Case Study 2: Essex, Thurrock and Southend – Early stage pilot for two key workers who act as coordinators and 'enforcers'

Overview

A new pilot scheme developed in 2019 and in place from February 2020 which will introduce two key workers across Essex, Southend and Thurrock, covering the whole Transforming Care Partnership of 7 CCGs ad 3 Local Authorities.

The key workers will provide a **coordinator** role, pulling together different services to ensure joined up provision and support for young people to remain in the community, where possible, and to have a smooth, supported discharge from inpatient settings. Keyworkers will sit on CETRs for vulnerable children and young people, and work to ensure the recommendations from these CETRs are being implemented. The service is for young people who are red or amber-red on the risk of admission register.

Whilst the role is new for children and young people, the area has had an equivalent role for adults with autism and/or learning disabilities for two years. This adult role is well regarded and has been linked to a significant reduction in admissions in inpatient services.

The service runs 9-5 Monday – Friday and is not a crisis service.

The **caseload** per key worker will be around **20,** with an average of 40 young people across the service. This is based on the total number of children and young people who are current inpatients (between 10-12) as well as those amber and red on the risk register (around 30 at any time), and is focused on a small number of young people who will most benefit from the service. This was based on assessments of realistic capacity for each key worker, but there is flexibility to change as the role develops if this proves necessary.

Role functions

- Primarily concerned with coordinating different teams and services around each young person
- An 'enforcer' – ensuring agencies are doing what they are supposed to, holding systems to account, challenging
- Problem solving, finding solutions
- Advocating for children and young people and their families
- Limited face-to-face work with families but the keyworkers would be the point of contact for families when things are not working as they should
- Holding up a mirror to local services, highlighting where and how they can be working better

Person specification and banding

Required skills and experience:

- Strong experience of children's mental health services and children's social care and education – ideally this would be in one person, but the LA recognise that this breadth (along with the necessary depth and authority) may not come from one person, so have planned to **recruit one key worker with predominantly MH experience and the other with a complex social care background** as the best way to ensure the right skill mix across the key worker service
- Experience and confidence to challenge services and hold them to account.
- Problem solving skills

The key workers can be recruited from either health or social care sector: the job description was sent to LAs and to NHS providers. The key worker **banding is Band 8a** in NHS scales or a senior social worker post. The area felt it was important for it to be a senior post so it had authority to challenge and hold services to account.

Team structure and management

The role sits within a jointly funded Learning disabilities and autism commissioning team.

> "This was something we thought about a lot... Our experience is that if you put the person within a CAMHS team then social care just perceive it to be a CAMHS function and won't engage, and if you put it in a social care team then CAMHS or health will perceive it as a social care function and they won't engage. So the role has to have the ability to sit over both"

Those interviewed were keen to ensure the keyworker service did not feel like an NHS initiative but felt owned by all parts of the system and role location was key to this.

Referrals/eligibility

Referrals for the service are open to all children and young people who are inpatients under Transforming Care criteria, as well as those who are amber-red and red on the Risk of Admission register.

Key workers will work with these young people at any stage of the pathway, whether during admission, inpatient stays, discharge or in the community and will engage in preventative work. Referral will usually be triggered when the young person is flagged on the risk register.

Interaction with registers

Children and young people are referred for keyworker support on the basis of risk registers. While keyworkers are not involved in *admitting* to the risk register, as this is maintained by CCGs, they are closely linked to them and also work alongside the CETR process to ensure that the recommendations of the reviews are happening and that the right support is in place.

Handover

The length of intervention is based on achieving the identified outcomes: "We see it very much as a task and finish activity." Keyworkers must ensure the right team and support network is in place and working well before they withdraw support.

Referrals back to the keyworker can be made during the 3-monthly CETR meetings which would also determine the level of involvement needed.

Responding to local context

This area spent around two years exploring the factors leading to admission, and found that a **lack of coordination between different teams** and services was a key reason for inpatient admittance or extended stays. They observed that by the point of admission, young people often have a high number of different professionals and services involved in their care but that coordination and communication between them could be very poor. Similarly, CETRs were well attended by a range of professionals but the recommendations from them were often not being actioned. Therefore, what was most needed was someone to coordinate these different teams to ensure they were working together and providing the proper support.

> "The key thing that was missing, and what will make the biggest difference, is someone that will coordinate services, sit on cases, problem solve and sort things out across agencies."

Direct face-to-face work with young people and their families often already happens through other services, for example through social workers, care coordinators or CAMHS involvement and they were wary of duplicating existing services. The area are exploring whether there is a need for an additional role with more face-to-face work in the future for those young people who do not already have face-to-face support from social workers or other professionals, however this was not seen as the key gap in provision.

Essex, Southend and Thurrock already has a good CETR process and strong risk registers, so wanted the keyworker service to link to these and build on them. Likewise, there are existing local resolution groups for health and social care to discuss at-risk cases and good jointly commissioned teams, which means there are existing multi-agency communication channels and support in the system for a new role which will sit across services.

System requirements and what works well

- The keyworker role has to fit within local systems and processes and support what already exists

  "To an extent, this is about supporting processes that are already in place rather than trying to take over or replicate what is there. Some of this is about **making what is already in place work better**"

- Recruiting from across health and social care to ensure the right skills mix within the service
- Sitting above different teams, being jointly owned by different parts of the system rather than seen as a health function
- Managing expectations, being clear about the purpose and limits of the role from the beginning so it is not expected to solve all problems, fill all gaps
- Taking the time to build strong relationships across health, social care, education teams will be vital to the success of the role

Impact

This is a new service for children and young people, so no impact measurement information is available yet.

In adult servicers however, the equivalent role has had a positive impact, and has been linked to a reduction in the length of average admission from 4 ½ months to 2, and a reduction in the number of inpatients from 76 to 41. There have also been qualitative changes, for example culture change around admissions, with very direct questions now being asked about what the purpose of admission is and how it would achieve its stated aims.