctuary team. Sanctuary staff have been able to safeguard Jordan ensuring he is transported home safely on occasion.

Jordan is working with a Sanctuary peer worker, who has been able to form a relationship with him, based on trust. The relationship has been built by providing him with Unconditional Positive Regard, where Jordan knows that his support does not necessarily agree with all his life choices, but he is not judged for them. His peer worker has been successful in fostering a more congruent relationship with him, which has been crucial in his development whilst receiving support. He initially found it very difficult to be open and articulate his feelings.

Jordan's Sanctuary worker has observed that when faced with police or hospital staff, he will often be incapable of finding the appropriate language to express himself and will use humour as a mask which was construed by medical staff as manipulative and ambivalent behaviour at a time when he is at breaking point and feeling totally lost and out of control. By identifying this, the Sanctuary have managed to attend hospital with Jordan on a night where he had self-harmed and had been expressing strong suicidal ideations. Jordan's support observed that the Mental Health Liaison Team appeared to be frustrated with him continually attending the hospital whilst Jordan was becoming angry and frustrated with what he perceived to be a total lack of care from the hospital staff. The Sanctuary worker was able to challenge some of the decisions and comments made by both Jordan and the hospital worker, resulting in another member of the Mental Health Team being called into the assessment and the decision being made to involve the Shift Team and being assigned someone from the NHS Trust to accompany the police doing welfare checks.

Sanctuary staff have supported Jordan to nurture him, including offering access to cooked wholesome food, which has induced a more positive attitude towards nutrition, and he has been buying himself meals to cook and has begun reconnecting with his mother, using food, and having meals with her.

When Sanctuary began working with Jordan, his accommodation was very dirty and unhygienic. His peer worker has been able to support him to organise and clean his room. It was impossible for him to access his sink and his microwave was not accessible or clean, and this has now all been rectified with support from Sanctuary. He is now showing an interest in keeping his living space healthy and, subsequently, his mother has begun helping him. Jordan is developing a relationship with his family again after having no contact.

Jordan was taken off of his depression medication as a precaution by his Doctor as he was stockpiling; this resulted in him being unmedicated and consequently, his mental health deteriorated. The peer worker explained to Jordan that it was unlikely the Doctor would reinstate his medication whilst there was a risk of him stockpiling again. It was agreed, with Jordan's consent, for the peer worker to contact his doctor, which resulted in an agreement for his medication to be reinstated on a weekly basis to reduce any risk.

Following the agreement regarding his medication, Jordan has felt a significant improvement in his wellbeing and his doctor is also now in the loop with regards to what is happening with the support being provided. Follow-ups are being completed regarding Jordan's progress with the Sanctuary peer worker where the Doctor is happy that he is receiving intensive support that was being followed up and taken seriously, agreeing that Jordan is a very vulnerable young individual.

The support provided by Sanctuary to Jordan has also been of great benefit to the police, medical staff and the Mental Health Liaison Team as Jordan has almost stopped talking about wanting to end his life and attending A&E on a regular basis. This is a huge step for him as he is now discussing the future with a more positive attitude and has had a significant impact with a substantial reduction in hospital visits.

Sanctuary have supported Jordan to access one to one therapy to further aid his recovery. Sanctuary workers have been a key stakeholder in Jordan's overall care and progression towards recovery, attending professionals' meetings whereby ongoing discussions are taking place with the NHS to establish an appropriate care plan for Jordan that will continue to support his recovery. Ultimately, without the intervention from Sanctuary, Jordan would still be a risk to himself and would not have made steps in his recovery.

There has been significant commitment and progress made to building skills across the system and areas of good practice. The Office of the Chief Social Worker has taken a strong focus on workforce development of social care, including the development of an ethical framework to promote strength-based approaches and the adoption of the Workforce Race Equality Standard for Social Care. Health Education England and Skills for Care are both providing system leadership in workforce planning and skills development, but approaches have not yet been developed at scale. There needs to be a strategic approach to how social care is considered and involved in emerging plans for integrated workforce planning (addressing action at national, regional and place levels) and clear priorities for investment in this complex and, in some respects, fragile workforce.

Workforce trends and pressures

What do we know about the current risks and pressures on the social care workforce?

Social care is part of a complex system of related services and informal support, including health, housing, welfare benefits, and leisure and is defined as much by a set of values and perspectives on the importance of a social, community and human rights lens as by tasks or employers. There are important distinctions that can be drawn related to operating within publicly funded and commissioned adult social care which falls

within local government responsibilities (including legal and statutory functions) and between the professional and unregulated roles in the sector. Crucially for understanding the distinctive commitments and histories of organisations in mental health, social care goes beyond the commonly understood view of adult social care as about older people, and there is arguably a distinctive field of social care practice in mental health unifying diverse organisations.

At the same time many (if not the majority) of organisations who deliver social care may have mental health services and/or benefits but do not identify solely as mental health organisations and these are equally important in the vision of the CMHF.

For the purposes of this paper, we are considering the workforce of those areas of social care most foregrounded in the Community Mental Health Framework, whilst acknowledging the overlapping and breath of implications for other parts of the sector i.e.:

- Professional groups that principally deliver social care functions within mental health social care provision (Social Work and Occupational Therapy are a key professional groups).
- Adult Social Care commissioned services and roles.
- Voluntary sector organisations working explicitly with a mental health focus and in relation to public service provision.
- Consultancy and development organisations which provide services for social care.
- Community support and advocacy organisations with a mental health focus including those that are service user led.
- People who use current mental health social care services and their families and carers.

There are major differences and inequalities between the NHS and social care, particularly in terms of workforce and industry structure. As well as pay and conditions, public perception and the status of the sector is acknowledged to be poor. The social care sector has a major and growing problem with recruitment and retention, a significant cause of which is poor pay and conditions.

In terms of employment numbers, there are 1.1 million FTE jobs in social care in England (Skills for Care 2018a), about the same as in the NHS. The voluntary sector in the United Kingdom is very large and diverse. Since 2010, the number of people working in the voluntary sector has grown almost continuously. In 2019, a total of 909,088 people worked for voluntary organisations, representing almost 3% of the total UK workforce. The overall makeup of the sector appears to be shifting towards bigger organisations, with the number of charities with an income of more than £100m increasing in recent years.

Covid-19 has exacerbated pressure on a workforce already affected by deep cuts in council budgets. A whole-system focus requires attention to the sustainability of the voluntary and independent sector which offers critical support for health and wellbeing, both through direct provision of health care services and broader support to vulnerable individuals and communities.

Charities have been hit particularly hard by the economic consequences of Covid-19, losing an estimated £4 billion of income in the first three months of lockdown.

User-led groups and smaller VCSE organisations have been particularly undermined and are disappearing with fewer and larger organisations dominating. Social workers comprise 75% of the local authority mental health workforce and the remainder are support staff.

In December 2018, Skills for Care published its first annual report on the AMHP workforce, following an amendment to the National Minimum Data Set for Social Care (NMDS-SC) (replaced by the new Adult Social Care (ASC) Workforce Data Set service in August 2019 (Skills for Care, 2018). This found that there were 3,900 AMHPs in England, but that only 3,400 were currently practising. There is a shortage of AMHPs in many areas due to the pressures on local authorities to train and support this essential professional group.

There has been significant work to scope the capacity and recruitment pressures on the AMHP workforce with the development of dedicated workforce plan.

There are growing recruitment and retention issues in the AMHP workforce and a need for improved workforce planning nationally and regionally.

The impact of Covid-19 on workforce

The impact of Covid-19 on the workforce is widening gaps within and across sectors Increasing mental health demand on community support is reshaping and depleting the workforce and requiring a focus on community wellbeing in new ways.

The Centre for Mental Health in its review of the mental health impacts of Covid-19 stated that the pandemic is likely to increase, by at least half a million, the number of people experiencing a mental health difficulty. Charities and community organisations nationwide have had to adapt services overnight or offer additional help where demand has increased, and statutory services have become less accessible. Demand is likely to remain high for a long time while opportunities to raise funds will continue to be curtailed.

Social care mental health provision is responding to increasing distress through a wide range of service (crisis houses, crisis cafes, integrated crisis helpline 'front door' for mental health services) which is profoundly shaping how sector skills are being deployed and has significant implications for workforce support and planning in the future.

Turning Point *is a social enterprise that provides health and social care services across England. This includes mental health support, at all stages of the mental health pathway. In 2019/20 their mental health services supported 45,599 people. Of those, the majority (21,100 people) were supported by talking therapies services which offer face-to-face, online, and telephone-based support for people with depression, anxiety, and other common mental*

health issues. A further 1,688 people accessed crisis services which provide a community-based alternative to hospital admission when someone suffers a mental health crisis.

Challenge 1 - Recruitment and retention

Retention and growth of the mental health workforce has been an issue that has persisted for many years. Turning Point has not been shielded from these issues. Staff turnover is 38% in mental health services (Feb 20-Feb 21). This compares to 30% across Turning Point as a whole. The biggest recruitment challenges are:

- *IAPT – There is a national shortage of qualified Psychological Wellbeing Practitioners (PWPs) although the situation is improving.*
- *Turning Point deliver training for PWPs (staff can join as trainees – an entry level role for a psychology graduate) but staff tend to leave at the end of their training to join the NHS.*
- *Recruiting for clinical roles –This is particularly a challenge in substance misuse services compared to specialist mental health services.*
- *Recruiting support workers in particular geographies - this includes areas where there are high levels of employment.*

Challenge 2 – Workforce Wellbeing

During the pandemic referrals to Turning Point's Occupational Health partner and Rightsteps (Turning Point's employee wellbeing arm) increased. Their staff health and wellbeing programme has focussed on anxiety, trauma, resilience, and connection; balanced with the challenge around reach and engagement with what our frontline need. Engagement with staff has been a success factor for us during the pandemic. The health and wellbeing programme includes:

- *Wellbeing Wednesdays - Each Wednesday they focus on a different area of wellbeing for staff.*
- *Wellbeing Webinars - They host fortnightly webinars on a wellbeing theme chosen by staff.*
- *Single Support Sessions - One-off telephone-based session with a fully qualified therapist available to all staff aimed at providing a safe space to talk about anxieties, worries, feelings or reactions in relation to Covid-19.*
- *Routine check-ins as part of Covid-19 risk assessments for all staff.*

Challenge 3 – Training for staff and volunteers

Turning Point found two key challenges regarding the training of their staff and volunteers:

It was found that it was a challenge for staff to find the time to access training particularly where there is no protected learning time due to the limitations of the contract. This is a particular issue in supported living (in people's homes)

They also found that training for peer mentors during the pandemic had been made more difficult. To enable this important training they are in the process of moving the accredited Peer Mentor training programme online.

Challenge 4 – Pay

Turning Point recognises the challenge of pay across the social care sector caused by the limited resources available to local authorities. However, we work to maximise the pay and benefits within the context of these contracts and support efforts to increase pay across the sector as a whole.

The Community Mental Health Framework and development of the social care workforce

The Community Mental Health Framework[1] outlines a strong vision of place-based care in which the role of social care and the voluntary sector are recognised more centrally, especially in community support.

The implication of this for the future development of social care have not been fully considered but it is clear that this will involve a further expansion of the workforce, particularly in providing different levels of wrap-around support, greater flexibility to work in new ways within hubs and teams and greater innovation of community-based services to respond to niche needs.

New planning and partnership structures are being established with areas overseen by Integrated Care System Boards that will work alongside local Health and Wellbeing Boards to plan and develop local health and care services. They will develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level, including the capacity and skills needed for population health. There are expectations that the new framework will convene the breadth of services in more connected ways with a stronger emphasis on prevention, wellbeing, and inclusion.

Some key implications for social care supply and skill development include:

- Expansion of primary care and community facing roles.
- Strengths-based approaches.
- An emphasis on personalised care and self-directed support services.
- Enhancing prevention and wellbeing interventions.
- Niche service provision for communities.

[1] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

- Educative work to upskill and mainstream support in specialist fields such as drugs and alcohol.
- Enhancement of team and system skills.
- Trauma-informed approaches.
- Group work and community support services.
- Social inequality and public health interventions.
- Safeguarding vulnerable adults from abuse (e.g. domestic violence)
- Advocacy skills and support for diverse communities.
- Anti-racist practice and service development.
- Crisis support in communities.

The case for integrated workforce planning

The level and breath of skill mix needed for workforce supply to support the CMHF requires local areas to develop workforce strategies that cross health and social care, paying attention to the interdependencies between the two sectors. Nationally, NHS workforce policy has recognised that current approaches to workforce planning need to be more flexible and integrated but in practice, developments are in their infancy in many systems.

Health Education England developed the workforce plan to underpin transformation plans (Stepping forward to 2020/21: The mental health workforce plan for England) but recognised this primarily addressed NHS-employed staff.

Though there has been recognition of social work as a core profession in the NHS, consideration of the wider role of social work, social care and the voluntary sector is less developed. Research of Councils and NHS Trust partnerships (Social Work for Better Mental Health) suggests opportunities for joint workforce planning, even within mature integrated partnerships, have not been well developed beyond joint training.

There are examples of innovation at local levels that have not been scaled up and the emergent nature of wider ICS planning structures also makes progress challenging. There is a significant role for the social care sector to establish a workforce strategy to inform both national and ICS place-based plans, and to accelerate innovation.

Key issues include:

- Lack of a clear framework for bringing together 'fit for purpose' methodologies for aligning NHS and social care in workforce planning.
- Clearly defining the social care and voluntary sector mental health workforce is difficult and crosses many interfaces and is poorly understood.
- There are innovative examples of new ways of organising the workforce, but insufficient strategic cross-sector investment and shared ownership.
- Government funding arrangements are different across health and care sectors and cause them to travel in different directions with different performance targets and outcomes.
- Historic poor levels of funding of the social care sector has profoundly impacted on investment in learning and workforce functions, and the availability of workforce expertise.

- Limited dedicated or funded investment in learning that enhances the system as a whole.
- The unintended destabilising impact of poorly integrated plans for the workforce across a place. The NHS exists as part of a local labour market and funding investment decisions can destabilise already financially distressed social care providers.
- Costs of new models of care being felt in other part of the system which are not resourced to respond.
- Workforce intelligence is fractured and absent for some parts of the workforce.
- The need for a diversity of approach to workforce development which considers the barriers and strengths of sectors. Unlike the NHS, the social care sector is mostly made up of workers who are not professionally regulated (although highly skilled).
- The need for greater collaboration across social care to harness better its distinctive voice and untapped potential.
- Competing and, sometimes, conflictual NHS versus Social Care operational priorities undermining workforce capacity and retention.

Arrangements for workforce planning

Workforce planning for social care is a complex and dispersed activity taking place at different levels and involving a multiplicity of stakeholders from public, independent, and voluntary sector employers who use different approaches for their own organisational workforce planning. This complexity includes the diversity of employers in the sector, in terms of both size and service area, and the different roles of, and interactions between, commissioners and service providers.

This differs markedly from the NHS landscape and considerable benefit can be gained from a clearer and more consistent approach to workforce planning within the sector, as a platform for innovation and improved alignment within the health and social care system.

There is significant progress with clear strategic national lead roles for the workforce from the Principle Social Work role (in statutory Adult Social Care), Health Education England and Skills for Care but there are many barriers to integrated approaches and it is vital that these are better understood and addressed consistently in shared planning. There also needs to be consideration to the capacity and skills for this type of workforce planning which are underdeveloped in both sectors.

In the NHS, workforce planning is being increasingly devolved to ICS regional and place-based level to enable plans to be more localised and relevant on the ground delivery of plans.[2]

[2] Integrated Care systems are intended to have increased responsibility for workforce planning across several levels:
- developing and managing the local workforce system architecture
- Control of local, long-term funding streams to support system-wide workforce planning, innovation, and collaboration
- Assessing system-wide demand and associated workforce need.
- Managing strategic workforce relationships with local external partners, including universities, colleges, mayors, combined authorities and LEPs.

This highlights the importance of social care using and developing its existing regional infrastructure, e.g. ADASS, the Principle Social Work Network, Skills for Care, and other regional forums to facilitate a stronger presence in strategic workforce planning which can broker the breath of connection across different parts of the sector and with people using social care and community support.

This development could be nurtured through national strategic action to inform and strengthen regional organising. Some key areas for joint development could be:

- Building further on the national strategic links and work under way on integrated planning between Health Education England and Skills for Care with shared development in data and tools for workforce planning.
- Strengthening the strategic leadership of the Principle Social Worker role and social care leadership in mental health to enable impact in ICS workforce developments.
- Creating platforms for sharing workforce and organisational development capacity and skills across local systems.
- Establishing a clear vision for the sector's contribution to new community facing roles and the projected workforce implications for supply and development.
- Clarifying the relationship between different roles in social care especially between the regulated and unregulated workforce e.g. what is the future role of Social Work as leaders in the social care system in relation to other social care roles including new roles such as social prescribing.
- Co-developing system-wide curricula, in association with local learning providers.
- Improved mutual education to better understand each other's roles and facilitate peer learning in addressing population health and community needs.
- Building further on the strategic work of the Principle Social Work network, the Office of the Chief Social Worker, and strategic links on integrated planning between Health Education England and Skills for Care to determine shared developments in data and tools for workforce planning.
- Building support for joint commissioning and shared skill development of commissioners in workforce issues.
- Developing closer links between commissioning and workforce development functions in social care to support innovation.
- Shared action on workforce challenges such as supply and retention.
- Joint action on engaging the full range of social care employers and their direct voice.
- Developing place-based strategies for employee wellbeing and retention.
- Organisational development support to develop the local leadership skill set needed for the range of new 'place-based' relationships.

Data availability and the mental health social care workforce

Health Education England has acknowledged the urgency to act to secure fuller access to data from social care and the voluntary sector. There is already considerable sharing of sector

data with Skills for Care and scope for shared analysis and reporting but further work is needed to make this a practical reality. This would enable the interdependencies of workforce development, and the risks for different parts of the sector to be reported in a systematic way.

Skills for Care provides the main source of data analytics[3] on social care, including the voluntary sector workforce, but this is not routinely disaggregated for mental health and is voluntary. Smaller organisations may not be visible in this reporting but are included in remodelling. For some parts of the workforce intelligence has improved. There has been concerted action across Skill for Care and Department of Health and Social Care to improve data on AMHPs and social work which have benefited from benchmarking and reports on trends.

Health and social care information is collected in different ways, and direct comparison across health and social care is difficult.

It would be helpful to review data availability for different parts of the mental health social care workforce, building on the work underway in strategic bodies; Skills for Care and Health Education England, NHS England and Improvement[4]

Skills Frameworks for system improvement

There have been successive efforts (see the Shared Capabilities Framework) to introduce cross-sector skills frameworks for mental health across the mental health workforce, but these have not been effectively implemented or resourced. Better cross-sector engagement with a shared skills framework in mental health would be an important first step in promoting the cultures for integrated practice and planning (see 'The Mental Health Core Skills Education and Training Framework', Skills for Care, Skills for Health, NHS England).[5]

A further promising development is a trauma-informed practice framework[6] which speaks to the diversity of roles and values across health and social care and promotes consistent cross-sector mental health education and training.

Skills development frameworks hold promise for promoting new ways of working but similarly need to be better informed about the context for social care and resourced.

[3] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/adult-social-care-workforce-data.aspx

[4] Key areas to address are: the numbers of people they employ and what they do; current deployment of staff; past trends and anticipated changes; what skills the workforce has and where there are gaps; what skills and staff will be needed to deliver future services and priorities; demand – the needs of the populations served; the intensity of care needed and the demand for different kinds of services; the financial resources available; and the availability, productivity and skill level of staff.

[5] https://www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/mental-health/Mental-health.aspx

[6] https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/social-workers/developments-whole-system-approaches-support-trauma-care

The untapped potential of social care for transformation of mental health services

A major obstacle for the development of the social care workforce in transformation planning is the partial understanding of its contribution to mental health. This must form a key starting point for building a new culture for effective workforce support.

Such educative work in the sector itself requires investment in learning not only for the NHS but across social care. There has been a strong national strategic focus through the Principle Social Worker Network and the Office of the Chief Social Worker to bring greater focus on the support of the social care workforce and the development of strengths-based approaches. There is also considerable scope for different parts of social care to align their work, for instance within communities, into a more coherent public health approach.

Social care and support contributes to mental health in multiple ways and is not a homogeneous group, but includes a range of attributes, capacities, and skills with distinct features which enable them to make significant contributions to health and wellbeing.

It is useful to differentiate levels of impact and contribution including:

- The wellbeing and prevention impacts, which flow from social care work in a wide range of context and activities. This may not even be recognised as mental health work but clearly has public health and prevention impact.
- Social care in the context of the provision of specialist mental health care and interventions within secondary care services.
- The development and growth of the digital agenda with specific reference to technologically enabled care services and virtual care options.
- Social care with a remit for mental health in non-specialist services such as schools and primary care.

There has been significant scoping and explication of the social work and voluntary sector role, and its relational and strengths-based approach (see also Health Education England Guidance on the Social work Role/National survey of the voluntary sector role in crisis). How can we use this new intelligence to better inform workforce development and investment priorities?

Key areas of contribution:

- Crisis support.
- Community engagement and support.
- Targeted support for different peoples' needs such as racialised communities, veterans, LGBT groups, or those having experienced domestic violence.
- Localised personalised care.
- Safeguarding vulnerable adults
- Digital solutions
- Carers' support
- User-led approaches.
- A bridging link to communities and commitment to helping marginalised groups over the longer term.
- Prevention, early intervention, and wellbeing services.
- Advice and counselling services.
- Anchoring and community leadership.
- Signposting to, and working in, partnership with other voluntary sector

organisations to provide individually tailored support.
- Advocacy.
- Inclusion and community cohesion.
- Specific services e.g. employment / housing.
- Housing support
- Group and peer support.
- Specialist advice and practice.
- Supported living

This paper was developed by Karen Linde on behalf of the Association of Mental Health Providers' Mental Health and Wellbeing Policy and Oversight Group. With thanks to the Group for their advice and support.

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